NAVAL MEDICAL CENTER SAN DIEGO
THE PRIDE OF NAVY MEDICINE

BARIATRIC PROGRAM

PREVIOUS BARIATRIC SURGERY HEALTH QUESTIONNAIRE
(PLEASE PRINT CLEARLY)

PERSONAL INFORMATION

Name: _____Date: _____

Sponsor's SSN# _____-_____-_____ Date of Birth: _____ Age: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Mobile Phone: _____ Home Phone: _____

Work Phone: _____ Email Address: _____

Marital Status: Single Married Divorced Widowed **Gender:** Male Female

Occupation: _____ How many hours a week do you work? _____

Number of Children: _____ **Ages of Children:** _____

Do you care for elder relatives? _____Who_____What is your involvement in the care? _____

Who lives with you? _____

Primary Language Spoken _____ Primary Language Reading _____

***PLEASE DO NOT COMPLETE THIS SECTION** COMPLETED BY PROVIDER AT TIME OF CONSULTATION*

HEIGHT	WEIGHT	IDEAL BODY WEIGHT	EXCESS BODY WEIGHT	BMI

BODY FRAME: Small Medium Large Waist: _____INCHES Hip: _____ INCHES

B/P _____ P _____ R _____ Neck circumference _____ INCHES

NAME:	SPONSOR'S SSN#:	DOB:

PERSONAL MEDICAL HISTORY: Do you have or have you ever had any of the following: Check/circle all that apply

CARDIOVASCULAR	Y	N	Do Not Know	GASTROINTESTINAL	Y	N	Do Not Know
Heart Disease				Do you experience heartburn or reflux?			
MI (Heart Attack)				How many times per week?			
Abnormal EKG				Do you take anti-reflux medications?			
				History of moderate or severe postoperative nausea and/or vomiting?			
Have you ever had a Stress Test?				**URINARY**			
Have you ever had an echocardiogram?				Difficulty with urination?			
High Blood Pressure				Frequent Bladder infections?			
High Cholesterol				Stress Incontinence?			
Do your legs or ankles swell easily?				Kidney disease or stones? If yes, please circle			
List reason for stress test/echo:				**GYNECOLOGICAL**			
ENDOCRINE				Last menstrual period: History of Heavy Periods: Y/N			
Do you have Diabetes?				Number of pregnancies: Miscarriages:			
Average daily blood sugars:				Number of birth(s):			
Do you take oral medications for diabetes?				Last mammogram: Date:			
Do you use Insulin or Pump?				Was it normal?			
Do you have Hypothyroidism?				Last PAP Exam: Date:			
Do you have Hyperthyroidism?				Are you taking hormones? (Birth Control or Hormone Replacement Therapy)			
Any personal history of serotonin syndrome?							
RESPIRATORY				**HEMATOLOGICAL**			
Do you have COPD?				Do you have a bleeding abnormality?			
Do you have Asthma?				If so, describe:			
Do you take oral medications or inhalers for Asthma?				Have you ever had a blood transfusion?			
Do you have shortness of breath?				If so, reason:			
How far can you walk before feeling short of breath?				History of **blood clots**, such as DVT or Pulmonary Embolism or Hypercoaguable State? If yes, please circle			
Do you currently smoke?				Date & Treatment:			
If yes, how much per day?				Family history of DVT?			
Do you have Obstructive Sleep Apnea? Y N				**MUSCULOSKELETAL**			
Do you use a C-PAP or Bi-PAP device?				Low Back or Hip Pain?			
PSYCHOLOGICAL				Knee, Ankle or Foot Pain?			
Depression				Which side? Right or Left or Both			
Panic Attacks				Have you seen an Orthopedic Surgeon for any of the above conditions?			
Anxiety				Have you had surgery for any of the above conditions?			
Bi-polar Disease				Is orthopedic surgery pending weight loss?			
Obsessive Compulsive Disorder				**INFECTIOUS DISEASES**			
Currently seeking Mental Health Therapy?				HIV/AIDS diagnosis/exposure?			
				Hepatitis			

NAME:	SPONSOR'S SSN#:	DOB:

LIST CURRENT AND PAST MEDICAL HISTORY: (IF NONE, PLEASE WRITE, N/A)

DATE	MEDICAL DIAGNOSIS

LIST PAST SURGICAL HISTORY: (IF NONE, PLEASE WRITE, N/A)

DATE	TYPE OF SURGERY

LIST ANY HOSPITALIZATIONS: (IF NONE, PLEASE WRITE, N/A)

DATE	ILLNESS	TREATMENT

NAME:	SPONSOR'S SSN#:	DOB:

LIST ALL PRESCRIPTION MEDICATIONS: (IF NONE, PLEASE WRITE, N/A)

MEDICATION	DOSE	FREQUENCY

LIST ALL NON-PRESCRIPTION MEDICATIONS: (IF NONE, PLEASE WRITE, N/A)

MEDICATION	DOSE	FREQUENCY

ALLERGIES:

Allergies to any Medications: Yes No
Allergies to any Foods: Yes No
Allergic to Latex: Yes No
List allergies: _____

Surgical tape: Yes No Type: _____

Steri-Strips: Yes No **DermaBond Glue**: Yes No **Iodine**: Yes No

NAME:	SPONSOR'S SSN#:	DOB:

BARIATRIC SURGERY HISTORY:

Date of Bariatric Surgery: _____

Type of Surgery: _____

Any Complications? _____

If Lap Band placement: What type? Allergan Lap Band or Ethicon Realize Band. What size? AP Standard or AP Large

Last Band Fill date?_____ Total fluid in Band? _____

Where was Surgery performed? _____

Name of surgeon? _____

Phone number of Facility where surgery performed? _____

Please have Facility fax all you medical records including pre-op evaluations, surgical report and post-op evaluations to NMCSD Bariatrics to 619-532-7673

What was your Pre-op Weight?_____

Total Weight Loss since your surgery?_____

What is your daily protein intake in grams? _____What type of Protein do you drink? _____

SOCIAL/FAMILY HISTORY:

Is there Obesity in your family? Yes No Who: _____

Are there any medical illnesses in your family? Yes No If so, what: Diabetes Hypertension Coronary Artery Disease

Other _____

Do you exercise regularly? Yes No If yes, what do you do? _____

Do you have any physical restrictions that keep you from exercising? ☐ Yes ☐ No Explain? _____

_____

SMOKING/ALCOHOL/DRUG HISTORY:

Do you smoke now? Yes No **Have you ever smoked cigarettes/cigars? Yes No**

If yes, how much did you smoke per day? _____ **If yes, when did you quit? _____**

Did you drink alcohol? Yes No What type of alcohol do you consume? _____

Do you drink more than 5 drinks per week? Yes No Less than 5 drinks per week? Yes No

Have you or are you currently using any recreational/illegal drugs? Yes No

Explain: _____

NAME:	SPONSOR'S SSN#:	DOB:

PLEASE LIST ALL YOUR CURRENT MEDICAL PROVIDERS:

SPECIALTY	NAME of PROVIDER	ADDRESS or EMAIL ADDRESS	PHONE & FAX NUMBERS
PRIMARY CARE/ INTERNAL MEDICINE			
CARDIOLOGIST			
PULMONARY SPECIALIST			
ENDOCRINOLOGIST			
PSYCHOLOGIST/ PSYCHIATRIST			
ORTHOPEDIC SURGEON			
BARIATRIC SURGEON			
OB/GYN			
PAIN MANAGEMENT SPECIALIST			

Signature: _____Date: _____

PLEASE HAVE QUESTIONNAIRE COMPLETED AT THE TIME OF YOUR BARIATRIC INFO SESSION APPOINTMENT AT THE GENERAL SURGERY CLINIC BLDG. 3, DECK 4.
CALL CLINIC FRONT DESK FOR QUESTIONS: 619-532-7576

Please note that your information will not be reviewed if this form is Incomplete at time of your appointment!

NAME:	SPONSOR'S SSN#:	DOB: