

The Bariatric Center at Albany Medical Center History Form

Thank you for your interest in the Bariatric Surgery program at Albany Medical Center.

Enclosed is a Personal History Form, please **complete it as thoroughly as possible** and bring it to your appointment.

Your Insurance Coverage:

Insurance Plan: _____

Insured's Name: _____

Insurance Number: _____

Group Number: _____

Effective Date of Insurance: _____

Address/Phone of Insurance Company: _____

(when possible please send copy of front and back of card)

Your Employment:

Employer Name: _____

Employer Address: _____

Employer Phone: _____

Patients Signature: _____ Date: _____

If you have any questions regarding completing these forms, please contact us at (518) 262-0942.

We look forward to working with you to make your life healthier and happier.

Sincerely,
The Bariatric Center Staff
2/10/09

The Bariatric Center at Albany Medical Center Hospital

PERSONAL DATA SHEET	
Your Name	
Mailing address, City, State & Zip	
Home Phone	
Work Phone	
Cell Phone	
Social Security Number	
Date of Birth	
Maiden Name (if applicable)	
Emergency Contact Name & cell phone #	
Health Care Proxy Name & Phone #	
RACE - circle	Hispanic, white Hispanic,black Hispanic, color unknown Black, not of Hispanic origin White, not of Hispanic origin American Indian or Alaska native Asian or pacific islander unknown
Your Physicians	
Primary Care Physician	
Address	
Office Phone	
Office Fax	
Clinical Nutrition Physician	
Other Physicians	
Specialty	
Name	
Address	
Office Phone	
Office Fax	
Specialty	
Name	
Address	
Office Phone	
Office Fax	
Address	
Specialty	
Name	
Address	
Office Phone	
Office Fax	
Address	

PERSONAL WEIGHT LOSS HISTORY				
YOUR NAME				
CURRENT HEIGHT			Was this MEASURED?	Yes or No
CURRENT WEIGHT				
Lowest weight while dieting & how long maintained?			Highest weight?	
	Underweight	Normal	Obese	Weight (lbs)
Pre-school				
Elementary school				
High school				
20s				
30s				
40s				
50s				
Personal Weight Loss Attempts <i>List dates, and how long it took</i>	Lbs. Lost		Supervised Weight Loss Attempts <i>List dates and how long it took</i>	Lbs. Lost
Body for Life – Bill Phillips			Diet Pills from MD	
Gloria Marshall			Diet Shots from MD	
Health Spa			Diet Center	
Dr. Phil			Overeaters Anonymous	
Richard Simmons			Optifast	
Low Carbohydrate			Weight Watchers	
Low Fat			HMR – Health Management	
Calorie Counting on my own			Resources	
Pritikin			Nutri-Systems	
Mayo Clinic			T.O.P.S.	
Scarsdale			Jenny Craig	
Stillman			New Direction	
Sugar Busters			National Weight Loss	
Slim Fast			Supervised Calorie Counting	
High Protein - other			Diet by Health Professionals	
Atkins			LA Weight Loss	
South Beach Diet			OTHER	
The Grapefruit Diet			OTHER	
Cabbage Soup Diet			OTHER	
Hypnosis			OTHER	

Please do not leave this area blank.

THIS INFORMATION IS NEEDED FOR PRE-SURGICAL CERTIFICATION.

MEDICATIONS FOR WEIGHT LOSS			
MEDICATION and date used	POUNDS LOST	MEDICATION and date used	POUNDS LOST
Acutrim		Obalan	
Adipex-P		Orlistat	
Amphetamines		Phendiet	
Anorex		Phentermine	
Benzphetamine		Phentrol	
Dexatrim		Plegine	
Dexfenfluramine		Pondimin	
Didrex		Redux	
Ephedra		Sanorex	
Fastin		Stacker II	
Fenfluramine		Tepanol	
Ionamin		Tenuate	
Mazanor		Wehless	
Meridia		Xenical (alli)	
OTHER medications not listed:			
Have you ever used the following methods FOR WEIGHT LOSS PURPOSES	Y/N	WHEN?	
TYPE			
Vomiting			
Fasting			
Water Pills			
IPECAC			
Laxatives			
Diet Pills:			
Prescription			
Over the Counter			
Excessive Exercising			
Extreme Food Restrictions			
Weight Loss Surgery Information Questions			
Do you know anyone that has had gastric bypass surgery?			Yes or No
Have you been to a support group for weight loss surgery?			Yes or No
Which Surgery are you thinking about?			Bypass <u>or</u> Band
What is your motivation for surgery?			
How did you find out about us?			

YOUR EATING HABITS	
Do you have an eating disorder	Yes or No
Do you binge eat	Yes or No
Are you a stress eater	Yes or No
Do you eat when you are bored	Yes or No
Are you addicted to certain foods	Yes or No If yes what?
Do you eat large meals	Yes or No
Do you eat much more rapidly than normal/others	Yes or No
Do you eat large amounts of food when not feeling physically hungry	Yes or No
Do you feel disgusted, depressed or guilty after overeating	Yes or No
Do you graze or snack throughout the day	Yes or No
How many meals do you eat each day	
How many snacks per day On what types of food	
Are you often hungry	Yes or No
How many meals do you eat out per week Include breakfast, lunch and dinner	
Do you wake up at night to eat	Yes or No
How much, what do you eat	
How Often/Week	
Do you need to eat in order to fall back asleep	Yes or No
Do you have a lack of appetite in the morning	Yes or No
Any special diet program now? (vegetarian, celiac, diabetic etc)	
LIST EVERYTHING YOU EAT IN A TYPICAL DAY CURRENTLY	
Breakfast	
Lunch	
Dinner	
Snack	
Liquids	
EXERCISE	EXERCISE
Do you exercise now?	Yes or No
Type of exercise:	
Amount of time:	
# of days/week:	
Do you have access to a Gym?	Yes or No
Did you exercise in the past?	Yes or No
If yes what type?	
Do you have limitations to exercise?	Yes or No
Did you need physical therapy?	Yes or No

SOCIAL ISSUES AND HABITS	
Are you currently working <u>If not, circle reason:</u> Unemployed retired disability: when _____ Reason: _____	Yes or No
Do you require assistance with activities of daily living <u>If YES, you are:</u> Partially dependent totally dependent	Yes or No
What is your occupation	
Does it require physical activity What kind	Yes or No
Is your job stressful If so, what kind of stress	Yes or No
Do you have a supportive person you can talk to Person's Name and their relationship to you	
What is your marital status (circle)	Single in a relationship married divorced separated widowed
Do you live with anyone	
What is the highest level of education you have completed	
Do you consume alcohol If so, how much:	Yes or No
Have you consumed alcohol in the past? If yes, how much	Yes or No
Have you had a problem with alcohol abuse, currently or in the past	Yes or No
Do you currently smoke	Yes or No
Have you every smoked	Yes or No
Tobacco use: What type of product: How many packs per day: How long: When did you quit:	> 1 year or < 1 year
Do you use any recreational drugs? Currently or in the past? How often: When was the last use: Which drugs: Any IV drug use	Yes or No Yes or No
Do you have any other habits or addictions? (Gambling, compulsive shopping etc)	Yes or No
Have you ever been physically abused?	Yes or No
Have you ever been sexually abused?	Yes or No
Have you ever gone through counseling for any reason? <u>If YES, is this current?</u> Please list reason:	Yes or No
Have you ever been hospitalized for depression/anxiety or any other psychological reason?	Yes or No

FAMILY HISTORY SHEET

Please answer and check off the boxes that apply to your family history

	Alive	Deceased	Age	Cancer (what type)	Diabetes Yes or No	Blood clot (where)	Stroke Yes or No	Heart Disease Heart Attack	Obesity	Other
Mother										
Father										
Siblings										
Siblings										
Siblings										
Siblings										

Currently or in the past	Y/N	IF YES, PROVIDE REASON
CARDIAC:		
Heart attack (MI)		
Stenting to heart or angioplasty		
Heart surgery		
Valve problems		
Arrhythmias		
Chest Pains or tightness		
Racing Heartbeat		
Skipping Heartbeat/palpitations		
High Blood Pressure > 140 SBP or > 90 DBP		
Medication for high blood pressure? How many?		
Shortness of Breath At rest? With exercise?		
High Cholesterol		
High Triglycerides		
Cholesterol medications at any time		
ENDOCRINE:		
Diabetes Mellitus (Type 1&2)		
When was it first diagnosed		
Are you on pills for it		
Are you on insulin for it		
Hypoglycemia (low blood sugar)		
Thyroid Problems		
Abnormal blood calcium level or parathyroid gland problem		
Osteoporosis or osteopenia		
Chronic steroid use for any reason		
Taking immunosuppressants		
GASTROINTESTINAL:		
Previous weight loss surgery		
Surgery to stomach, esophagus, duodenum or pancreas		
Pancreatitis or pancreas problems		
Fatty liver		
Liver problems		
Hepatitis		
Gallstones diagnosed by imaging		
Surgery to remove gallbladder		
Heartburn (reflux/gerd): How often do you have heartburn Do you take medication for it Have you had a stomach ulcer		
Stomach or intestinal bleeding		
Polyps in your colon Were they removed		
Chronic diarrhea or constipation		

RESPIRATORY SYSTEM:	
Asthma? Mild moderate severe	Yes or No
COPD or emphysema? Mild moderate severe FEV1? _____ Do you use inhalers Have you been hospitalized for this Are you disabled from it	Yes or No Yes or No Yes or No
Bronchitis	Yes or No
Pneumonia	Yes or No
Blood clots in Lungs (pulmonary embolism)?	Yes or No
SLEEP APNEA QUESTIONS:	
Do you snore	Yes or No
Do you ever stop breathing during sleep	Yes or No
Do you wake up with headaches	Yes or No
Do you fall asleep regularly while reading	Yes or No
Do you have heartburn/reflux while sleeping	Yes or No
Do you have difficulty falling asleep or staying asleep	Yes or No
Are you tired during the day	Yes or No
Use CPAP or BIPAP? list your settings:	Yes or No
Do you use oxygen at night	Yes or No

MUSCULOSKELETAL SYSTEM:	
DEGREE OF PAIN 1-10 (10 being the worst)	
Location	
Hip	
Knee	
Ankle	
Feet	
Back	
Neck	
Any injuries to your joints	Yes or No
Do you use a mobility device If so, what:	Yes or No
Limitations in activity because of joint pain	Yes or No
Do you have arthritis	Yes or No
Do you use anti-inflammatory or pain medication	Yes or No
Have you had a joint replacement	Yes or No
Do you need a joint replacement	Yes or No
Do you have swelling in your legs or feet	Yes or No
Do you have varicose veins	Yes or No
Do you have ulcers of the leg	Yes or No
Do you have poor circulation in your legs	Yes or No
Do you wear compressive stockings	Yes or No
Do you have reddish/brown skin changes on your legs	Yes or No

FOR WOMEN ONLY:	
Have you had trouble conceiving/infertility	Yes or No
Have diabetes during your pregnancy	Yes or No
How many pregnancies have you had	
How many children have you delivered	
Number of miscarriages	
Are you still menstruating	Yes or No
Are you in menopause	Yes or No
Had surgery to remove your ovaries or uterus	Yes or No
Do you experience any pain with your period	Yes or No
Do you have irregular periods	Yes or No
Do you have polycystic ovarian syndrome	Yes or No
<i>When</i> was your last PAP smear	
Any abnormal PAP smears	Yes or No
<i>When</i> was your last mammogram	
Any abnormal mammograms or need for breast biopsy	Yes or No
Are you on estrogen or birth control pills	Yes or No
Do you plan on becoming pregnant in the future	Yes or No