

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 return it to the following address:

Albany Medical College Bariatric Center
47 New Scotland Avenue
Mail Code 61GE
Albany, NY, 12208-3479

The forms may also be faxed to 518-262-6081.

Or bring the **completed form** to your next appointment if you were unable to complete it at your initial 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

10/08/2007

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	
Emergency Contact Phone	
Emergency Contact Cell Phone	
Health Care Proxy Name & Phone #	
Your Physicians	
Primary Care Physician	
Address	
Office Phone	
Office Fax	
Clinical Nutrition Physician	
Name	
Address	
Office Phone	
Office Fax	
Other Physicians	
Specialty	
Name	
Address	
Office Phone	
Office Fax	
Specialty	
Name	
Address	
Office Phone	
Office Fax	
Specialty	
Name	
Address	
Office Phone	

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?	
Weight History	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		
High Protein		Overeaters Anonymous		
Hypnosis		Optifast		
Low Carbohydrate		Weight Watchers		
Low Fat		HMR – Health Management		
Calorie Counting on my own		Resources		
Pritikin		Nutri-Systems		
Richard Simmons		T.O.P.S.		
Scarsdale		Jenny Craig		
Stillman		New Direction		
Sugar Busters		National Weight Loss		
Slim Fast		Supervised Calorie Counting		
Mayo Clinic		Diet by Health Professionals		
Atkins		LA Weight Loss		
Dr. Phil		OTHER		
The Grapefruit Diet		OTHER		
OTHER		OTHER		

Please do not leave this area blank.
This information is important for your surgical pre-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	
OTHER medications not listed:			
Have you ever used the following methods for weight loss?		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	
Are you a stress eater or eat when 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?	Yes or No
Do you eat large amounts of food when not feeling physically hungry?	Yes or No
Do you feel disgusted with yourself, 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 during the day?	Yes or No
Do you wake up to eat?	Yes or No
How much?	
How Often/Week?	
Do you need to eat in order to fall back asleep?	Yes or No
Are you following any special diet program now? Please list: (celiac, vegetarian, diabetic etc...)	
LIST EVERYTHING YOU EAT IN A TYPICAL DAY CURRENTLY	
Breakfast	
Lunch	
Dinner	
Snack	
EXERCISE	EXERCISE
Do you exercise currently?	Yes or No Type of exercise: Amount of time: Days a week: Do you have access to a Gym?
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?

SOCIAL ISSUES & HABITS	
Are you currently working? If not, provide reason	Yes or No
What is your occupation?	
Does it require physical activity? What kind?	
Is your job stressful? If so, what kind of stress?	
Do you have a supportive person you can talk to? Person's Name and what is their relationship to you?	
What is your marital status?	
Do you live with anyone?	
What is the highest level of education you have completed?	
Do you consume alcohol? If so, how much?	
Have you consumed alcohol in the past? If yes, how much?	
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 much? How long? When did you quit?	
Do you use any recreational drugs? Currently or in the past?	Yes or No
How often do/did you use recreational drugs? How recently? Which drugs?	
Do you have any other habits? (Gambling, compulsive shopping etc)	
Have you ever been physically abused?	
Have you ever been sexually abused?	
Have you ever gone through counseling for any reason? Is this current? Please list reason:	

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	Eating Disorder or obesity	Other
Mother										
Father										
Siblings										
Siblings										
Siblings										
Siblings										

ISSUE	Y/N	IF YES, PROVIDE REASON
CARDIAC:		
Heart Problems		
Chest Pains		
Chest Tightness		
Racing Heartbeat		
Skipping Heartbeat		
High Blood Pressure		
Shortness of Breath		
While Resting?		
While Exercising?		
High Cholesterol		
High Triglycerides		
ENDOCRINE:		
Diabetes Mellitus (Type 1&2)?		
When was your diabetes first diagnosed?		
How long have you taken pills?		
How long have you taken insulin		
Hypoglycemia (low blood sugar)		
Thyroid Problems (Requiring medication)		
GASTROINTESTINAL:		
Do you have fatty liver?		
Do you have gallstones diagnosed by ultrasound?		
Have you had your gallbladder removed?		
Stomach Ulcers:		
Have you taken medication for ulcers?		
Heartburn:		
How often do you have heartburn?		
Do you take medication for it?		
Have you ever had bleeding from your stomach		
or intestines?		

RESPIRATORY SYSTEM:	
Asthma	Yes or No
Bronchitis	Yes or No
Pneumonia?	Yes or No
Blood clots in Lungs?	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
Do you use CPAP or BIPAP?	Yes or No
Please list your settings:	

MUSCULOSKELETAL SYSTEM:	
DEGREE OF PAIN 1-10 (10 being the worst)	
Location	
Hip	
Knee	
Ankle	
Feet	
Back	
Neck	
Did you have any injuries to your joints?	Yes or No
	If yes, describe:
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
KIDNEY & BLADDER	
Do you spill urine while laughing or coughing?	Yes or No
Have you had frequent bladder infections?	Yes or No
Have you had frequent kidney infections?	Yes or No
Have you had kidney stones?	Yes or No
Do you have a problem with your kidney function?	Yes or No

NEURO-PSYCHIATRIC:	
Depression or Anxiety?	Yes or No
Because of Obesity?	Yes or No
Do you have any other mental health issues?	Yes or No
History of suicidal thoughts?	Yes or No
History of self harming?	Yes or No
Hospitalization for psychiatric illness?	Yes or No
Seizures?	Yes or No
Severe Headaches?	Yes or No
Visual Problems?	Yes or No
Do you use glasses or contacts?	Yes or No
BLOOD:	
Have you ever had a bleeding problem?	Yes or No
Have you ever had bleeding after surgery?	Yes or No
Have you ever had a blood clot in your leg?	Yes or No
Do you take medication to thin your blood?	Yes or No
Have you ever had a blood transfusion?	Yes or No
Any other blood related problem?	Yes or No
HAD ANY OF THESE TESTS?	When?
PSA or blood work for prostate	
Colonoscopy	
Heart Catherization	
Echocardiogram	
Stress Test	
MRIs	
CT scans ("cat scans")	
Xrays	
Ultrasounds (liver, gallbladder)	

FOR WOMEN ONLY:	
Have you had trouble conceiving?	Yes or No
Did you have diabetes during your pregnancy?	Yes or No
How many pregnancies have you had?	
How many children have you delivered?	
Do you experience any pain with your period?	Yes or No
Do you have irregular periods?	Yes or No
<i>When</i> was your last PAP smear?	
Abnormal PAP smears?	Yes or No
<i>When</i> was your last mammogram?	
Are you on estrogen or birth control pills?	Yes or No
Do you plan on becoming pregnant in the future?	Yes or No