

Michigan Bariatric Surgery Center of Excellence, P.C.

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INFORMATION ABOUT YOU

Name		Home Phone ()	
(First) (Middle) (Last)		Work Phone ()	
Home Address		Mobile No. ()	
Employed? <input type="checkbox"/> Yes (if Yes, please provide address below) <input type="checkbox"/> No		Alternate No. ()	
Nature/Type of Employment Activity		Alternate No. (2) ()	
Please explain how you found out about us			
Date of Birth (mm/dd/yy)		Social Security No. - -	
Age		Height _____ ft _____ in	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Current Weight _____ lbs	
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Other _____		B M I (Body Mass Index)	
Do you have Children? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, how many? _____		Do you have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Name of Company _____	

INFORMATION ABOUT YOUR SUPPORT PERSON

Name of Support Person		Home Phone ()	
(First) (Middle) (Last)		Work Phone ()	
Home Address		Mobile No. ()	
Work Address		Alternate No. ()	
How is your support person related to you?		Alternate No. (2) ()	

INFORMATION ABOUT YOUR PRIMARY CARE PHYSICIAN

Primary Physician's Name:	<input type="checkbox"/> M.D. <input type="checkbox"/> D.O.
Primary Physician's Office Address	Telephone: ()

MEDICAL HISTORY

Have you ever been told that you have gallstones? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been diagnosed with diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been diagnosed/treated for high blood pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you lose small amounts of urine with coughing or straining? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you experience heartburn? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you snore? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you experience back pain? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have daytime sleepiness? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever experienced chest pain or angina pectoris? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have morning headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a heart murmur? <input type="checkbox"/> Yes <input type="checkbox"/> No	In the past year, has anyone told you that you hold your breath for a long time while asleep? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had palpitations/arrhythmia? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been diagnosed or treated for asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what type of medication was prescribed? <input type="checkbox"/> Inhaler <input type="checkbox"/> Oral Medications <input type="checkbox"/> Steroids
Year and month of your last EKG: _____ Is it your understanding that this EKG was normal? <input type="checkbox"/> Yes <input type="checkbox"/> No	Year and month of your last chest x-ray: _____ Is it your understanding that this chest x-ray was normal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a heart attack? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had hepatitis or liver problems? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had blood clots or phlebitis (inflammation in leg veins)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever experienced tarry black stool or blood in the bowel movements? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you experience joint pain? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please indicate what type of joint pain: <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> Other (Specify) _____	Have you ever been diagnosed as having stomach or intestinal ulcers or other disorders of the gastrointestinal systems? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please explain: _____
Have you ever had trouble sleeping? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you ever wish you were dead and away from it all? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you usually feel tired? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever contemplated or attempted suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you sometimes feel depressed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you often feel anxious or nervous? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever suffered from Anemia? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had thyroid problems? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever received a blood transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever received hormone therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been abused? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please mark below the type(s) of abuse: <input type="checkbox"/> Physical <input type="checkbox"/> Mental <input type="checkbox"/> Sexual	
WOMEN: Date of last PAP test: _____ Is it your understanding that this PAP was normal? <input type="checkbox"/> Yes <input type="checkbox"/> No If you have not had a PAP in the last year, are you scheduled for one? <input type="checkbox"/> Yes - Date: _____ <input type="checkbox"/> No	
WOMEN: Date of last mammogram: _____ Is it your understanding that this mammogram was normal? <input type="checkbox"/> Yes <input type="checkbox"/> No	

PREVIOUS SURGICAL OPERATIONS/ANESTHETICS

With respect to each and every operation which you have undergone, please provide the following information. (if you need more space please attach a separate sheet)

<u>Operation</u>	<u>Date</u>	<u>Type of Anesthesia</u>	<u>Problems/Complications (if any)</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL CONDITIONS

Please provide the following information concerning each and every one of your medical conditions. (if you need more space please attach a separate sheet)

Nature/Name of Condition

Date Diagnosed

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS

Please provide the following information concerning each and every medication that you are currently taking. (if you need more space please attach a separate sheet)

Name of Medication

Dosage

Average Frequency

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATION ALLERGIES

Are you allergic to any medications?

Yes No

If so, please provide the following information concerning each and every medication to which you are allergic. (if you need more space please attach a separate sheet)

Name of Medication

Type of Each Reaction

Date of Each Reaction

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to Latex?

Yes No

Are you allergic to IV Dye?

Yes No

PHEN-FEN

Have you ever taken PHEN-FEN?

Yes No If Yes, when? _____

NUTRITIONAL/DIETARY INFORMATION

Do you drink soda, juice, or other liquids with high sugar content? Yes No

If so, what type of soda or liquids? _____

How often? _____

How much? _____

Do you binge eat? Yes No (e.g. eat much more than you feel you should eat)

If Yes, have you ever binged to the point of vomiting? Yes No

Do you exercise? Yes No
If Yes, how many days a week? _____
What do you do for exercise? _____

Do snack between meals? Yes No
If Yes, how many times between meals? _____
What type of food do you usually snack on? _____

ALCOHOL, TOBACCO AND DRUG CONSUMPTION

How often to you drink alcohol?
Never Rarely (2 times per month or less) Occasionally (Twice per week or less) Daily (at least once per day)
If you indicated above that you drink 'Daily', please state: How many times per day? _____ What type of alcoholic drink? _____

Have you ever participated in an alcohol or drug rehabilitation program? Yes No

Do you currently use illicit drugs? Yes No

If Yes, what type of drugs do you currently use?

Do you presently smoke tobacco? Yes No

If yes:
How many packs per day? _____

How often do you use illicit drugs? _____

Have you ever smoked tobacco? Yes No

If yes:
How many packs per day? _____
For how many years? _____
When did you quit? _____

Have you ever used illicit drugs? Yes No

When was the last time that you used illicit drugs? _____

What type of illicit drugs? _____

How often? _____

PSYCHIATRIC/PSYCHOLOGICAL INFORMATION

Have you ever been hospitalized or confined for psychiatric, psychological or mental health related reasons? Yes No

Have you ever been seen by a psychiatrist or a psychologist or other mental health professional? Yes No

If Yes, provide the following information:

The name of your mental healthcare provider: _____ Telephone No.: () _____

