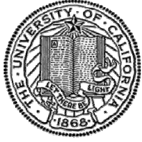

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UCSF BARIATRIC SURGERY CENTER
NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

Please complete this form to provide information regarding your medical condition. Feel free to ask your primary care physician for assistance. All information will be kept confidential. Please return the completed questionnaire with the following:

- ☐ Formal letter from your primary care physician, including a three - to- five year summary of diet and weight history, a list of co-morbid conditions you have in addition to obesity, and why you are being referred for bariatric surgery.
- ☐ Current authorization for an initial surgical consultation.
- ☐ Photocopy of the front and back of your insurance card.

To prepare for your visit, please obtain copies of all reports relevant to your surgical problem and bring them with you. Examples would be reports of upper endoscopies, pathology, CT scans, laboratory blood tests, barium swallows, and so on. If you have had any x-rays, have your hospital put the images on a CD-ROM and hand carry the copy to your appointment. We need to look at the images, not just the reports. We strive to be detail-oriented and thorough. Your answers here will become part of the UCSF medical record and will be confidential.

Name: ________________________________ Insurance: ______________________________

Date of Birth: ___________________________ Subscriber No: __________________________

Home phone: __________________________ Group _________________________________

Other phone: ___________________________

Address: ______________________________ Insurance: ______________________________

_______________________________________ Subscriber No: __________________________

City / State / Zip: _______________________ Group ________________________________

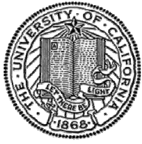
Primary language: ______________________ Social Security No: _______________________

Names of the doctors who referred you, your primary care doctor and any other doctor from whom you are receiving care?

Doctor who referred you: ____________________________________ City: ___________________

Primary care doctor: _______________________________________ City: ___________________

Additional doctor:_ ____City: ___________________



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Additional doctor: ____ City: ___________________

Additional doctor: ____ City: ___________________

Additional doctor: ____ City: ___________________

FOR OFFICE USE:
Ideal Body Weight: _________________________

Excess Body Weight: _________________________

WEIGHT HISTORY

What is your height? __________________

What is your current weight? ____________

What is your goal weight? ______________

When did your obesity begin? (circle one): childhood adolescence early adulthood adulthood

What diet / weight loss programs have you tried in the past? (circle all that apply)

Weight Watchers
Jenny Craig
Curves
South Beach Diet
The Zone
Rosemary Conley
Other:

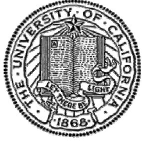
Slim-Fast
Nutrisystem
Glycemic Impact Diet
Denise Austin Diet
diettogo
Life Diet

What was the most weight you ever lost on a diet? ________________________

Have you ever used diet pills? If so, which ones? _________________________

Circle YES or NO for each question

YES NO Do you live alone?
YES NO Do you have difficulty shopping or carrying home a 10 pound bag?
YES NO Do you have difficulty dressing yourself?
YES NO Are you receiving any special help at home?
YES NO Have you had 3 or more falls in the past year?



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ALLERGIC REACTIONS TO MEDICATIONS

Have you ever had a reaction to any of the following:

YES NO Latex
YES NO Iodine
YES NO Intravenous contrast agent (used in CT scans)

Are you allergic to any medications? If so, list the medication and the reaction that you had:

MEDICATION	REACTION (circle all that apply)
Example: Aspirin	anaphylaxis/shock (rash) itching nausea/vomiting short-of-breath other:
	anaphylaxis/shock rash itching nausea/vomiting short-of-breath other:
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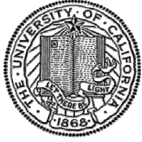
PAST MEDICAL HISTORY

Please circle any illnesses you have now or in the past.

GENERAL MEDICAL PROBLEMS	OBESITY-RELATED PROBLEMS
Seasonal allergies (hay fever)	Hypertension (high blood pressure)
Anemia	Congestive heart failure
Anxiety	Coronary artery disease (heart attacks)
Arthritis	Varicose veins / venous stasis disease
Bleeding disorders	Diabetes (high blood sugar)
Blood disorder	Dyslipidemia (high cholesterol)
Blood transfusion in the past	Polycystic Ovarian Syndrome
Cancer (list types)	Gout
Clotting disorder	Osteoarthritis (painful joints)
Chronic bronchitis or emphysema	Intertrigo (yeast infections in skin folds)
Glaucoma	Obstructive Sleep Apnea (stop breathing at night)
Heart disease	Pickwickian Syndrome (low blood oxygen)
HIV/AIDS	Asthma
Intestinal disease	Gastroesophageal reflux (Heartburn)
Kidney disease	Fatty liver disease
Liver disease	Urinary Stress Incontinence (leak urine with cough)
Myocardial infarction	Intracranial hypertension
Nerve / muscle disease	Migraines
Osteoporosis	Depression
Seizures	Blood clots in legs or lungs
Sinus disorder	Gallstones or gallbladder disease
Skin disease	
Stroke	
Substance abuse	
Thyroid disease	
Ulcers	
OTHER:	

Have you ever been hospitalized? If yes, list the date(s) and reasons.



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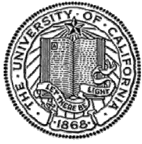
PAST SURGICAL HISTORY

Please circle any operations you have had.

	Year performed
Appendectomy	
Brain surgery	
Breast surgery	
Coronary artery bypass surgery	
Cholecystectomy (gallbladder removal)	
Colon surgery	
Cosmetic surgery	
Cesarian section	
Eye surgery	
Fracture surgery	
Hernia repair	
Hysterectomy (uterus removal)	
Joint replacement	
Prostate surgery	
Small intestine surgery	
Spine surgery	
Tubal ligation	
Valve replacement	
Vasectomy	
OTHER:	



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FAMILY HISTORY

Mark an "X" in the box if any of relative of yours had one of these diseases:

	Alcoholism	Lou Gehrig's	Alzeihmeris	Arthiritis	Asthma	Bleeding disorder	Breast cancer	Cancer	Colon Cancer	Depression	Diabetes	Drug abuse	Early death	Heart disease	Hyperlipidemia	Hypertension	Kidney disease	Liver disease	Mental illness	Osteoporosis	Stroke	Thyroid disease	Tuberculosis	Vision loss
Mother																								
Father																								
Sister																								
Brother																								
Son																								
Mat Aunt																								
Mat Uncle																								
Pat Aunt																								
Pat Uncle																								
Mat GM																								
Mat GF																								
Pat GM																								
Pat GF																								
Cousin																								

SOCIAL HISTORY

Do you drink alcohol? YES NO

If yes, what is your average number of:

	glasses of wine per week
	cans of beer per week
	shots of liquor per week

Do you use drugs recreationally now? YES NO

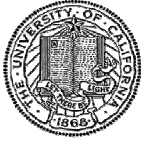
If yes, circle the drugs you use:

amphetamines	amyl nitrate	anabolic steroid	barbituates	benzodiazepines
"crack" cocaine	cocaine	codeine	fentanyl	GHB
heroin	hydrocodone	hydromorphone	ketamine	LSD
marijuana	MDMA	methamphetamine	methaqualone	methylphenidate
morphine	nitrous oxide	opium	oxycontin	PCP
psilocybin	solvent inhalants	IV drugs	other:	other:

Are you a (circle one): current smoker former smoker never smoker passive smoker

How many packs of day do you smoke, on average? ___________________________

How many years have you smoked? ____



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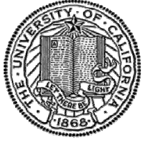
REVIEW OF SYSTEMS

Have you experienced any of the following symptoms in the past 3 months?

			Symptom	Comments
GENERAL	YES	NO	fevers	
	YES	NO	chills	
	YES	NO	weight loss	
	YES	NO	malaise or fatigue	
	YES	NO	sweating	
	YES	NO	weakness	
SKIN	YES	NO	rash	
	YES	NO	itching	
HEAD	YES	NO	headaches	
	YES	NO	hearing loss	
	YES	NO	tinnitus	
	YES	NO	ear pain	
	YES	NO	ear discharge	
	YES	NO	nosebleeds	
	YES	NO	congestion	
	YES	NO	stridor (groan when you breathe)	
	YES	NO	sore throat	
EYES	YES	NO	blurred vision	
	YES	NO	double vision	
	YES	NO	irritation with lights (photophobia)	
	YES	NO	eye pain	
	YES	NO	eye discharge	
	YES	NO	eye redness	
CARDIOVASC	YES	NO	chest pain	
	YES	NO	palpitations (fluttering in the chest)	
	YES	NO	orthopnea (difficulty breathing while flat in bed)	
	YES	NO	claudication (pain in legs with exercise)	
	YES	NO	leg / ankle swelling	
	YES	NO	difficulty breathing during sleep	
LUNGS	YES	NO	cough	
	YES	NO	hemoptysis (coughing up blood)	
	YES	NO	sputum production (coughing up phlegm)	
	YES	NO	shortness of breath	
	YES	NO	wheezing	
ABDOMEN	YES	NO	heartburn	
	YES	NO	nausea	
	YES	NO	vomiting	
	YES	NO	abdominal pain	
	YES	NO	diarrhea	
	YES	NO	constipation	
	YES	NO	bright red blood in stool	
	YES	NO	melena (dark, tar like stools from old blood)	
URINARY	YES	NO	dysuria (burning when you pee)	
	YES	NO	urgency (need to pee quickly, can't barely hold it)	
	YES	NO	frequency (need to pee often)	
	YES	NO	hematuria (blood in the urine)	
	YES	NO	flank pain	



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MUSCLES	YES	NO	myalgias (crampy muscle pain)	
	YES	NO	neck pain	
	YES	NO	back pain	
	YES	NO	joint pain	
	YES	NO	falls	
BLOOD	YES	NO	easy bruising or easy bleeding	
	YES	NO	seasonal allergies	
	YES	NO	polydipsia (always thirsty)	
NEURO	YES	NO	dizziness	
	YES	NO	tingling	
	YES	NO	tremor	
	YES	NO	sensory change	
	YES	NO	speech change	
	YES	NO	focal weakness	
	YES	NO	seizures	
	YES	NO	loss of consciousness	
PSYCHIATRIC	YES	NO	depression	
	YES	NO	suicidal ideas	
	YES	NO	substance abuse	
	YES	NO	hallucinations	
	YES	NO	nervous / anxious	
	YES	NO	insomnia	
	YES	NO	memory loss	