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 to the following address:

Bariatric Surgery Center
UCSF Medical Center
400 Parnassus Avenue, Room A655
San Francisco, CA 94143

FOR OFFICE USE ONLY

UNIT NUMBER ____________________ RECEIVED ____________
PT NAME ____________________
BIRTHDATE ____________________
DATE REVIEWED ________________ REVIEWED BY __________
TEST DATE ____________________
DATE OF SURGERY ____________________
LOCATION ____________________ DATE ______________

Date Form Completed ____________________________

Name ____

Birth date ______________________ Race ___________

Marital Status   Single   Married   Significant Other/partner   Divorced   Widowed

Occupation __________________________________

Height _____________ Weight _____________ M / F ____

1) Insurance ____________________________
   - Subscriber No. ____________________
   - Group ____________________________

2) Insurance ____________________________
   - Subscriber No. ____________________
   - Group ____________________________

Social Security No. ____________________________

Number of Children ____________________________

Education (last grade or degree completed) ____________________

Address/City/State/Zip ____

Home phone: ________________________________

Work phone ________________________________

Primary language: ____________________________

Do you need an interpreter: Y N

Notify in case of emergency:

Name: ________________________________

Relationship: ____________________________

Address: ______________________________

Phone: ________________________________

Please list any of the following that apply:

Primary Care Physician ____________________________
Address ____________________________
Phone / Fax Number ____________________________

Cardiologist / Heart Physician ____________________________
Address ____________________________
Phone / Fax Number ____________________________

Other Health Care Providers

1. Name ____________________________
   Address ____________________________
   Phone / Fax Number ____________________________

2. Name ____________________________
   Address ____________________________
   Phone / Fax Number ____________________________

3. Name ____________________________
   Address ____________________________
   Phone / Fax number ____________________________

This form completed by (name)
____

Signature ____________________________
Date ____________________________

Past Medical History

1. **Have you had any operations? If yes, list:**

Type of operation / Reason for operation	Hospital	Date of operation

2. **Major injuries, auto accidents, or broken bones?**

Blood transfusions?

Exposure to dangerous chemicals?

3. **Have you ever been hospitalized for reasons other than operations? If yes, list:**

Reason for hospitalization	Hospital	Dates of hospitalization

4. **Please list all your CURRENT MEDICATIONS and doses (include medicines and supplements not needing a prescription:**

Medication	Dose

5. **Please list any allergies or reactions to medications:**

6. Please indicate if you have had any of the following problems **CURRENTLY OR IN THE PAST?**

	Yes	No		Yes	No
Anemia	☐	☐	Kidney Disease/Stones	☐	☐
Arthritis	☐	☐	Liver Disease/Hepatitis	☐	☐
Asthma or Emphysema	☐	☐	Lung Disease/Pneumonia	☐	☐
Bladder or Kidney Infections	☐	☐	Pancreatitis	☐	☐
Blood Clots / Bleeding disorders	☐	☐	Polyps	☐	☐
Chronic Diarrhea	☐	☐	Rheumatic Fever	☐	☐
Diverticulosis	☐	☐	Skin Disease	☐	☐
Diabetes	☐	☐	Sleep apnea	☐	☐
If yes, at what age? ________			Stroke	☐	☐
Emotional Problems	☐	☐	Venereal Disease/Syphilis/	☐	☐
Epilepsy or Seizures	☐	☐	Gonorrhea/Chlamydia		
Gallstones / Gallbladder Disease	☐	☐	Thyroid Disease/Goiter	☐	☐
Gout	☐	☐	Tuberculosis	☐	☐
Heart Disease	☐	☐	Tumors/Cancer	☐	☐
High Blood Cholesterol	☐	☐	Ulcers (stomach or intestinal)	☐	☐
High Blood Pressure	☐	☐	Acid Reflux (Heartburn)	☐	☐

If yes to any of the above, please explain: ____

____

____

____

Personal Habits

7. Do you smoke? Yes ☐ No ☐

If Yes:

How many years have you smoked? ______________

How many packs per day do you smoke? __________

How soon after you awaken do you smoke you first cigarette? <30 minutes ☐ >30 minutes ☐

If No:

Have you ever smoked? ____________________

How many years did you smoke? _____________

How many packs per day did you smoke? ______

When did you quit smoking? ________________

8. Do you drink alcohol? Yes ☐ No ☐

If no: Have you in the past? Yes ☐ No ☐

If yes: Specify frequency and quantity ___________________

On days when you had a drink, about how many drinks (beer, wine, or liquor did you have? ______________ drinks

Have you ever felt you ought to cut down on your drinking? Yes ☐ No ☐

Have people criticized your drinking? Yes ☐ No ☐

Have you ever felt bad or guilty about your drinking? Yes ☐ No ☐

Have you ever had to have a drink first thing in the morning to steady your nerves or get rid of a hangover? Yes ☐ No ☐

Have you ever had black-outs or memory loss? Yes ☐ No ☐

9. Have you ever used any drugs such as marijuana, cocaine, stimulants, sedatives, narcotics, diet pills? If so, please specify types, quantity and duration of use: ______________________________

____

Have you ever injected any such drugs? ______________________________

10. Risk factors for infection with HIV, the AIDS virus, include homosexual or bisexual activity, intravenous drug use, hemophilia, received a blood transfusion between 1979-1985, sexual contact with an HIV-positive individual or contact with a person with these risk factors.

If you have any of these risk factors, or are interested in being tested for HIV infection, please check this box ☐

11. Do you and your sexual partner(s) practice safe sex? Yes ☐ No ☐ Not sure ☐

12. Do you exercise regularly? Yes ☐ No ☐ If yes, what do you do? ______________________________

____

____

Dietary History

13. Body Weight:

Current weight:__________________

Heaviest weight:__________________ Date: __________________

Lightest weight:__________________ Date: __________________

14. Please list any diets/weight loss programs that you have participated in:

Type of diet / weight loss program	Amount of weight lost	Date

Family History

15. Have any members of your family (including grandparents, parents, brothers, sisters or children) had any of the following conditions?

	Yes	No	Family Relationship
Alcoholism	☐	☐	____________
Domestic Violence	☐	☐	____________
Anemia/Bleeding problems	☐	☐	____________
Bowel/Colon Cancer	☐	☐	____________
Breast Cancer	☐	☐	____________
Diabetes	☐	☐	____________
Heart Disease/Angina	☐	☐	____________
Hepatitis	☐	☐	____________
High Blood Pressure	☐	☐	____________
High Cholesterol	☐	☐	____________
Kidney Disease	☐	☐	____________
Strokes	☐	☐	____________
Tuberculosis	☐	☐	____________
Other ____________	☐	☐	____________

Review of Symptoms

16. Please indicate if you have any of the following problems NOW:

	Yes	No	Comments
1. Severe or unusual headache	☐	☐	____________
2. Hearing problems	☐	☐	____________
3. Problems with vision (other than nearsightedness or farsightedness)	☐	☐	____________
4. Sinus problems or hay fever	☐	☐	____________
5. Hoarseness	☐	☐	____________
6. Problems with teeth or gums	☐	☐	____________
7. Severe skin problems	☐	☐	____________
8. Weight loss or gain	☐	☐	____________
9. Chest pains or discomfort	☐	☐	____________

10. Shortness of breath	☐	☐	______________
11. Cough or phlegm	☐	☐	______________
12. Stomach problems (pain, nausea, or vomiting)	☐	☐	______________
13. Diarrhea or constipation	☐	☐	______________
14. Blood in bowel movements or black bowel movements	☐	☐	______________
15. Difficulty or pain on urinating or blood in urine	☐	☐	______________
16. Painful Joints	☐	☐	______________
17. Sexual difficulties, depression, severe sleep problems, severe stress	☐	☐	______________

Preventive Care

17. Have you received a vaccine to prevent any of the following diseases?

	Yes	No	If Yes, when:
Tetanus	☐	☐	______________
Polio	☐	☐	______________
Pneumonia	☐	☐	______________
Hepatitis B	☐	☐	______________
Influenza ("flu")	☐	☐	______________
Tuberculosis	☐	☐	______________
Rubella (German Measles)	☐	☐	______________

18. Have you had any of the following tests?

	Yes	No	If Yes, when?	Result, if known?
Cholesterol	☐	☐	______________	__________
Tuberculosis skin test	☐	☐	______________	__________
Syphilis test	☐	☐	______________	__________
Stool test for blood	☐	☐	______________	__________

19. When was your last:

Eye Examination? ______________ Dental Examination? ______________

	Yes	No
20. Do you live alone?	☐	☐
21. Do you have difficulty shopping or carrying home a 10 pound bag?	☐	☐

22. Do you have difficulty dressing yourself? ☐ ☐

23. Are you receiving any special help at home? ☐ ☐

24. Have you had three or more falls during the past year? ☐ ☐

Other

25. Who will help you when you go home after a surgery?

____

26. Do you receive help from any community agency now or do you anticipate needing help after your surgery?

____

For Women Only

Age at start of menstrual period? ____________________years

Date most recent menstrual period began ____________________

Usual length of menstrual period ____________________days

Have you stopped having menstrual periods? Yes ☐ No ☐ If yes, when ____________________

Do you have problems with:	Yes	No	Comments
1. Irregular, painful or heavy menstrual periods	☐	☐	____________________
2. Bleeding between periods or after menopause	☐	☐	____________________
3. Vaginal discharge, pain or itching	☐	☐	____________________
4. Hot flashes	☐	☐	____________________

Please indicate (if any):		Complications
1. Number of deliveries	________	____________________
2. Number of miscarriages	________	____________________
3. Number of abortions	________	____________________
4. Total number of pregnancies	________	____________________

	Yes	No	If yes, what	For how long
Are you using any form of birth control?	☐	☐	____________	____________

Date of last Pap smear? ____________________

Have you ever had an abnormal Pap smear?	☐	☐	if yes, please give date and describe: ______________________________
Do you have problems with pain or lumps in your breasts?	☐	☐	if yes, please give date and describe: ______________________________
Have you ever had a mammogram (breast X-ray)?	☐	☐	if yes, when:__________ Result:_________________

How often do you examine your breasts? ____________________ Date of last exam:_________________