John P. Daly., FACS

Medical History for Bariatric Patients

The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you.

Name: _____

Height: _____ Weight: _____ Ideal Body Weight: _____

Age when you first remember being overweight: _____

Age you first began dieting: _____

Weight when you graduated from High School: _____

Detailed Diet History

Diet Programs	Weight Loss	Year	Duration	M.D. Supervised?
Jenny Craig				
Fen-Phen				
Nutri System				
Redux				
Weight Watchers				
Optifast				
Behavior Modification Type				
Nutritionist Supervised Name:				
Physician Supervised Name:				
Other Medications:				
1.				
2.				
Other Programs:				
1.				
2..				
3..				

What X-Rays, Mammograms, Ultrasounds, Labwork. Bloodwork. Or other test have you had recently?

Test	Date	Where was this done?	Result

Past Health: (General Statement)

Previous Surgeries:

Date	Operation	Hospital	Doctor

Do you smoke cigarettes: Yes ( ) No ( ) How much : (packs per day) _____ How long: (years) _____

Other Tobacco use: (Describe) _____

Do you have sleep apnea? Yes ( ) No ( )

If so, do you use a BIPAPP Machine? _____ Which Doctor supervises this? _____

Do you have problems with your joints? (Arthritis) Yes ( ) No ( )

If so describe these problems:

Do you have Stress Urinary Incontinence? (Lose control of your urine when laughing sneezing or coughing)? Yes ( ) NO ( )

Medical Illnesses: (place an X in the appropriate box)

High Blood Pressure	Yes ( ) No ( )	Diabetes	Yes ( ) No ( )
Hepatitis	Yes ( ) No ( )	HIV/AIDS	Yes ( ) No ( )
Heart Disease	Yes ( ) No ( )	Anemia	Yes ( ) No ( )
Cancer	Yes ( ) No ( )	Kidney Problems	Yes ( ) No ( )
Type (s):		Pneumonia	Yes ( ) No ( )
		Emphysema	Yes ( ) No ( )
Arthritis:	Yes ( ) No ( )	Asthman	Yes ( ) No ( )
Thyroid Problems:	Yes ( ) No ( )	Tuberculosis	Yes ( ) No ( )
Sickle Cell Anemia	Yes ( ) No ( )	Hemophilia	Yes ( ) No ( )
Blood Clots	Yes ( ) No ( )	Bleeding Problems	Yes ( ) No ( )
Stroke	Yes ( ) No ( )	Heart Attack	Yes ( ) No ( )

Other: _____

Previous Medical Examinations: (Insurance, Employment, Military, School, Other. Please include all the Names of Physicians currently treating you.)

Physician	Date	Results

Medications: Name	Dose	Reason

Allergies to Medications:

Medicine	Reaction