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PATIENT HISTORY FORM:

Knowing your detailed medical history information is very important for our assessment of your health. Obesity and its associated diseases and risk factors increase mortality and surgical complications. **We rely on the information you provide, therefore it is imperative for safety and insurance purposes that a detailed medical history be performed.**

I am also aware of the following:

- NO tobacco products are permitted for 8 weeks before surgery- this gives your lungs a chance to better provide oxygen to your blood, which can help decrease the risk of infection, pneumonia, and especially improve wound healing.
- Second hand smoke is also irritating to the lungs.
- We will not operate on any patient that is an active smoker and may require you to take a laboratory test that confirms you are smoke free.

PATIENT STATEMENT

I am aware that Bariatric surgery is not a “quick fix” but rather a tool for controlling weight, combined with exercise and proper nutrition. I am aware that I will be expected to follow up post op on a regular basis, and be required to take vitamins, and supplements for the rest of my life. I am also aware that reversal of this surgery is not recommended. The information on my medical history form is true and correct to the best of my belief.

Patient’s signature

Date

YOUR NAME _____ YOUR EMAIL ADDRESS _____

PRIMARY CARE PHYSICIAN

FULL NAME

ADDRESS

PHONE # FAX #

SPECIALIST PHYSICIAN (pulmonologist, gastroenterologist, endocrinologist)

FULL NAME

ADDRESS

PHONE # FAX #

FULL NAME

ADDRESS

PHONE # FAX #

FULL NAME

ADDRESS

PHONE # FAX #

FULL NAME

ADDRESS

PHONE # FAX #

WEIGHT LOSS HISTORY

YOUR NAME.....

Most insurance companies require documented evidence of previous weight loss attempts so it is critical that you fill this out in detail. Please include dates as well as length of time of each diet, to the best of your knowledge.

How tall are you?

How much do you weight?.....

What was your best weight loss with dieting?

NON-SUPERVISED ATTEMPTS

- | | | | |
|---|-----------------------------|---|-----------------|
| G | Body for Life/Bill Phillips | G | Pritikin |
| G | Gloria Marshall | G | Richard Simmons |
| G | Health Spa | G | Scarsdale |
| G | High Protein | G | Stillman Diet |
| G | Hypnosis | G | Sugar Busters |
| G | Low Carbohydrate | G | Slim Fast |
| G | Low Fat | G | Mayo Clinic |
| G | Calorie counting on my own | G | Other..... |
| G | Other | G | Other..... |

SUPERVISED ATTEMPTS

- | | | | |
|---|---|---|----------------------------------|
| G | Diet Pills from MD Type_____ | G | Diet Shots from MD Date: _____ |
| G | Diet Center Date: _____ | G | Overeaters Anonymous Date: _____ |
| G | Optifast Date: _____ | G | Weight Watchers Date: _____ |
| G | HMR – Health Management Resources | G | Nutri-Systems Date: _____ |
| G | T.O.P.S. Date: _____ | G | Jenny Craig Date: _____ |
| G | New Directions | G | National Weight Loss Date: _____ |
| G | Supervised calories counting diet by health professionals | | |
| G | Other | | |

MEDICATION PRESCRIBED FOR WEIGHT LOSS

Medications may be listed as both as generic and name brand. Check the one prescribed to you and the length of time you were on these medications.

- | | | | |
|---|-----------------|---|-------------|
| G | Acutrim | G | Obalan |
| G | Adipex-P | G | Orlistat |
| G | Amphetamines | G | Phendiet |
| G | Anorex | G | Phentermine |
| G | Benzphetamine | G | Phentrol |
| G | Dexatrim | G | Piepine |
| G | Dexfenfluramine | G | Pondimin |
| G | Didrex | G | Redux |
| G | Fastin | G | Sanorex |
| G | Fenfluramine | G | Tepanol |
| G | Ionamin | G | Tenuate |
| G | Mazanor | G | Wehless |
| G | Meridia | G | Xenical |
- Surgeons Initials/date_____

REVIEW OF MEDICAL PROBLEMS (Please check and/or explain any of the items listed)

CARDIOVASCULAR

- G Heart problems
- G Chest pains
- G Racing heart/skipping
- G High blood pressure
- G Chest tightness
- G Shortness of Breath
- G SOB while exercising
- G High cholesterol
- G High triglycerides
- G Feel tired all the time

DIABETES AND ENDOCRINE SYSTEM

Diabetes Mellitus (Type 1 or 2)

- When was your diabetes first diagnosed?
- How long have you been taking oral agents?
- How long have you been taking insulin?
- Does your diabetes resolve with weight loss?

Pre-diabetic

(Abnormal glucose tolerance test)

Gestational

Age of diagnosis

Hypoglycemia

Thyroid problems (requiring medication)

GASTROINTESTINAL

Gallbladder Problems

- Do you have gallstones diagnosed by ultrasound?
- Have you had your gallbladder removed open or laparoscopically?

Stomach Ulcers

Have you taken medicine for ulcers?

Heartburn

How often do you have heartburn and do you take medications for it?

Surgeons Initials/Date _____

RESPIRATORY

Asthma

Last attack?

Bronchitis

of times in past 2 years

Is it recurring?

Pneumonia?

Blood clots in lungs?

Blood clots in legs?

Smoking History

Starting age?

When did you stop?

How many packs per day?

Sleep Apnea History

Do you snore?

Have you been told that you hold your breath or stop breathing during sleep?

Do you wake up gasping for breath?

_____ Do you awaken with headaches?

_____ Do you fall asleep frequently while reading?

_____ Do you have heartburn or "reflux" while sleeping? _____

_____ Do you have repeated difficulty falling asleep or staying asleep? _____

Do you often wake up with a dry mouth, sore throat, or headache in the morning?

Do you use CPAP or BIPAP?

Previous Sleep Study or do you have one scheduled? Yes No

MUSCULOSKELETAL

	MILD	MODERATE	SEVERE
Hip pain			
Knee pain			
Ankle pain			
Feet pain			
Back pain			
Neck pain			
Arthritis			

Surgeons Initials/Date _____

Musculoskeletal continued

- Are you using anti-inflammatory or pain medicine?
- Do you have swelling of your legs?
- Do you have swelling of your feet?
- Do you have varicose veins?
- Do you have ulcers of the leg?

KIDNEY & BLADDER

- Do you spell urine when coughing or laughing?
- Have you had bladder or kidney infections?
- Have you had kidney stones?

BLOOD

- Have you ever had a bleeding problem?
- Have you ever had low platelets?
- Have you ever had a blood transfusion?

NEURO-PSYCHIATRIC

- Depression/Anxiety
- Because of obesity?
- Requiring medication?
- Seizures
- Requiring Medication?
- Severe headaches?
- Requiring Medication?
- Visual problems?
- Been in counseling?
- History of alcohol abuse?
- How long have you been sober?
- History of drug abuse?
- How long have you been clean?
- Eating disorder?
- Bulimia?
- Anorexia Nervosa?

ALLERGIES

- Do you have any allergies to medicine?
- If so, what was the reaction?

Have you ever had reaction to anesthesia or has a family member had a reaction? Yes No

Are you allergic to Latex products? Yes No

Surgeons Initials/Date _____

SOCIAL

Are you employed? Full Time Part Time Retired Homemaker Unemployed

Describe your work and home life (family members, etc)

.....
.....
.....
.....
.....

Name a close, supportive friend or family member who I can talk to:

.....

FAMILY HISTORY (Parents, Grandparents, Brothers, Sisters)

	Mother	Father	Sibling	Aunt/Uncle	Grandparent
Obesity					
Diabetes					
Heart disease					
High blood pressure					
Cancer					
Arthritis					
Early death					
Cause					

Has any member of your family suffered from Blood Clots or Pulmonary Embolism? Yes No

If yes, please describe:

.....
.....

How did you hear about us?

.....
.....

Surgeons Initials/Date _____

NEURO-PSYCH SCREENING

Below is a list of problems and complaints that people sometimes experience. Please read each one carefully. After you have done so, use the scale below to describe HOW MUCH that each problem has BOTHERED or DISTRESSED you during the past week, including today.

NOT AT ALL A LITTLE BIT MODERATELY QUITE A BIT EXTREMELY
0 1 2 3 4

- 1. Nervousness or shakiness inside.
- 2. Unwanted thoughts, words, or ideas that won't leave your mind.
- 3. The idea that someone else can control your thoughts.
- 4. Feeling others are to blame for most of your troubles.
- 5. Trouble remembering things.
- 6. Feeling easily annoyed or irritated.
- 7. Feeling afraid in open spaces or on the street.
 - 8. Thought of ending your life.
 - 9. Hearing voices that other people do not hear.
 - 10. Feeling that most people cannot be trusted.
 - 11. Crying easily.
 - 12. Feeling or being trapped or caught.
 - 13. Suddenly scared for no reason.
 - 14. Temper outbursts that you could not control.
 - 15. Feeling afraid to go out of your house alone.
 - 16. Feeling blue.
 - 17. Worrying too much about things.
 - 18. Feeling fearful.
 - 19. Other people being aware of your private thoughts.
 - 20. Feeling afraid to travel on buses, subways, or trains.
 - 21. Having to avoid certain things, places, or activities because they frighten you.
 - 22. Your mind going blank.
 - 23. Feeling hopeless about the future.
 - 24. Trouble concentrating.
 - 25. Having thoughts that are not your own.
 - 26. Having urges to beat, injure, or harm someone.
 - 27. Having urges to break or smash things.
 - 28. Having ideas or beliefs that others do not share.
 - 29. Spells of terror or panic.
 - 30. Getting into frequent arguments.
- 31. Feeling nervous when you are left alone.
- 32. Feeling so restless you couldn't sit still.
- 33. Feeling of worthlessness.
- 34. Feeling that familiar things are strange or unreal.
- 35. Shouting or throwing things.

Surgeons Initials/Date _____

NAME

Date.....

TWO-DAY FOOD DIARY

Please record your food for one weed day and one weekend day.

WEEKDAY

WEEKEND

Breakfast	Breakfast
Lunch	Lunch
Dinner	Dinner
Snack	Snack

Problem areas/notes

Surgeons Initials/Date _____