PHYSICIANS' CLINIC
of Iowa, P.C.

BARIATRIC SURGERY PATIENT INTAKE

Today's Date _____ First Name _____ Middle Initial_____ Last Name _____

Nickname _____ Date of Birth _____ Gender: ☐ Male ☐ Female ☐ Fluid/Other

Family Physician _____ Referring Physician _____ How did you hear about the program? _____

MEDICAL HISTORY: Check any condition that applies to you

- ☐ Problems with Anesthesia
- ☐ Acid Reflux
- ☐ Angina
- ☐ Anxiety
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Bleeding
- ☐ Blood Clots
- ☐ Blood Transfusion
- ☐ Cardiomyopathy
- ☐ Carpal Tunnel
- ☐ Cirrhosis
- ☐ Clotting Disorder
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Depression
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Difficulty Swallowing
- ☐ Dizzy/Loss of Balance
- ☐ Fatigue
- ☐ Fibromyalgia
- ☐ Gallbladder Disorder
- ☐ GI Ulcer
- ☐ Gout
- ☐ Headaches
- ☐ Heart Attack
- ☐ Hearing Loss
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Insomnia
- ☐ Irritable Bowel Syndrome
- ☐ Liver Disease
- ☐ Low Blood Sugar
- ☐ Lupus
- ☐ Malignant Hyperthermia
- ☐ Metabolic Disorder
- ☐ Morbid Obesity
- ☐ Numbness/Tingling
- ☐ Osteoarthritis
- ☐ Peripheral Vascular Disease
- ☐ Polycystic Ovarian Syndrome
- ☐ Pseudotumor Cerebri
- ☐ Rash/Skin Problem
- ☐ Rheumatoid Arthritis
- ☐ Scleroderma
- ☐ Seizures
- ☐ Shortness of Breath/on Exertion
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Leak Urine when Cough/Sneeze
- ☐ Stroke
- ☐ Superventricular Tachycardia
- ☐ Swelling in Legs
- ☐ Varicose Veins
- ☐ Vision Problems
- ☐ Other

Please check any previous surgeries/hospitalizations:

- ☐ Adnoidectomy
- ☐ Appendectomy
- ☐ Bariatric Surgery
  - ___ Duodenal Switch
  - ___ Gastric Bypass
  - ___ Lap Band
  - ___ Sleeve Gastrectomy
- ☐ Biliopancreatic Diversion
- ☐ Brain Surgery
- ☐ Breast Surgery
- ☐ Cardio Defibrillator
- ☐ Colon/Large Intestine Surgery
- ☐ Coronary Angioplasty
- ☐ C-section
- ☐ Eye Surgery
- ☐ Fracture Surgery
- ☐ Gallbladder Removal
- ☐ Gastric Stimulator Implant
- ☐ Heart Bypass
- ☐ Heart Stents
- ☐ Heart Valve Replacement
- ☐ Hernia Repair
- ☐ Hysterectomy
- ☐ Intestinal Bypass
- ☐ Joint Replacement
- ☐ Plastic Surgery
- ☐ Small Intestine Surgery
- ☐ Spine Surgery
- ☐ Tonsillectomy
- ☐ Tubal Ligation
- ☐ Vertical Banded Gastroplasty

☐ Other (please describe) _____

Are you disabled? ☐ Yes ☐ No Reason Disabled: ☐ Motor Vehicle Accident ☐ Illness ☐ Work-related Injury ☐ Other_____

Assistive Device(s) (check all that apply): ☐ Cane ☐ Crutches ☐ Walker ☐ Sling ☐ Wheelchair ☐ Power Scooter Years in wheelchair/scooter_____

SOCIAL HISTORY:

Occupation: _____ ☐ Working Full Time ☐ Working Part Time

☐ Retired ☐ Currently Disabled ☐ Unemployed ☐ Student

Marital Status:

☐ Single
☐ Currently Married/Partnered Spouse/Partner Name: _____
☐ Divorced
☐ Widowed

Alcohol/Drug Use:

Do you use alcohol? ☐ Yes ☐ No How many drinks per week? _____
Have you used drugs for non-medicinal purposes? ☐ Yes ☐ No If yes, ☐ Current ☐ Past

Tobacco Use:

☐ Yes ☐ No Current Smoker How much/how long? _____
☐ Yes ☐ No Former Smoker/Date Quit _____
☐ Yes ☐ No Chewing Tobacco
☐ Yes ☐ No Vaping
☐ Yes ☐ No Never Smoked

SOCIAL HISTORY (continued):

Sexually Active? ☐ Yes ☐ No

Birth Control/Protection (check all that apply): ☐ Abstinence ☐ Condom ☐ Implant ☐ Injection ☐ IUD ☐ Pill ☐ Patch ☐ Surgical ☐ Post-menopausal ☐ None ☐ Other _____

REVIEW OF SYSTEMS: Please check any new symptoms you have experienced in the last MONTH.

Constitutional/General
☐ Yes ☐ No Fever
☐ Yes ☐ No Chills
☐ Yes ☐ No Heavy Sweating/Night Sweats
☐ Yes ☐ No Loss of Appetite
☐ Yes ☐ No Sleep Disturbances
☐ Yes ☐ No Unexplained Weight Loss/Gain
☐ Other: _____

Eyes
☐ Yes ☐ No Blurry Vision
☐ Yes ☐ No Double Vision
☐ Yes ☐ No Wear Glasses
☐ Other: _____

Ear/Nose/Throat
☐ Yes ☐ No Sore Throat
☐ Yes ☐ No Mouth Sores
☐ Yes ☐ No Nasal Congestion/Sinus Issues
☐ Yes ☐ No Hearing Loss
☐ Other: _____

Respiratory
☐ Yes ☐ No Cough
☐ Yes ☐ No COPD
☐ Yes ☐ No Wheezing
☐ Yes ☐ No Recurrent Respiratory Infections
☐ Yes ☐ No Shortness of Breath
☐ Other: _____

Endocrine
☐ Yes ☐ No Excessive Thirst/Fluid Intake
☐ Yes ☐ No Temperature Intolerance
☐ Yes ☐ No Feeling Tired (Fatigue)
☐ Yes ☐ No Hot Flashes
☐ Other: _____

Genitourinary
☐ Yes ☐ No Painful urination
☐ Yes ☐ No Urinary Frequency
☐ Yes ☐ No Loss of Urinary Control
☐ Yes ☐ No Enlarged Prostate
☐ Yes ☐ No Difficulty Urinating
☐ Other: _____

Skin
☐ Yes ☐ No Skin Rash
☐ Yes ☐ No Itching
☐ Yes ☐ No Discoloration
☐ Yes ☐ No Lumps or Masses
☐ Other: _____

Musculoskeletal
☐ Yes ☐ No Joint Pain
☐ Yes ☐ No Joint Swelling
☐ Yes ☐ No Back Pain
☐ Yes ☐ No Limitation of Motion
☐ Yes ☐ No Neck Pain
☐ Yes ☐ No Pain with Walking
☐ Other: _____

Cardiovascular
☐ Yes ☐ No Chest Pain or Discomfort
☐ Yes ☐ No Swelling Feet, Ankles, Legs
☐ Yes ☐ No Irregular Heartbeat
☐ Yes ☐ No Heart Attack
☐ Yes ☐ No Palpitations
☐ Yes ☐ No Varicose Veins
☐ Other: _____

Pain
Current pain rating (0-10) _____
Location _____

Hematologic/Lymphatic
☐ Yes ☐ No Swollen Glands
☐ Yes ☐ No Blood Clotting Problem
☐ Yes ☐ No Easy Bruising
☐ Yes ☐ No Bleeding Tendencies
☐ Other: _____

Neurological
☐ Yes ☐ No Tremors
☐ Yes ☐ No Dizzy Spells
☐ Yes ☐ No Numbness/Tingling
☐ Yes ☐ No Headache
☐ Yes ☐ No Unsteady Gait
☐ Yes ☐ No Feeling Weak
☐ Yes ☐ No Convulsions/Seizures
☐ Other: _____

Gastrointestinal
☐ Yes ☐ No Abdominal Pain
☐ Yes ☐ No Nausea/Vomiting
☐ Yes ☐ No Indigestion/Heartburn
☐ Yes ☐ No Blood in Stools
☐ Yes ☐ No Change in Bowel Habits
☐ Yes ☐ No Rectal Bleeding
☐ Yes ☐ No Diarrhea
☐ Yes ☐ No Constipation
☐ Yes ☐ No Swallowing Difficulties
☐ Other: _____

Female Patients Only
Age of first menstrual period _____
Last menstrual period _____
Number of pregnancies_____
Number of life births _____
Age menopause occurred _____
☐ Yes ☐ No Breast Pain
☐ Yes ☐ No Breast Lump/Mass
☐ Yes ☐ No Change in Nipple

MEDICATIONS: List all medications you have been taking. Please include over the counter and any supplements; list dosages and frequency.

Name of Medication (☐ See attached list for additional medications)	Dose	Frequency

ALLERGIES: Please list any allergies

Drug	Describe Reaction	Other *(seasonal, food, etc.)*	Describe Reaction

Do you have sensitivity to Latex? ☐ Yes ☐ No Describe Reaction: _____

FAMILY HISTORY: Has any member of your immediate family (father/mother/brother/sister/son/daughter) ever had the following conditions. If yes, indicate family member.

		Family Member			Family Member
☐ Yes ☐ No	Arthritis		☐ Yes ☐ No	High Blood Pressure	
☐ Yes ☐ No	Cancer (include type)		☐ Yes ☐ No	Kidney Disease	
☐ Yes ☐ No	Diabetes Mellitus		☐ Yes ☐ No	Lung Disease (COPD)	
☐ Yes ☐ No	Eye Conditions		☐ Yes ☐ No	Stroke	
☐ Yes ☐ No	Heart Disease		☐ Yes ☐ No	Stomach/Intestinal Problems	
☐ Yes ☐ No	High Cholesterol/Lipids		☐ Yes ☐ No	Ulcers	
☐ Yes ☐ No	Liver Disease/Hepatitis		☐ Yes ☐ No	Obesity	

☐ Unable to obtain family history due to adoption or other circumstances.

BARIATRIC SLEEP ASSESSMENT: Please estimate your risk of falling asleep in the following situations, using the scale below:

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (theater or meeting)	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
As a passenger in a car for an hour without a break	
TOTAL	

0 = No chance of dozing
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Do you snore loudly (loud enough to be heard through closed doors or your bed partner elbows you for snoring at night)?
☐ Yes ☐ No

Do you often feel tired, fatigued or sleepy during the daytime?
☐ Yes ☐ No

Has anyone observed you stop breathing or choking/gasping during your sleep?

☐ Yes ☐ No

Are you being treated for High Blood Pressure?

☐ Yes ☐ No

Body Mass Index more than 35 kg/m^2

☐ Yes ☐ No

Age older than 50?

☐ Yes ☐ No

Neck size large? (measured around Adam's apple)
Is your shirt collar 16 inches/40 cm or larger?

☐ Yes ☐ No

PSYCHIATRIC HISTORY:

Condition	Name of Medication/Treatment	Hospitalized? (Y/N)	Dates
Depression/Severe Depression			
Schizophrenia			
Bipolar			
Anorexia/Bulimia/Other Eating Disorder			
Suicide Attempt			
Other (please specify)			

What type of bariatric surgery are you interested in?

☐ Gastric Bypass (RNY, Roux-N-Y) ☐ Sleeve Gastrectomy (Sleeve) ☐ Single Anastomosis Duodenal Switch (SADI)

☐ Revision Surgery

What type of bariatric surgery did you have previously? _____

When was your previous surgery performed? _____

Where was your previous bariatric surgery performed and by whom? _____

Reason for seeking a revision: _____

☐ Unsure

WEIGHT HISTORY

My obesity began: ☐ Childhood ☐ Puberty ☐ Adulthood ☐ After Pregnancy ☐ After a Traumatic Event ☐ Other: _____

Highest Adult Weight: _____ At What Age? _____ Lowest Adult Weight: _____ At What Age? _____

Most Weight Lost on Any Program: _____ Program Name/Type: _____

Have you ever taken medication to lose weight? ☐ Yes ☐ No

How long did you take this medication and what was the effect? _____

WEIGHT LOSS/DIET HISTORY

Please list any weight loss programs or diets that you've tried in the past (for example, Weight Watchers).

_____

_____

_____

_____

EXERCISE TOLERANCE

Can you independently perform acts of daily living (ADLs)? ☐ Yes ☐ No

Functional Limits: ☐ None (can walk 200 ft. without assistance) ☐ Require Wheelchair ☐ Cane/Crutch ☐ Bedridden ☐ Require Assistance with ADLs ☐ Can Only Perform ADLs ☐ Dependent for ADLs ☐ Other _____

Do you perform any additional exercise? ☐Walking/Treadmill ☐Chair Exercise ☐Swimming ☐Stationary Bike ☐Other _____

How many times per week do you exercise?_____ How long, in minutes, do you exercise each week? _____

EATING PATTERNS/HABITS

Counting all meals and snacks, how many times per day do you usually eat? _____ What times during the day? _____

How many days per week do you eat out? _____ ☐ Breakfast _____days per week ☐ Lunch _____days per week ☐ Dinner/Supper _____days per week

In the past 6 months, have you experienced any food cravings? ☐ Yes ☐ No

Did you ever eat a very large amount of food within a short time, such as 2 hours or less? ☐ Yes ☐ No

TYPICAL DIET

Please complete this as honestly as possible for a typical weekday and weekend day. Include amount consumed, food preparation (steamed, fried, baked, raw, etc) and beverages.

Meal	Typical Week Day Menu	Typical Weekend Menu
Breakfast		
Lunch		
Dinner/Supper		
Snack #1		
Snack #2		
Snack #3		