Intake Form

BAPTIST HEALTH | Center for Bariatrics

Changing Health Care for Good.®

Patient Name _____ Today's Date _____

Age _____ Date of Birth _____ Phone _____

Contact Person(s)

This information is vital to us if we need to contact you urgently. Occasionally people move or have new phone numbers and do not notify our office.

Next of kin: (Not living with you)

Name _____ Relationship _____

Address _____

Phone (H) (_____) _____ (W) (_____) _____ (C)(_____) _____

Physicians:

Referring Physician _____

Primary Care Physician _____

Cardiologist (heart doctor) _____

Pulmonologist (lung doctor) _____

Endocrinologist _____

Orthopedic Surgeon _____

Psychologist _____

Psychiatrist _____

Other physician(s):

Physician _____

Physician _____

Weight and weight loss history:

Height: _____ ft. _____ in. Weight: _____ lbs.

Age of obesity onset:

☐ 0-2 years old ☐ 12-18 years old ☐ Pregnancy

☐ 2-12 years old ☐ Young adult ☐ Middle age

How many years have you been at your present weight? _____

Five year weight history:

YEAR	WEIGHT (pounds)

Have you ever had an eating disorder? _____

_____

_____

☐ Anorexia Nervosa ☐ Bulimia

Are you a "sweets" eater? _____

Please complete the following diet history:

NAME OF PROGRAM	YEAR & LENGTH OF PARTICIPATION	WEIGHT LOSS
Weight Watchers®		
Nutrisystem®		
Atkins™		
Diet Center®		
Jenny Craig®		
OPTIFAST®		
Slim-Fast®		
Herbal Diet		
TOPS®		
Richard Simmons®		
Low fat		
Cabbage soup diet		
American Heart Association® diet		
Dexatrim®		
Sibutramine (Meridia)		
Orlistat (Xenical, Alli)		
Phentermine (Ionamin, Adipex)		
Phentermine/Fenfluoramine (Phen/Fen)		
Other:		
Other:		

What kind of exercise can you do:

_____

_____

_____

Details of any other weight loss measures (including surgical):

_____

_____

_____

_____

Past medical history:

List all hospitalizations and illnesses for which you have been treated, e.g. diabetes, hypertension, heart disease, lung disorders, etc.)

_____

_____

_____

_____

Medical history:

Do you have any of the following conditions? (please check)

Diabetes	☐ No	☐ Yes	(complete section below)
Hypertension	☐ No	☐ Yes	(complete section below)
Sleep apnea	☐ No	☐ Yes	(complete section below)
GERD (reflux disease)	☐ No	☐ Yes	(complete section below)
Cancer	☐ No	☐ Yes	(complete section below)
Arthritis	☐ No	☐ Yes	
Joint pain	☐ No	☐ Yes	
Urinary incontinence	☐ No	☐ Yes	
Elevated cholesterol	☐ No	☐ Yes	
Anemia	☐ No	☐ Yes	
Osteoporosis	☐ No	☐ Yes	

Diabetes – If you have been diagnosed with or treated for diabetes, please complete the following section:

Juvenile onset	☐ No	☐ Yes	Year diagnosed _____
Adult onset	☐ No	☐ Yes	Year diagnosed _____

Current form of control:

Diet control only	☐ No	☐ Yes	
Oral hypoglycemics	☐ No	☐ Yes	
Insulin	☐ No	☐ Yes	Number of injections per day_____

Do you have glycosylated hemoglobin (HgA1c) levels tested? ☐ No ☐ Yes

If yes, what is your level (if you know) _____

Hypertension – If you have hypertension, please complete the following section:

How long have you had hypertension?_____

Are you taking medication for hypertension? ☐ No ☐ Yes _____# of meds

Sleep Apnea – If you have sleep apnea, please complete the following section:

When were you diagnosed with sleep apnea? _____

Do you use CPAP? ☐ No ☐ Yes (what settings?) _____

Do you use BiPAP? ☐ No ☐ Yes (what settings?) _____

GERD – If you have GERD, please complete the following section:

Do you have reflux during the day? ☐ No ☐ Yes

If yes, how often?

☐ Many times per day ☐ Every day ☐ Most days ☐ Most weeks ☐ Occasionally

Do you suffer from heartburn/indigestion during the night? ☐ No ☐ Yes

If yes, how often?

☐ Many times per night ☐ Every night ☐ Most nights ☐ Most weeks ☐ Occasionally

Does food or fluid reflux in the mouth? ☐ No ☐ Yes

Do you vomit with reflux? ☐ No ☐ Yes

Treatments you may use for reflux, heartburn, or indigestion, either prescribed or over the counter.
Check all that apply.

☐ Zantac ☐ Tagamet ☐ Pepcid ☐ Prevacid

☐ Nexium ☐ Prilosec ☐ Surgery

Cancer – If you have been treated for cancer, please check all that apply:

☐ Breast ☐ Endometrial ☐ Prostate ☐ Colon

☐ Thyroid ☐ Skin ☐ Blood ☐ Other (name) _____

Year diagnosed _____ Cancer free for _____ years

Treatment (check all that apply):

☐ Surgery ☐ Chemotherapy ☐ Radiation ☐ Medication

Past surgical history:

_____

_____

_____

_____

Any problems with anesthesia? ☐ No ☐ Yes

If yes, please describe: _____

_____

_____

Have you had a previous blood transfusion? ☐ No ☐ Yes

If yes, date _____ reason _____

Have you had a transfusion reaction? ☐ No ☐ Yes

If yes, describe _____

Will you accept blood products in an emergency? ☐ No ☐ Yes

Current medications:

DRUG	DOSE	FREQUENCY

Allergies and adverse reactions:

Include x-ray dye, antibiotics, skin preps, latex, pain medications, if applicable.

_____

_____

Latex allergy screening questionnaire:

Do you have an allergy to any latex products?	☐ No	☐ Yes
Have you experienced local swelling, itching, or dermatitis associated with latex contact?	☐ No	☐ Yes
Do you have a history of wheel or blister formation on contact with latex products	☐ No	☐ Yes
Have you had an allergic reaction to tape?	☐ No	☐ Yes
Have you had any food allergies?	☐ No	☐ Yes

If yes, list here: _____

_____

Family history:

FAMILY MEMBER	ALIVE OR DECEASED	AGE	HEALTH PROBLEMS AND/OR CAUSE OF DEATH
Father			
Mother			
Sibling			
Sibling			
Sibling			

Is there a family history of morbid obesity? _____

Social history: Check all that apply.

Marital Status: ☐ Single ☐ Married ☐ Divorced since _____ ☐ Widowed since _____

Number of children: _____

Living Will: ☐ No ☐ Yes

Tobacco use: ☐ None ☐ Use smokeless tobacco

☐ Currently smoke _____ PPD for _____ years

☐ Previously smoked _____ PPD for _____ years, stopped in _____

Alcohol: ☐ None ☐ Minimal ☐ Moderate ☐ Heavy ☐ Previously heavy

Caffeine: ☐ None ☐ Minimal ☐ Moderate ☐ Heavy

Drug Use: ☐ Marijuana ☐ Cocaine ☐ Crack ☐ Heroin

☐ Other (please list): _____

Occupation: _____

If you are unemployed, how long? _____

What is your functional status?

☐ Independent ☐ Partially dependent ☐ Dependent

Are you currently disabled or on disability? ☐ No ☐ Yes

If so, how long? _____

Review of systems: Please check yes or no for each question.

General

Are you currently pregnant?	☐ No	☐ Yes
Have you had any surgery in the past 20 days?	☐ No	☐ Yes

Gastrointestinal

Do you have any liver disease?	☐ No	☐ Yes
Have you had any yellow color to your eyes/skin?	☐ No	☐ Yes
Have you had trouble with your gallbladder?	☐ No	☐ Yes
Have you had any abdominal pain recently?	☐ No	☐ Yes
Have you had any rectal bleeding recently?	☐ No	☐ Yes

Cardiac

Do you have irregular heart beats?	☐ No	☐ Yes
Do you have a heart valve abnormality?	☐ No	☐ Yes
Do you have a pacemaker?	☐ No	☐ Yes
Have you ever had congestive heart failure?	☐ No	☐ Yes
Have you ever had a heart attack (MI)?	☐ No	☐ Yes
Have you had previous heart surgery?	☐ No	☐ Yes
Have you had an angioplasty or stent placement?	☐ No	☐ Yes
Have you had any chest pain or angina in the past 30 days?	☐ No	☐ Yes

Results of previous cardiac testing:

Have you ever had an EKG?	☐ No	☐ Yes	
If yes, what were the results?	☐ Normal	☐ Abnormal	☐ Further testing required
Have you ever had a stress test?	☐ No	☐ Yes	
If yes, what were the results?	☐ Normal	☐ Abnormal	☐ Further testing required
Have you ever had an echocardiogram?	☐ No	☐ Yes	
If yes, what were the results?	☐ Normal	☐ Abnormal	☐ Further testing required
Have you ever had cardiac catheterization?	☐ No	☐ Yes	
If yes, what were the results?	☐ Normal	☐ Abnormal	☐ Further testing required

Pulmonary

Do you have any history of severe emphysema?	☐ No	☐ Yes
Do you have any history of severe bronchitis?	☐ No	☐ Yes
Do you have any history of severe COPD?	☐ No	☐ Yes
Do you have asthma?	☐ No	☐ Yes
Are you using supplemental oxygen?	☐ No	☐ Yes
Do you have shortness of breath at rest?	☐ No	☐ Yes
Do you have shortness of breath on exertion?	☐ No	☐ Yes
Do you have a history of pulmonary embolism?	☐ No	☐ Yes

Vascular

Have you had a previous amputation?	☐ No	☐ Yes
Have you had bypass surgery in a leg?	☐ No	☐ Yes
Do you have pain in your legs at rest?	☐ No	☐ Yes
Are you on dialysis for renal failure?	☐ No	☐ Yes
Have you ever had a deep venous thrombosis (DVT) that required treatment?	☐ No	☐ Yes
Do you have renal insufficiency?	☐ No	☐ Yes
Do you have venous stasis?	☐ No	☐ Yes
Do you have varicose veins?	☐ No	☐ Yes

Musculoskeletal

Do you have any bone or joint problems?	☐ No	☐ Yes
Do you have arthritis?	☐ No	☐ Yes
Do you have chronic back problems?	☐ No	☐ Yes
Do you have fibromyalgia?	☐ No	☐ Yes
Is your ability to walk limited?	☐ No	☐ Yes

Central Nervous System

Do you have any paralysis or partial paralysis of legs/arms?	☐ No	☐ Yes
Do you have a history of TIA's or mini-strokes?	☐ No	☐ Yes
Do you have any history of CVA (stroke)?	☐ No	☐ Yes
Do you have any history of seizures?	☐ No	☐ Yes

Skin

Do you have rashes? ☐ No ☐ Yes
Do you have psoriasis? ☐ No ☐ Yes
Do you have non-healing lesions? ☐ No ☐ Yes
Do you have any history of melanoma? ☐ No ☐ Yes
Do you have any history of other skin cancers? ☐ No ☐ Yes
Do you have any open wounds? ☐ No ☐ Yes

Emotional

Do you have anxiety? ☐ No ☐ Yes
Do you have depression? ☐ No ☐ Yes
Are you undergoing psychiatric therapy? ☐ No ☐ Yes

Endocrine

Do you have any history of thyroid disorder? ☐ No ☐ Yes
Do you have any history of heat or cold intolerance? ☐ No ☐ Yes
Are you taking thyroid medication? ☐ No ☐ Yes
Do you have any history of an adrenal disorder? ☐ No ☐ Yes
Do you have any history of a pituitary disorder? ☐ No ☐ Yes
Do you take any steroids or immunosuppressants for a chronic condition? ☐ No ☐ Yes

Hematologic/Lymphatic

Do you have any history of anemia? ☐ No ☐ Yes
Do you bruise easily? ☐ No ☐ Yes
Do you have any history of excessive bleeding? ☐ No ☐ Yes
Have you had a blood transfusion in the last six months? ☐ No ☐ Yes
Do you have any history of leukemia or lymphoma? ☐ No ☐ Yes
Do you have sickle cell? ☐ No ☐ Yes
Are you on medication for anti-coagulation? ☐ No ☐ Yes

Infectious

Are you HIV positive? ☐ No ☐ Yes
Do you have any history of hepatitis? ☐ No ☐ Yes
If yes, what type? ☐ A ☐ B ☐ C
Do you have any history of staph infection? ☐ No ☐ Yes
Do you have any history of MRSA or ORSA? ☐ No ☐ Yes

Breasts

Do you have a personal history of breast cancer? ☐ No ☐ Yes
Do you have a current abnormal mammogram or sonogram? ☐ No ☐ Yes
When was your last mammogram? _____
Are you overdue for mammogram? ☐ No ☐ Yes

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations? This survey refers to your usual way of life today. Even if you have not done some of these things recently, try to imagine how you would have been affected. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

ACTIVITY	SCORE
Sitting and reading	
Watching TV	
Sitting, inactive, in a public place (e.g. movie theater)	
As a passenger in a car for an hour with no break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch with alcohol	
Sitting quietly after lunch with no alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL	

I attended the Baptist Center for Bariatrics informational seminar on _____/_____/_____

Patient's signature _____ Date _____

You may wish for Baptist Center for Bariatrics to discuss your confidential information with others (such as spouse, partner, family member, etc.). We need your permission to do this.

☐ I DO NOT authorize Baptist Center for Bariatrics to discuss my confidential information.

☐ I DO authorize Baptist Center for Bariatrics to discuss my confidential information with:

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Patient's signature _____ Date _____

PLEASE COMPLETE THIS FORM AND EITHER BRING IT TO YOUR STEP 2 OFFICE VISIT OR RETURN IT PRIOR TO YOUR VISIT BY FAX:

Fax: 904-391-5451, ATTN: Bariatric Coordinator

Questions? Call 904.202.7546

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