

**Name:** \_\_\_\_\_ **DOB** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

We will not share your information with any third party outside of our organization.

**Primary Care Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Emergency Contact :** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Pharmacy Name and Phone Number:** \_\_\_\_\_

**1. Medical problems: (check all that apply)**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> High Blood Pressure                | <input type="checkbox"/> High cholesterol                        | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> COPD                    |
| <input type="checkbox"/> Congestive Heart Failure           | <input type="checkbox"/> Heart Attack                            | <input type="checkbox"/> Kidney Disease    | <input type="checkbox"/> Urinary Incontinence    |
| <input type="checkbox"/> Polycystic Ovaries                 | <input type="checkbox"/> Back Pain                               | <input type="checkbox"/> Joint Pain        | <input type="checkbox"/> Pseudotumor Cerebri     |
| <input type="checkbox"/> Asthma                             | <input type="checkbox"/> Atrial Fibrillation                     | <input type="checkbox"/> Chronic Fatigue   | <input type="checkbox"/> Heartburn (Acid Reflux) |
| <input type="checkbox"/> Stomach Ulcers                     | <input type="checkbox"/> Migraines                               | <input type="checkbox"/> Stroke            | <input type="checkbox"/> Liver Disease           |
| <input type="checkbox"/> Gout                               | <input type="checkbox"/> Deep Vein Thrombosis                    | <input type="checkbox"/> Pulmonary Embolus | <input type="checkbox"/> Depression              |
| <input type="checkbox"/> Anxiety                            | <input type="checkbox"/> Sleep Apnea – CPAP/BiPaP settings _____ |  |  |
| <input type="checkbox"/> Cancer (please specify type) _____ |  |  |  |
| <input type="checkbox"/> Other _____                        |  |  |  |

**2. Previous Surgeries/ procedures: (This includes all c-sections and hysterectomy, also include year of the procedure and if it was open or laparoscopic)**

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3. For women: Have you had a tubal ligation, Essure procedure or IUD implanted for pregnancy prevention? Yes/No

4. Are you medications up to date in our computer system? Yes / No

**5. Allergies – please include any drug allergies, and the type of reaction (for example, rash, or vomiting, or breathing difficulty) and level of severity (mild, moderate or severe):**

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**6. Have you been hospitalized or seen in the ER for any reason in the past year? Yes / No**  
 If Yes, please explain why (for example: chest pain, or abdominal pain, or car accident, etc):

Date:	What Hospital?	Reason for visit/admission?



**11. Weight Loss Program History Form: (PLEASE LIST ALL ATTEMPTS AT WEIGHT LOSS)**

Type of weight loss program (for example: Weight Watchers®, physician supervised diet, prescription diet pills, cutting calories etc):	Number of times tried	How long did you follow the diet	What year(s) did you try the diet	What were the results (long-term and short-term?)

**12. Are you currently experiencing any of the following problems on a frequent basis?**

<b>Constitutional:</b>			<b>GI:</b>		
Fevers	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Nausea	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Chills	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Reflux Symptoms (Heartburn)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Night Sweats	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Frequent Diarrhea	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>SLEEP:</b>			Frequent Constipation	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Daytime sleepiness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Black, tarry stools	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Snoring	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bloody stools	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Stop breathing during sleep	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Abdominal pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Morning headaches	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<b>GU:</b>		
<b>HEENT:</b>			Painful urination	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Frequent headaches	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Blood in urine	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Difficulty eating or swallowing	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<b>Musculoskeletal:</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>Cardiovascular:</b>			Joint pains	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Chest pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Back pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Difficulty breathing while lying down	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Frequent muscular pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Shortness of Breath	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<b>Neurologic:</b>		
Palpitations	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Dizziness	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Lower extremity swelling	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Seizures	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>Respiratory:</b>			Numbness	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Frequent cough	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Weakness	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pain on inspiration	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Wheezing	Yes <input type="checkbox"/>	No <input type="checkbox"/>			

<b>Psychiatric:</b>			<b>Endocrine:</b>		
Depression	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Frequent urination	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anxiety	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Frequent thirst	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>Dermatologic:</b>			<b>Hematologic:</b>		
Rashes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Easy bruising	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Non-healing wounds	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bleeding of gums	Yes <input type="checkbox"/>	No <input type="checkbox"/>
			Frequent nose bleeds	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**13. How did you hear about Tulane Bariatric Center?**

- Referred by a doctor    Doctor's Name \_\_\_\_\_ Doctor's Specialty \_\_\_\_\_
- Social media (please circle) Facebook Instagram
- Internet search
- Heard from a friend
- Other (Please describe) \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**For office use only: STOP BANG Questionnaire**

- Snoring Yes / No
- Tired during the day Yes / No
- Observed apneas Yes / No
- Blood pressure (dx or being treated) Yes / No
- BMI (>35) Yes / No
- Age (> 50) Yes / No
- Neck circumference (>40 cm) Yes / No
- Gender (male) Yes / No

**Pictures have been taken and uploaded into EWC**