Tulane
Health System
BARIATRIC CENTER

MWL NEW PATIENT INFORMATION
Place Patient Sticker Here
Date _____

Name:_____DOB_____SS#(optional): _____

Preferred Name: _____ Preferred Pronouns: he/his, she/her, they/their,_____

Gender: _____Sex Identified at Birth: _____

Email Address:_____ Phone: _____

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

Primary Care Provider: _____ Phone: _____

Emergency Contact :_____ Phone: _____

Pharmacy Name and Phone

Number:_____

1. Medical problems: (circle all that apply)

High Blood Pressure	High Cholesterol	Diabetes	COPD
Congestive Heart Failure	Heart Attack	Kidney Disease	Urinary Incontinence
Polycystic Ovaries	Mitral Valve Prolapse	Joint Pain	Pseudotumor Cerebri
Asthma	Atrial Fibrillation	Chronic Fatigue	Heartburn (Acid Reflux)
Stomach Ulcers	Migraines	Stroke	Liver Disease
Gout	Deep Vein Thrombosis	Pulmonary Embolus	Depression
Anxiety	Sleep Apnea	MEN Syndrome	Bulimia/Anorexia
Back pain	Glaucoma	Cancer	

End stage renal disease on dialysis (Please list renal dietitian name & Phone number)

2. Have you ever been treated for…

Drug abuse? Yes No

Laxative abuse? Yes No

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

_____

_____

4. Are you pregnant or trying to get pregnant? Yes No

Have you had a tubal ligation, Essure procedure or IUD implanted for pregnancy prevention?

Yes No N/A

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5. Do you have any allergies? Yes No

If yes – please list 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 (including psychiatric care) 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?**

7. Social history:

Do you smoke/ have you smoked in the past?

Yes / No # packs/day_____ # of years _____ Quit date: _____

Do you use tobacco products (dip, chew, e-cigarette)?

Yes No How often_____ # of years_____ Quit date:_____

Do you drink alcohol? Yes / No Amount_____ How often:_____

Do you work night shift?_____

8. Family History: (check all that apply)

- □ Morbid Obesity
- □ High Blood Pressure
- □ Heart Disease
- □ LungDisease
- □ Diabetes
- □ Bleeding Problems
- □ Cancer
- □ Blood clot
- □ MEN Syndrome
- □ Other

9. Activity History

- What is the most demanding physical activity you participate in? _____
- Can you walk for 1 block or 50 yards without stopping? Yes No
- Can you do light house work, like dusting or doing dishes, without stopping? Yes No
- Can you climb a flight of stairs without stopping? Yes No
- What limits your activity (for example, joint or back pain, chest pain, or shortness of breath, or balance limitations, or vision limitations)? _____
- Do you use any of the following devices for assistance?

  walker cane wheelchair □ other _____

10. Weight Loss Program History Form: Check all the following that you have tried

Have you tried?	Did you lose weight? If so, how much?
☐ Phentermine (Adipex)	
☐ Topiramate (Topamax)	
☐ Contrave	
☐ Liraglutide (Saxenda)	
☐ Other weight loss medication _____	
☐Physician supervised weight loss program	
☐ Weight watchers	
☐ Prepared food program	
☐ Macro or calorie counting	
☐ Keto	
☐ Weight loss surgery	
☐ Other _____	

11. How motivated are you to lose weight? (1 not motivated at all -> 10 extremely motivated)
1 2 3 4 5 6 7 8 9 10

12. How confident are you that you can lose weight? (1 not confident at all -> 10 extremely confident)
1 2 3 4 5 6 7 8 9 10

13. Do you have a scale to weigh yourself at home? Yes No

14. Do you have a blood pressure cuff at home? Yes No

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

Constitutional:			**GI:**		
Fevers	Yes	No	Black, tarry stools	Yes	No
Chills	Yes	No	Bloody stools	Yes	No
Night Sweats	Yes	No	Abdominal pain	Yes	No
Unexplained Weight Loss	Yes	No	**GU:**		
SLEEP:			Painful urination	Yes	No
Daytime sleepiness	Yes	No	Blood in urine	Yes	No
Snoring	Yes	No	**Musculoskeletal:**		
Stop breathing during sleep	Yes	No	Joint pains	Yes	No
Morning headaches	Yes	No	Back pain	Yes	No
HEENT:			Frequent muscular pain	Yes	No
Frequent headaches	Yes	No	**Neurologic:**		
Difficulty eating or swallowing	Yes	No	Dizziness	Yes	No
Cardiovascular:			Seizures	Yes	No
Chest pain	Yes	No	Numbness	Yes	No
Difficulty breathing while lying down	Yes	No	Weakness	Yes	No
Shortness of Breath	Yes	No	**Psychiatric:**		
Palpitations	Yes	No	Depression	Yes	No
Lower extremity swelling	Yes	No	Anxiety	Yes	No
Respiratory:			**Dermatologic:**		
Frequent cough	Yes	No	Rashes	Yes	No
Pain on inspiration	Yes	No	Non-healing wounds	Yes	No
Wheezing	Yes	No	**Endocrine:**		
GI:			Frequent urination	Yes	No
Nausea	Yes	No	Frequent thirst	Yes	No
Reflux Symptoms (Heartburn)	Yes	No	**Hematologic:**		
Frequent Diarrhea	Yes	No	Easy bruising	Yes	No
Frequent Constipation	Yes	No	Bleeding of gums	Yes	No
			Frequent nose bleeds	Yes	No

11. How did you hear about Tulane Bariatric Center?

☐ Referred by a doctor Doctor's Name _____ Doctor's Specialty

☐ Social media (please circle) Facebook or Instagram

☐ Internet search

□ Heard from a friend

☐ Other (Please describe) _____

Patient Signature: _____Date: _____