OHSU BARIATRIC SERVICES

Health History

Please fill out this form completely and email or fax to the contact information at the bottom of this form. We will contact you to set up an appointment.

Date _____

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

Age _____ Height _____ Weight _____ BMI _____

Date of birth _____ ☐ Male ☐ Female

Email _____

Are you currently a patient at OHSU? ☐ Yes ☐ No

What is your OHSU medical record number? _____

Primary insurance company _____

Secondary insurance company _____

Does your insurance cover bariatric surgery for morbid obesity? ☐ Yes ☐ No ☐ Don't know (If you don't know, please obtain a summary of benefits from your insurance company.)

Which type of bariatric procedure are you interested in? ☐ Lap band ☐ Gastric bypass ☐ Sleeve

Primary care provider _____

Office address _____ Phone _____

City _____ State _____ Zip _____

Referring provider (if different than above) _____

Office address _____ Phone _____

City _____ State _____ Zip _____

OHSU Bariatric Services; 3303 S.W. Bond Avenue, CHH6D; Portland, OR 97239
Phone: 503-494-1983 | Fax: 503-418-3683 | Email: w8reduce@ohsu.edu | www.ohsu.edu/bariatric

Personal Health History

Have you ever had or do you currently have any of the conditions listed below?

General

Are you able to walk? ☐ Yes ☐ No

If yes, how far? _____

Assistive devices used:

☐ Cane ☐ Walker ☐ Wheelchair

Do you use extra oxygen ☐ Yes ☐ No

If so, how much? _____

When? _____

Brain/nervous system

Stroke/TIA	☐ Yes	☐ No
Tumor	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Dizziness/vertigo	☐ Yes	☐ No
Numbness in hands or feet	☐ Yes	☐ No

Cardiovascular

Blood clot/DVT/PE	☐ Yes	☐ No
Chest pain/angina	☐ Yes	☐ No
Congestive heart failure	☐ Yes	☐ No
Fainting	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
High cholesterol	☐ Yes	☐ No
Murmur	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Palpitation	☐ Yes	☐ No

Skin

Leg sores/infections	☐ Yes	☐ No
Other skin infections	☐ Yes	☐ No

Where _____

Intestinal tract

Heartburn/GERD	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No
Nausea/vomiting	☐ Yes	☐ No
Loss of appetite	☐ Yes	☐ No
Abdominal pain	☐ Yes	☐ No
Spleen removed	☐ Yes	☐ No
Gallstones	☐ Yes	☐ No
Stomach bleeding	☐ Yes	☐ No
Intestinal blockage	☐ Yes	☐ No
Change in bowels	☐ Yes	☐ No
Blood in stool	☐ Yes	☐ No
Irritable bowel	☐ Yes	☐ No
Liver disease/hepatitis	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No

GI tests done _____

Mental health

Anxiety	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Bipolar disease	☐ Yes	☐ No
Obsessive-compulsive disorder	☐ Yes	☐ No
Schizophrenia	☐ Yes	☐ No

Muscle/bone/autoimmune

Osteoarthritis	☐ Yes	☐ No
Rheumatoid arthritis	☐ Yes	☐ No
Lupus	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No
Degenerative disc disease	☐ Yes	☐ No
Multiple sclerosis	☐ Yes	☐ No
Gout	☐ Yes	☐ No

Respiratory

Short of breath ☐ Yes ☐ No
Asthma ☐ Yes ☐ No
Pneumonia ☐ Yes ☐ No
Emphysema ☐ Yes ☐ No
Cough ☐ Yes ☐ No
Sleep apnea ☐ Yes ☐ No
BiPAP/CPAP ☐ Yes ☐ Setting _____

Urinary and reproductive

Kidney disease ☐ Yes ☐ No
Kidney stones ☐ Yes ☐ No
Urine leakage ☐ Yes ☐ No
Prostate problems ☐ Yes ☐ No
Irregular periods ☐ Yes ☐ No
Abnormal Pap test ☐ Yes ☐ No
Last period _____
Birth control method _____

Other

Diabetes ☐ Yes ☐ No
Thyroid disease ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No
Anemia ☐ Yes ☐ No
PCOS: Polycystic ovarian syndrome ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Type _____
When _____
Serious injuries _____
Other medical problems _____
_____

Please list all previous surgeries

Operation	When	Where

Family medical history

	Age	Health problems	Alive/dead	Cause of death
Father				
Mother				
Brother				
Sister				
Children				

Habits

	Currently	In the past
Caffeine	☐ Yes ☐ No	☐ Yes ☐ No
Cocaine	☐ Yes ☐ No	☐ Yes ☐ No
Amphetamines	☐ Yes ☐ No	☐ Yes ☐ No
Marijuana	☐ Yes ☐ No	☐ Yes ☐ No
Smoking	☐ Yes ☐ No	☐ Yes ☐ No
Number of packs smoked per day		
How many total years have you smoked?		
Alcohol consumption	☐ Yes ☐ No	☐ Yes ☐ No
How many drinks per week?		
Have you been in treatment for alcohol or drug use?	☐ Yes ☐ No	☐ Yes ☐ No
When		

Social history

Are you currently working? ☐ Yes ☐ No Occupation _____

Does your job require lifting? ☐ Yes ☐ No If yes, how much? _____

If on disability, please list reason _____

Are your married or living with someone? ☐ Yes ☐ No

Who will be available to help you after surgery? _____

What are your expectations with weight loss surgery? _____

List all your prescribed and non-prescribed medications including herbal products.

Medication	Dosage	How often taken

Do you take Coumadin, aspirin or other blood thinners? ☐ Yes ☐ No

Pharmacy name and address _____

Phone _____

Drug allergies and reactions _____

_____

_____

Diet history

How old were you when you first decided you were overweight? _____ How much did you weigh? _____

How old were you when you started your first diet? _____ How much did you weigh? _____

Please list the diets you have tried. (For example, Weight Watchers, Phen-Phen , cabbage soup diet) We realize that you may not be able to remember each effort of weight loss. However, this information is very necessary to justify your insurance coverage and/or qualification for the surgery. So please fill out as best as you can.

Date	Kind of weight loss episode/attempt – medicine, exercise	Supervised? By whom	Starting weight	Amount of weight loss	Over how many months	Number of months main-tained	How much gained back	Over how long

To the best of my knowledge, the information provided above is accurate.

Signature _____ Date _____

OHSU BARIATRIC SERVICES

Nutrition questionnaire

Please complete this form and bring it to the dietician visit, along with the eating pattern questionnaire

1. Did you attend an OHSU bariatric seminar or watch one online? ☐ Yes ☐ No
2. List below any changes you've made since the seminar related to food or beverage intake.

   _____

3. Do you have any food allergies? ☐ Yes ☐ No If yes, please indicate food and allergic reaction symptoms.

   _____

4. List foods that do not agree with you (example, cause gas or heartburn).

   _____

5. Do you have lactose intolerance (gas, bloating or diarrhea) after consuming milk, ice cream, yogurt or cheese? ☐ Yes ☐ No
6. List all dairy foods that you consume. _____
7. List foods that you do not like or will not eat. _____
8. Do you feel you are an emotional eater? ☐ Yes ☐ No If yes, which circumstances trigger your emotional eating behavior?

   _____

9. Indicate your best "diet success" and why it worked for you.

   _____

10. List any physical activity you are currently doing for exercise.

    _____

11. List activities you are not doing now, but would like to do in the future.

    _____

12. Height _____ Weight _____ lbs.
13. Has your weight changed in the past year? ☐ Yes ☐ No
14. Medical conditions: (please circle)
    - ☐ Diabetes
    - ☐ High blood pressure
    - ☐ High cholesterol
    - ☐ Depression and/ or anxiety
    - ☐ Joint or back pain
    - ☐ Polycystic ovaries
    - ☐ Sleep apnea

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Eating pattern questionnaire

Name _____ **Date** _____

Please answer the following questions and check the boxes that most closely describe your eating patterns.

1. Do you follow a special diet? ☐ Yes ☐ No ☐ Diabetic ☐ Low sodium ☐ Low fat ☐ Kosher ☐ Vegetarian ☐ Other Give examples of the guidelines or diets, if any you follow _____

2. Which meals do you regularly eat? ☐ Breakfast ☐ Lunch ☐ Brunch ☐ Dinner

3. When do you snack? ☐ Morning ☐ Afternoon ☐ Evening ☐ Late night ☐ Throughout the day ☐ Middle of the night What are your favorite snack foods? _____

4. Do you eat out or order food in? ☐ Yes ☐ No How often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other What kind of restaurant/eating facilities? _____ What kinds of cuisine? _____

5. How is your food usually prepared? (check all that apply) ☐ Baked ☐ Broiled ☐ Boiled ☐ Fried ☐ Steamed ☐ Poached ☐ Other _____

6. How many times each day do you eat the following food items?

A.	Starch (bread, bagel, roll, cereal, pasta, noodles, rice, potato)	☐ never	☐ less than 1	☐ 1-2	☐ 3-5	☐ 6-8	☐ 9-11
B.	Fruit	☐ never	☐ less than 1	☐ 1-2	☐ 3-5	☐ 6-8	☐ 9-11
C.	Vegetables	☐ never	☐ less than 1	☐ 1-2	☐ 3-5	☐ 6-8	☐ 9-11
D.	Dairy (milk, yogurt)	☐ never	☐ less than 1	☐ 1-2	☐ 3-5	☐ 6-8	☐ 9-11
E.	Meat, fish, poultry, eggs, cheese	☐ never	☐ less than 1	☐ 1-2	☐ 3-5	☐ 6-8	☐ 9-11
F.	Fat (butter, margarine, mayonnaise, oil, salad dressing, sour cream, cream cheese)	☐ never	☐ less than 1	☐ 1-2	☐ 3-5	☐ 6-8	☐ 9-11
G.	Sweets (candy, cake, regular soda, juice)	☐ never	☐ less than 1	☐ 1-2	☐ 3-5	☐ 6-8	☐ 9-11

7. What beverages do you drink daily and how much?
   - ☐ Water _____ times or glasses per day (8 oz)
   - ☐ Coffee _____ times or cups per day
   - ☐ Tea _____ times or cups per day
   - ☐ Soda _____ times or glasses per day (12 oz)
   - ☐ Alcohol _____ times or glasses per day (12 oz)
   - ☐ Other _____ times or glasses per day (specify) _____

8. Would you like to change your eating habits? ☐ Yes ☐ No Which habits would you like to begin to change? _____

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