



BARIATRIC CENTER
AT COLUMBUS REGIONAL HOSPITAL

2325 18TH STREET • COLUMBUS, INDIANA 47201 • (812)375-3972

PATIENT HEALTH INFORMATION

PERSONAL INFORMATION

Form containing personal information fields: NAME (Last, First, Middle Initial), AGE, SEX (M/F), BIRTHDATE (MM/DD/YY), SOCIAL SECURITY NUMBER, ADDRESS (Street, City, State, Zip Code), TELEPHONE (patient's), Can we leave a message at work, Can we share phone/e-mail with support group patients to update you, E-Mail, Name of Person to Notify in Case of Emergency, Name & Full Address of Personal Physician, Insurance Name, (Name), Address, (Address), Insurance Telephone Number (with extensions), (Relationship), Physician Office Telephone Number, SS#, Home Phone, Cell Phone, D.O.B.

PERSONAL HISTORY

HEALTH HABITS

- A. Do you currently smoke? Yes No If yes, how many a day? Cigars or Chewing Tobacco?
B. If you used tobacco products in the past, when did you quit?
C. Eat sweets frequently Yes No If yes, how much a day?
D. Do you drink alcohol? Yes No How much/how often?
E. Do you now or have you ever used illegal drugs? Yes No Explain
F. Do you drink coffee or use caffeine products? Yes No If yes, how much per day?
G. How many carbonated beverages do you drink per day? Are they Sugar Free? Yes No
H. Marital Status:
I. Do you have children? Yes No Ages:
J. Do you wear any of the following: Ortho Braces Special shoes Hearing aid(s) Glasses Dentures CPAP/Bipap Other (specify):
K. Do you exercise? Yes No If yes, what type of exercise and how often?
L. Are there any barriers that prevent you from exercising or walking after surgery?
M. What is your occupation: Do you lift heavy objects in your job? Yes No
N. Please list your hobbies, recreational activities or any other job activities in which you may be involved.
O. Do you do any heavy lifting? Yes No Explain:
P. Do you in a routine day do excessive walking / standing? Yes No Explain:
Q. In your own words, please tell us the reason why you are seeing the doctor today?
R. Do you have problems reading or writing beyond the 6th grade level? Yes No

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2400 EAST 17TH STREET, COLUMBUS, INDIANA 47201
1-800-841-4938 812-379-4441

Patient Health Information

PATIENT LABEL OR

Patient Name:
DOB:
MR #:

HEALTH HISTORY

I certify that all the information I provide is true and complete to the best of my knowledge. I understand that it is important the physician has complete and accurate information in order to provide safe medical evaluation and care. I understand that this medical history is used in providing care through the Bariatric Center, and that some information may need to share with referring physicians / counselors.

Signature _____ Date ____/____/____

As part of The Bariatric Center Program, we will periodically obtain pictures.
I agree that my pictures may be used for statistical / educational purposes.

Signature _____ Date ____/____/____

Can we release any records to family members? Yes No _____

ALLERGIES

Do you have any allergies to Drugs, Environmental Agents, Food Agents or Latex?

No Known Allergies Yes

If Yes, List:

Allergy	Describe Reaction

MEDICATIONS

Please **List All Medications** You Are Currently Taking or Have Taken During the Last 30 Days (including Vitamins, Birth Control Pills, Herbal Medications, etc.) **Include actual dosage and frequency.**

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY
1)			8)		
2)			9)		
3)			10)		
4)			11)		
5)			12)		
6)			13)		
7)			14)		

HOSPITALIZATIONS and SURGERIES

TYPE / REASON	SURGEON	PLACE OF SURGERY	DATE (if known)
1.			
2.			
3.			
4.			
5.			

PREVIOUS WEIGHT LOSS SURGERY Yes No

Type	Surgeon	Date	Results
1.			
2.			

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FAMILY HISTORY

Check Correct Box	Father	Mother	Brothers	Sisters	Father's Father	Father's Mother	Mother/s Father	Mother's Mother	Other
Asthma									
Heart Attack									
Cancer									
Diabetes									
Gall Bladder Disease									
High Blood Pressure									
Strokes									
Weight Problems									
Arthritis / Gout									
Seizures									
Problems with Anesthesia									

As Bariatric Patients have a high rate of Sleep Apnea and Blood Clot problems; please complete the Sleep Screening and Blood Clot Risk Factor forms. It is also important that a Weight Loss History be completed for insurance approval.

FOR DIABETIC PATIENTS ONLY

- A. Do you manage your diabetes with: Meal Plan Exercise Oral Meds Insulin
- B. Do you routinely test your blood sugar? Yes No If yes, how often? _____
- C. Do you have a Glycagon Kit? Yes No
- D. Do you have an Insulin Pump Yes No If yes, type and dose _____
- E. History of low or high blood sugar reactions: _____

FOR WOMEN ONLY

Please complete the following:

- A. Menstrual Cycle problems Yes No Explain: _____
- B. Hysterectomy Yes No Date: _____ Tubal Ligation Yes No Date: _____
- C. Menopausal Yes No Hot Flashes Yes No
- D. Problems having children Yes No Explain: _____
- E. Pregnant now Yes No Date of last period: _____
- F. Date of last Mammogram: _____ Date of last Pap Smear _____

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THROMBOSIS RISK FACTOR

Please read the list of risk factors below, and check all the factors that pertain to you, in lefthand column

✓ Check	Category	Score
	Age above 40	1
	Previous blood clot in legs (DVT) or Lungs (PE)	3
	Inability to walk more than a few steps	1
	Previous history of cancer	2
	Obesity (BMI >35=1 / BMI >55=2)	1
	Heart disease / Congested Heart Failure	3
	Varicose veins	1
	Limb trauma / injury	1
	Undergoing surgery (including proposed Bariatric Surgery)	1
	Hormone Replacement or Birth Control Pills	1
	History of Auto Immune Disease (Lupus, SLE, Rheumatoid Arthritis)	1
	Disease affecting the clotting of blood	2
SCORE: 0-1 Factor = Low Risk 2-4 Factors = Moderate Risk >4 Factors = High Risk		TOTAL SCORE

SLEEP SCREENING

Please check the following as they apply for you:

	QUESTION	YES	NO
2	Do you snore?		
2	If you snore, do others say your snoring is interrupted by choking or snoring sounds?		
2	Do others say you stop breathing while you sleep?		
2	Do you have trouble staying awake when you want to be awake?		
2	Do you fall asleep during any of the following? A. Watching TV: <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently B. While at work: <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently C. At the movies, church: <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently		
1	Do you fall asleep frequently while reading books or newspapers?		
2	Have you ever fallen asleep while driving?		
1	Do you have trouble getting to sleep or staying asleep when you want to sleep?		
1	Do you feel tired after 8 hours of sleep?		
1	Do you frequently get less than 7 hours of sleep in 24 hours?		
1	Do you have restless or crawling feelings in your legs when you sit or lie down?		
1	Do others say you have jerking movements of your legs during your sleep?		
5 or less = LOW 5-8 = MODERATE Above 8 = HIGH RISK		TOTAL	

How much caffeine do you have a day?

Coffee _____ Soft drinks _____ Tea _____ Chocolate _____ Other _____

Do you have any other sleep-related problems? Yes No

Have you had a sleep study in the last 2 years? Yes No Use CPAP/Bipap? Yes No

If yes explain: _____

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WEIGHT LOSS HISTORY

Please spend time completing this questionnaire in as complete detail as possible. This information is extremely important in determining your appropriateness for weight loss surgery.

Ideal weight _____ Age weight was first problem _____ Highest weight _____
Age at first weight loss attempt _____. Obese as a child Yes No Birth weight _____

Check all boxes below that apply to you

- Medi-Fast Opti-Fast Jenny Craig Richard Simmons Weight Watchers
 Nutri-Systems Gloria Marshall Pritikin T.O.P.S. Scarsdale
 Herbal Life Susan Powter Sweet Success Cal Ban 3000 Accutrim
 Slim fast Beverly Hills Physician's Weight Loss Center Dieter's Tea
 Atkins Cal Slim Diurex Amphetamines Fen-Phen
 Hypnosis Thyroid Supplements Fat Burners Cambridge Cabbage Soup
 Stillman Dexatrim Gastric Bubble Acupuncture Jaw Wiring
Injections: B-6 B-12 H.C.G Urine Other

Give complete details of all boxes checked above. (Start with most recent)
Please try to give as much specific information as possible

Name of Method _____ Date Tried: _____ To _____
Weight Loss _____ Weight Gained _____ Results _____

Name of Method _____ Date Tried: _____ To _____
Weight Loss _____ Weight Gained _____ Results _____

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