A Division of Arizona Community Surgeons

Patrick M. Chiasson, MD Stephen E. Burpee, MD
Billi Jo Koepke, FNP Julie Moreau, MSN, APRN

MEDICAL HISTORY INFORMATION

Surgeon: Chiasson ☐ or Burpee ☐

Last Name _____ **First Name** _____ **MI** _____

Date of Birth _____ **Gender:** Male Female **Primary Care:** _____

Race: (For Multi-racial choose all that apply)

☐ African American ☐ Caucasian ☐ Native American or Alaska Native ☐ Other
☐ Asian ☐ Hispanic ☐ Native Hawaiian or Other Pacific Islander

Employment Status:

☐ Full Time ☐ Part Time ☐ Self Employed ☐ Homemaker ☐ Not Specified
☐ Student ☐ Retired ☐ Disabled ☐ Unemployed

Employer: _____ **Occupation:** _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed

PREVIOUS BARIATRIC SURGERIES

Have you had a previous bariatric procedure? ☐ **YES** ☐ **NO**

If yes: Year _____ Surgeon_____

Original Weight _____lbs Lowest weight _____lbs

Which procedure?

☐ Biliopancreatic diversion (BPD) ☐ BPD with duodenal switch Gastrectomy
☐ Gastric band, adjustable ☐ Gastric band, non-adjustable
☐ Gastric bypass (Roux-en-Y), laparoscopic ☐ Gastric bypass (Roux-en-Y), open
☐ Gastric bypass (Roux-en-Y) with distal Gastrectomy, laparoscopic
☐ Gastric bypass (Roux-en-Y) with distal Gastrectomy, open
☐ Gastric bypass, banded ☐ Gastric bypass, mini loop
☐ Gastric pacing ☐ Intestinal bypass
☐ Sleeve gastrectomy ☐ Vertical banded gastroplasty
☐ Other _____

Did you have complications? ☐ **YES** ☐ **NO** If so, please describe _____

VITAMINS - *Please check any vitamins that you are currently taking.*

- ☐ Multi-Vitamin
- ☐ Vitamin A, D, E Combo
- ☐ Vitamin D
- ☐ Iron
- ☐ Calcium
- ☐ Calcium w/D
- ☐ Vitamin B-12

SURGICAL HISTORY - *Please check all that apply.*

- ☐ Anti-reflux procedure
- ☐ Breast cancer, biopsy
- ☐ CABG
- ☐ Cholecystectomy/Gallbladder Laparoscopic or Open
- ☐ Knee replacement
- ☐ Peripheral vascular procedure
- ☐ Vasectomy
- ☐ Hip replacement
- ☐ Breast cancer, mastectomy
- ☐ Cesarian section
- ☐ Appendectomy Laparoscopic or Open
- ☐ Laminectomy
- ☐ Tubal ligation
- ☐ Other: _____
- ☐ Breast cancer, radiation
- ☐ Bowel resection
- ☐ Discectomy
- ☐ Nissen fundoplication Laparoscopic or Open
- ☐ Hysterectomy (+/- oophorectomy)
- ☐ Vagotomy
- ☐ Other: _____

MEDICAL HISTORY - *Please check all that apply.*

Cardiovascular Disease

- ☐ Hypertension/High Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Ischemic Heart Disease
- ☐ Angina – chest pain
- ☐ Peripheral Vascular Disease
- ☐ Lower Extremity Edema
- ☐ DVT/PE - Blood Clots

Metabolic

- ☐ Glucose Metabolism – Diabetes
- ☐ Gout
- ☐ High Cholesterol/Lipids
- ☐ Thyroid – Hyper or Hypo

Pulmonary

- ☐ Sleep Apnea Syndrome
- ☐ Obesity Hypoventilation Syndrome
- ☐ Pulmonary Hypertension
- ☐ Asthma

Gastrointestinal

- ☐ GERD - Acid Reflux
- ☐ Gallstones
- ☐ Liver Disease

Musculoskeletal

- ☐ Musculoskeletal Disease - Arthritis
- ☐ Back Pain
- ☐ Fibromyalgia

Reproductive

- ☐ Polycystic Ovarian Syndrome
- ☐ Menstrual Irregularities (not PCOS)

Psychosocial

- ☐ Psychosocial Impairment
- ☐ Depression
- ☐ Bipolar disorder
- ☐ Anxiety/panic disorder
- ☐ Personality disorder

General - *Please check all that apply.*

Pseudotumor Cerebri

- ☐ Headaches, no visual symptoms
- ☐ Headaches with visual symptoms

☐ Stress Urinary Incontinence

☐ Abdominal Hernia

☐ Abdominal Skin/Pannus

☐ Blood Transfusion – date _____

Functional Status

- ☐ Requires assistance device to walk
- ☐ Requires wheelchair
- ☐ Bedridden

☐ Other: _____

☐ Other:_____

☐ MRS

SOCIAL HISTORY

Please check the boxes that apply.

Alcohol Use

☐ Never ☐ Rare ☐ Occasional ☐ Frequent

Tobacco Use

☐ Never ☐ Rare ☐ Occasional ☐ Frequent

Substance Abuse (Prescription or Illegal)

☐ Never ☐ Rare ☐ Occasional ☐ Frequent

FAMILY HISTORY

Please list illnesses that affected your parents (cancer, heart disease, blood clots, stroke, obesity)

Mother	Father

MEDICATIONS

Please list all prescription and over-the-counter medications you are currently taking and dosage.

Drug	Dosage	Drug	Dosage

ALLERGIES: ☐ No known allergies

Please list type and reaction

Drug	Reaction

Are you allergic to latex or tape? ☐ Yes ☐ No

DIET HISTORY

Age when you first dieted: _____ Total # of weight loss attempts: _____ Ideal weight: _____ lbs

Efforts at supervised weight loss
Note the programs that you have tried. Please complete all that apply to you.

PROGRAMS	Dates	MD Supervised	Max Wt Loss
Jenny Craig		Y / N	
Nutri-systems		Y / N	
Weight Watchers		Y / N	
Opti/Medi Fast		Y / N	
Phentermine		Y / N	
Meridia		Y / N	
Lindora		Y / N	
T.O.P.S.		Y / N	
O.A.		Y / N	
Acupuncture		Y / N	
Atkins		Y / N	
South Beach		Y / N	
Other		Y / N	

The above information is true and accurate.

_____
Patient signature

_____
Date