PHYSICIANS' CLINIC
of Iowa, P.C.

BARIATRIC SURGERY PATIENT INTAKE

Today's Date _____ First Name _____ Middle Initial_____ Last Name _____

Nickname _____ Date of Birth _____ Gender: ☐ Male ☐ Female

Family Physician _____ Referring Physician _____

Hospital Preference: ☐ Mercy Medical Center (Cedar Rapids) ☐ UnityPoint-St. Luke's Hospital

MEDICAL HISTORY: Check any condition that applies to you

☐ Problems with Anesthesia	☐ Depression	☐ Hyperthyroidism	☐ Rash/Skin Problem
☐ Acid Reflux	☐ Diabetes Type 1	☐ Hypothyroidism	☐ Rheumatoid Arthritis
☐ Angina	☐ Diabetes Type 2	☐ Insomnia	☐ Scleroderma
☐ Anxiety	☐ Difficulty Swallowing	☐ Irritable Bowel Syndrome	☐ Seizures
☐ Asthma	☐ Dizzy/Loss of Balance	☐ Liver Disease	☐ Shortness of Breath/on Exertion
☐ Bipolar Disorder	☐ Fatigue	☐ Low Blood Sugar	☐ Sleep Apnea
☐ Bleeding	☐ Fibromyalgia	☐ Lupus	☐ Snoring
☐ Blood Clots	☐ Gallbladder Disorder	☐ Malignant Hyperthermia	☐ Leak Urine when Cough/Sneeze
☐ Blood Transfusion	☐ GI Ulcer	☐ Metabolic Disorder	☐ Stroke
☐ Cardiomyopathy	☐ Gout	☐ Morbid Obesity	☐ Superventricular Tachycardia
☐ Carpal Tunnel	☐ Headaches	☐ Numbness/Tingling	☐ Swelling in Legs
☐ Cirrhosis	☐ Heart Attack	☐ Osteoarthritis	☐ Varicose Veins
☐ Clotting Disorder	☐ Hearing Loss	☐ Peripheral Vascular Disease	☐ Vision Problems
☐ Congestive Heart Failure	☐ High Blood Pressure	☐ Polycystic Ovarian Syndrome	☐ Other
☐ COPD	☐ High Cholesterol	☐ Pseudotumor Cerebri	

Please check any previous surgeries/hospitalizations:

☐ Adnoidextomy	☐ Biliopancreatic Diversion	☐ Fracture Surgery	☐ Intestinal Bypass
☐ Appendectomy	☐ Brain Surgery	☐ Gallbladder Removal	☐ Joint Replacement
☐ Bariatric Surgery	☐ Breast Surgery	☐ Gastric Stimulator Implant	☐ Plastic Surgery
___ Duodenal Switch	☐ Cardio Defibrillator	☐ Heart Bypass	☐ Small Intestine Surgery
___ Gastric Bypass	☐ Colon/Large Intestine Surgery	☐ Heart Stents	☐ Spine Surgery
___ Lap Band	☐ Coronary Angioplasty	☐ Heart Valve Replacement	☐ Tonsillectomy
___ Sleeve Gastrectomy	☐ C-section	☐ Hernia Repair	☐ Tubal Ligation
	☐ Eye Surgery	☐ Hysterectomy	☐ Vertical Banded Gastroplasty

☐ Other (please describe) _____

Are you disabled? ☐ Yes ☐ No Reason Disabled: ☐ Motor Vehicle Accident ☐ Illness ☐ Work-related Injury ☐ Other_____

Assistive Device(s) (check all that apply): ☐ Cane ☐ Crutches ☐ Walker ☐ Sling ☐ Wheelchair ☐ Power Scooter Years in wheelchair/scooter_____

PREGNANCY HISTORY

Pregnancy	Year	Weight at Start	Weight at Delivery

SOCIAL HISTORY:

Alcohol/Drug Use:

Do you use alcohol? ☐ Yes ☐ No

How many drinks per week?

Glasses of Wine _____

Cans of Beer _____

Shots of Liquor _____

Comments on alcohol use: _____

_____

Have you used drugs for non-medicinal purposes?

☐ Yes ☐ No

If yes, how many times per week?

Marijuana ____ Cocaine____ Inhalants____

Methamphetamine_____ IV ____ Other_____

Date last used_____

Comments on drug use: _____

_____

Tobacco Use:

☐ Yes ☐ No Current Smoker

How much/how long? _____

☐ Yes ☐ No Chewing Tobacco/Snuff

☐ Yes ☐ No Vape

☐ Yes ☐ No Former Smoker/Date Quit

_____

☐ Yes ☐ No Never Smoked

Sexually Active? ☐ Yes ☐ No

Birth Control/Protection (check all that apply): ☐ Abstinence ☐ Condom ☐ Implant ☐ Injection ☐ IUD ☐ Pill ☐ Patch ☐ Surgical ☐ Post-menopausal ☐ None ☐ Other _____

BARIATRIC SLEEP ASSESSMENT: Please estimate your risk of falling asleep in the following situations, using the scale below:

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (theater or meeting)	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
As a passenger in a car for an hour without a break	
TOTAL	

0 = No chance of dozing
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

How frequently do you snore or have been told you snore loud enough to disturb others' sleep?
☐ Never ☐ Rarely (less than once a week) ☐ Occasionally (1-3 times per week) ☐ Frequently (3+ times per week) ☐ Unsure

How often have you been told you pause or stop breathing while sleeping?
☐ Never ☐ Rarely (less than once a week) ☐ Occasionally (1-3 times per week) ☐ Frequently (3+ times per week) ☐ Unsure

Do you sleep during the day? ☐ Yes ☐ No Do you sleep excessively? ☐ Yes ☐ No

PSYCHIATRIC HISTORY:

Condition	Name of Medication/Treatment	Hospitalized? (Y/N)	Dates
Depression			
Severe Depression			
Schizophrenia			
Bipolar			
Anorexia			
Bulimia			
Other (please specify)			

What type of weight loss surgery are you interested in?

☐ Gastric Bypass (RNY, Roux-N-Y)
☐ Sleeve Gastrectomy (Sleeve)
☐ Revision Surgery
What type of bariatric surgery did you have previously? _____
When was your previous surgery performed? _____
Where was your previous bariatric surgery performed? _____
Reason for seeking a revision: _____
☐ Unsure

WEIGHT HISTORY

My obesity began: ☐ Childhood ☐ Puberty ☐ Adulthood ☐ After Pregnancy ☐ After a Traumatic Event ☐ Other: _____

Highest Adult Weight: _____ At What Age? _____ Lowest Adult Weight: _____ At What Age? _____

Most Weight Lost on Any Program: _____ Program Name/Type: _____

Current Weight (lbs): _____ BMI: _____ Current Height: _____ Feet _____ Inches

EXERCISE TOLERANCE

Can you independently perform acts of daily living (ADLs)? ☐ Yes ☐ No

Functional Limits: ☐ None (can walk 200 ft. without assistance) ☐ Require Wheelchair ☐ Cane/Crutch ☐ Bedridden ☐ Require Assistance with ADLs ☐ Can Only Perform ADLs ☐ Dependent for ADLs ☐ Other _____

Do you perform any additional exercise? ☐Walking/Treadmill ☐Chair Exercise ☐Swimming ☐Stationary Bike ☐Other _____

How many times per week do you exercise?_____ How long, in minutes, do you exercise each week? _____

EATING PATTERNS/HABITS

Counting all meals and snacks, how many times per day do you usually eat? _____ What times during the day? _____

How many days per week do you eat out? _____ ☐ Breakfast _____days per week ☐ Lunch _____days per week ☐ Dinner/Supper _____days per week

In the past 6 months, have you experienced any food cravings? ☐ Yes ☐ No

Did you ever eat a very large amount of food within a short time, such as 2 hours or less? ☐ Yes ☐ No

TYPICAL DIET

Please complete this as honestly as possible for a typical weekday and weekend day. Include amount consumed, food preparation (steamed, fried, baked, raw, etc) and beverages.

Meal	Typical Week Day Menu	Typical Weekend Menu
Breakfast		
Lunch		
Dinner/Supper		
Snack #1		
Snack #2		
Snack #3		

MEDICATIONS

Please list any medications, vitamins or supplements you are currently taking.

Medication	Physician Who Prescribed	Dose	Frequency	For?

WEIGHT LOSS/DIET HISTORY

Diet Program	Number of Months	Amount of Weight Lost	Physician Supervised? (Y/N)	Year
Atkins				
Jenny Craig				
Biggest Loser				
Cabbage Soup				
Grapefruit				
Ideal Protein				
Slim Fast				
Mayo Clinic				
Mediterranean				
Paleo				
TOPS				
Metabolite				
Hypnosis				
LA Weight Loss				
Nutri-System				
Weight Watchers				
South Beach				
Registered Dietitian				
Optifast/Medifast				
Calorie Controlled				
Other				