

# HEART OF AMERICA BARIATRICS

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Center of  
Excellence  
BARIATRIC SURGERY

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[WWW.HOAB.ORG](http://WWW.HOAB.ORG)

## Medical History for Bariatric Surgery

### PATIENT INFORMATION – Please Print Clearly

\_\_\_\_\_  
Last Name    First Name    M. I.    Today's Date

\_\_\_\_\_  
Address    City

\_\_\_\_\_  
State                      Zip Code                      Occupation    Employer

\_\_\_\_\_  
Date of Birth    Age                      Height    Weight                      BMI – if known

\_\_\_\_\_  
Social Security Number    Gender: MALE    FEMALE    E-mail Address

\_\_\_\_\_  
Home Telephone    Mobile Phone    Work Phone

Marital Status (Circle):    Married    Single    Separated    Widowed    Divorced

Ethnicity:    Caucasian    African American    Native American    Asian    Hispanic    Other

Surgery Interest:    Lap-Band®    Realize® Band    Gastric Bypass    Sleeve Gastrectomy    Uncertain

EDUCATIONAL SEMINAR:    Date Attended \_\_\_\_\_    Date Planned \_\_\_\_\_

### PRIMARY CARE PHYSICIAN

\_\_\_\_\_  
Last Name    First Name    M. I.    Degree (MD or DO)

\_\_\_\_\_  
Address    City    State                      Zip

\_\_\_\_\_  
Phone    Fax Number – if known    Specialty

How long has he/she provided your medical care? \_\_\_\_\_

Please list the name, phone, and specialty of other Health Care Professionals who treat you:

\_\_\_\_\_

**OBESITY HISTORY**

**Weight History (in pounds)**

2006:\_\_\_\_\_ 2007:\_\_\_\_\_ 2008:\_\_\_\_\_ 2009:\_\_\_\_\_ 2010:\_\_\_\_\_ 2011:\_\_\_\_\_

What was your **HIGHEST** weight ever? \_\_\_\_\_ pounds.

What **AGE** was that highest weight? \_\_\_\_\_ years old.

How much did you weigh at 14 years of age? \_\_\_\_\_ pounds. At 18? \_\_\_\_\_ pounds.

What was your **LOWEST** weight since you were 18 years old or older? \_\_\_\_\_ pounds.

What **AGE** was that lowest weight? \_\_\_\_\_ years old.

How many **YEARS** have you been overweight? \_\_\_\_\_ years.

How many **YEARS** have you been trying to lose weight, with your best efforts? \_\_\_\_\_ years.

How long have you been researching or thinking about weight loss surgery? \_\_\_\_\_ years.

**MEDICAL PROBLEMS RELATED TO OBESITY**

Please answer all the questions related to your current or past medical history.

Cardiovascular Disease	YES	NO		YES	NO
High Blood Pressure or Hypertension?	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral Vascular Disease or Stroke?	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure?	<input type="checkbox"/>	<input type="checkbox"/>	Lower Extremity Edema or Swelling?	<input type="checkbox"/>	<input type="checkbox"/>
Ischemic Heart Disease or Heart Attack?	<input type="checkbox"/>	<input type="checkbox"/>	Leg Blood Clot or Pulmonary Embolus?	<input type="checkbox"/>	<input type="checkbox"/>
Anginal Chest Pain?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Stress Test or Heart Catheterization?	<input type="checkbox"/>	<input type="checkbox"/>

Metabolic Disease	YES	NO		YES	NO
Diabetes Mellitus Type 2 ?	<input type="checkbox"/>	<input type="checkbox"/>	Insulin Resistance or High Blood Sugar?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus Type 1 ?	<input type="checkbox"/>	<input type="checkbox"/>	Elevated Cholesterol or Lipids?	<input type="checkbox"/>	<input type="checkbox"/>
Gout or Hyperuricemia?	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder?	<input type="checkbox"/>	<input type="checkbox"/>

Pulmonary Disease	YES	NO		YES	NO
Sleep Apnea?	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Hypertension?	<input type="checkbox"/>	<input type="checkbox"/>
C-Pap or Bi-Pap use?	<input type="checkbox"/>	<input type="checkbox"/>	Obesity Hypoventilation Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
Asthma?	<input type="checkbox"/>	<input type="checkbox"/>			

Gastrointestinal Disease	YES	NO		YES	NO
Heartburn, Reflux or GERD?	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease or Abnormal Liver Tests?	<input type="checkbox"/>	<input type="checkbox"/>
Barrett's Esophagitis?	<input type="checkbox"/>	<input type="checkbox"/>	Gallstones or Gallbladder Removal?	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease or Ulcerative Colitis?	<input type="checkbox"/>	<input type="checkbox"/>	Lupus or Autoimmune Disorder?	<input type="checkbox"/>	<input type="checkbox"/>

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Musculoskeletal Disease	YES	NO		YES	NO
Back Pain?	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain requiring Medical Treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Hip, Knee, or Ankle Pain?	<input type="checkbox"/>	<input type="checkbox"/>	Leg Pain requiring Medical Treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia?	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Back Surgery?	<input type="checkbox"/>	<input type="checkbox"/>

Reproductive Disorders	YES	NO		YES	NO
Polycystic Ovarian Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Irregularities?	<input type="checkbox"/>	<input type="checkbox"/>
Infertility?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a Hysterectomy?	<input type="checkbox"/>	<input type="checkbox"/>

General	YES	NO		YES	NO
Urinary Stress Incontinence?	<input type="checkbox"/>	<input type="checkbox"/>	Pseudotumor Cerebri?	<input type="checkbox"/>	<input type="checkbox"/>
Excess Abdominal Skin or Pannus?	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Hernia?	<input type="checkbox"/>	<input type="checkbox"/>
Previous Weight Loss Surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Previous Ulcer or Reflux Surgery?	<input type="checkbox"/>	<input type="checkbox"/>

## Psychosocial Information – Mark Only One Box for Each Question

### Psychosocial Impairment

- No impairment
- Mild impairment in psychosocial functioning but able to perform all primary tasks
- Moderate impairment in psychosocial functioning but able to perform most primary tasks
- Moderate impairment in psychosocial functioning and unable to perform some primary tasks
- Severe impairment in psychosocial functioning and unable to perform most primary tasks
- Severe impairment in psychosocial functioning and unable to function

### Depression

- No symptoms of depression
- Mild and episodic, not requiring treatment
- Moderate, accompanied by some impairment, may require treatment or medications
- Moderate, with significant impairment, treatment indicated
- Severe, definitely requiring intensive treatment
- Severe, requiring hospitalization

### Confirmed Mental Health Diagnosis

- None
- Bipolar disorder
- Anxiety/panic disorder
- Personality Disorder
- Psychosis or schizophrenia

### Functional Status (ability to walk)

- No impairment of functional status
- Able to walk 200ft with cane or crutch
- Cannot walk 200ft with cane or crutch
- Requires wheelchair
- Bedridden

Alcohol Use:  None  Rare  Occasional  Frequent

Tobacco Use:  None  Rare  Occasional  Frequent

Substance Abuse:  None  Rare  Occasional  Frequent

**MEDICAL HISTORY**

List ANY OTHER Medical Problems (like cancer, diverticulitis, etc.) not found above:

\_\_\_\_\_

\_\_\_\_\_

**Prescription Medications Currently Taking**

Name	Strength	Frequency	Purpose	When started

**Non-prescription Medications and Vitamins Currently Taking**

Name	Strength	Frequency	Purpose	When started

**ALLERGIES** to Medications, Latex, or other Substances

Allergic Substance Name	Reaction to Substance

List any **SURGERY** (Please write "Lap" if done Laparoscopically)

Surgery	Date	Reason

**FAMILY HISTORY of Medical Problems (parents, grandparents, siblings, aunts, uncles)**  
Mark All that apply

- |  |                                   |  |
|--|-----------------------------------|--|
| <input type="checkbox"/> High Blood Pressure           | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Heart Disease or Heart Attack | <input type="checkbox"/> Stroke   | <input type="checkbox"/> Clotting Disorder |
| <input type="checkbox"/> Cancer                        | <input type="checkbox"/> Obesity  | <input type="checkbox"/> Unknown           |

**CONSENT TO RELEASE INFORMATION**

I authorize the office of Van L. Wagner, MD to release my personal and confidential information to my health insurance carrier for the purpose of verifying my coverage, benefits and payment information.

\_\_\_\_\_ (signature)

\_\_\_\_\_ (print name)

\_\_\_\_\_ (date)

**INSURANCE INFORMATION**

\_\_\_\_\_  
**PRIMARY Insurance Company**

\_\_\_\_\_  
Subscriber's Name

\_\_\_\_\_  
Subscriber's Birth Date

\_\_\_\_\_  
Subscriber's S. S. No.

\_\_\_\_\_  
Subscriber's Employer

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
Group Number

\_\_\_\_\_  
Ins. Customer Service Phone Number

\_\_\_\_\_  
Relationship to Subscriber: (Circle) Self Spouse Child

\_\_\_\_\_  
**SECONDARY Insurance Company**

\_\_\_\_\_  
Subscriber's Name

\_\_\_\_\_  
Subscriber's Birth Date

\_\_\_\_\_  
Subscriber's S. S. No.

\_\_\_\_\_  
Subscriber's Employer

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
Group Number

\_\_\_\_\_  
Ins. Customer Service Phone Number

\_\_\_\_\_  
Relationship to Subscriber: (Circle) Self Spouse Child

**REFERRAL SOURCE**

How did you hear about Dr. Wagner?  Physician  Friend/Relative  Web  Other

Please specify: \_\_\_\_\_

## PATIENT REGISTRATION - Heart of America Bariatrics, LLC

PATIENT INFORMATION							
Patient's Last Name (Full Legal Name)		First	Middle	Preferred Name to be Addressed			
Patient Mailing Address			City	State	Zip Code		
Patient Ethnicity (circle) <input type="checkbox"/> Caucasian <input type="checkbox"/> African America <input type="checkbox"/> Native America <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Other							
Patient Birth Date	Age	Social Security Number		Home Phone		Cell Phone	
— —		— —		( )		( )	
Patient FORMER Name		Sex	Marital Status				
		M    F	(circle)    Single    Married    Divorced    Separated    Widow				
Patient E-Mail		Patient Occupation			Employer		
Employer Address			City	State	Zip	Work Phone	
						( )	
PHYSICIAN INFORMATION (Please obtain full information of your Primary Care Physician)							
Physician Last Name		First	M. I.	Degree		Physician Phone	
				MD    DO		( )	
Physician Address			City	State	Zip	Physician Fax	
						( )	
INSURANCE INFORMATION (Please give your insurance card to the receptionist)							
PRIMARY Insurance Company		Subscriber's Name		Subscriber's Birth Date	Subscriber's S. S. Number		
Subscriber's Employer		Policy Number		Relationship to Subscriber			
				(circle)    Self    Spouse    Child			
SECONDARY Insurance Company		Subscriber's Name		Subscriber's Birth Date	Subscriber's S. S. Number		
Subscriber's Employer		Policy Number		Relationship to Subscriber			
				(circle)    Self    Spouse    Child			
IN CASE OF EMERGENCY							
Name of Local Friend or Relative (not living at same address)			Relationship to Patient	Home Phone		Cell Phone	
				( )		( )	

The above information is true and complete to the best of my knowledge. I authorize my insurance benefits to be paid directly to Van L. Wagner, MD. I understand that I am financially responsible for any balance due or if the procedure or service is a denied benefit. I understand that I am responsible to make sure that a referral for office visits are obtained prior to each visit and that the proper copayment is made at the time of each visit. I also authorize Van L. Wagner, MD or the insurance company to release any information required to process my claims.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date