

VAN L. WAGNER, M.D.

1400 LEMAY FERRY ROAD SUITE A ST. LOUIS, MO 63125
WEBPAGE: WWW.HOAB.ORG PH: 314.776.7112 FAX: 314.776.7114 EMAIL: OFFICE@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)

2005: _____ 2006: _____ 2007: _____ 2008: _____ 2009: _____ 2010: _____

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 High Blood Pressure or Hypertension? Congestive Heart Failure? Ischemic Heart Disease or Heart Attack? Anginal Chest Pain?	YES NO	Peripheral Vascular Disease or Stroke? Lower Extremity Edema or Swelling? Leg Blood Clot or Pulmonary Embolus? Heart Stress Test or Heart Catheterization?	YES NO
Metabolic Disease Diabetes Mellitus Type 2 ? Diabetes Mellitus Type 1 ? Gout or Hyperuricemia?	YES NO	Insulin Resistance or High Blood Sugar? Elevated Cholesterol or Lipids? Thyroid Disorder?	YES NO
Pulmonary Disease Sleep Apnea? Asthma?	YES NO	Pulmonary Hypertension? Obesity Hypoventilation Syndrome?	YES NO
Gastrointestinal Disease Heartburn, Reflux or GERD? Barrett's Esophagitis? Crohn's Disease or Ulcerative Colitis?	YES NO	Liver Disease or Abnormal Liver Tests? Gallstones or Gallbladder Removal? Lupus or Autoimmune Disorder?	YES NO

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Musculoskeletal Disease	YES NO		YES NO
Back Pain?		Back Pain requiring Medical Treatment?	
Hip, Knee, or Ankle Pain?		Leg Pain requiring Medical Treatment?	
Fibromyalgia?		Joint Replacement or Back Surgery?	
Reproductive Disorders	YES NO		YES NO
Polycystic Ovarian Syndrome?		Menstrual Irregularities?	
Infertility?		Have you had a Hysterectomy?	
General	YES NO		YES NO
Urinary Stress Incontinence?		Pseudotumor Cerebri?	
Excess Abdominal Skin or Pannus?		Abdominal Hernia?	
Previous Weight Loss Surgery?		Previous Ulcer or Reflux Surgery?	

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

Functional Status (ability to walk)

- | | |
|----------------------------|--|
| None | No impairment of functional status |
| Bipolar disorder | Able to walk 200ft with cane or crutch |
| Anxiety/panic disorder | Cannot walk 200ft with cane or crutch |
| Personality Disorder | Requires wheelchair |
| Psychosis or schizophrenia | 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:

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Prescription Medications Currently Taking

Name	Strength	Frequency	Purpose	When started
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Non-prescription Medications and Vitamins Currently Taking

Name	Strength	Frequency	Purpose	When started
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ALLERGIES to Medications, Latex, or other Substances

Allergic Substance Name	Reaction to Substance
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List any **SURGERY** (Please write “Lap” if done Laparoscopically)

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

High Blood Pressure	Diabetes	Bleeding Disorder
Heart Disease or Heart Attack	Stroke	Clotting Disorder
Cancer	Obesity	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: _____