GHP
Grand Health
PARTNERS

Bariatric History & Physical Form

To be completed by the patient

Today's Date: _____

Name: _____ DOB: _____
First Middle Last

Primary Care Physician (PCP): _____ Office Phone #: _____

Preferred Pharmacy: _____ Phone #:_____ Fax #: _____

Pharmacy Address:_____
City State Zip

Other Physician(s): Ex: Cardiologist, GI etc.

Providers Name: _____ Office Phone #: _____

Providers Name: _____ Office Phone #: _____

Providers Name: _____ Office Phone #: _____

Weight/Dietary History

Years Overweight: _____ (# of years)

Please list all weight loss programs or attempted methods to lose weight in the past:

Name of Program:	**Date:**	**Name of Program:**	**Date:**
1._____	_____	2._____	_____
3._____	_____	4._____	_____

Past & Current Medical Diagnosis **(Check all that apply)**

- ☐ High Blood Pressure
- ☐ Coronary Artery Disease
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Arthritis
- ☐ Depression
- ☐ Diabetes Mellitus Type 2
- ☐ Arrhythmia
- ☐ Lung Disease
- ☐ Seizures
- ☐ Polycystic Ovarian Disease
- ☐ Diabetes Mellitus Type 1
- ☐ Congestive Heart Failure
- ☐ Liver Disease
- ☐ Blood Clots
- ☐ Stroke
- ☐ Anxiety
- ☐ Reflux Disease/GERD
- ☐ Obstructive Sleep Apnea
- ☐ Bleeding Tendencies
- ☐ Peptic Ulcer Disease
- ☐ Hypothyroidism

Other:_____

Other:_____

Other:_____

OVER →

PATIENT LAST NAME: _____

Prior Surgeries

Type: _____ Date of Operation:_____

Type: _____ Date of Operation:_____

Type: _____ Date of Operation:_____

Type: _____ Date of Operation:_____

Type: _____ Date of Operation:_____

Have you ever had prior **Bariatric Surgery**? If YES please list the type of operation/date performed.

Type: _____ Date of Operation:_____

Name of Surgeon: _____ Facility: _____

Past problems with Anesthesia (Please describe in detail):_____

Will you accept a blood Transfusion (if necessary)? YES or NO

Current Medications

(List Current Prescriptions)

1._____	Dose:_____	Time/Day_____
2._____	Dose:_____	Time/Day_____
3._____	Dose:_____	Time/Day_____
4._____	Dose:_____	Time/Day_____
5._____	Dose:_____	Time/Day_____
6._____	Dose:_____	Time/Day_____
7._____	Dose:_____	Time/Day_____
8._____	Dose:_____	Time/Day_____
9._____	Dose:_____	Time/Day_____
10._____	Dose:_____	Time/Day_____

Please list any Dietary Supplements, Herbs, or Vitamins you are currently taking:

1. _____ 2_____ 3. _____4._____

Medical Allergies

Medication Name/Reaction:

1._____ 2._____

3._____ 4. Food Allergies: _____

PATIENT LAST NAME: _____

Family Medical History

(Describe Medical Diagnosis, Weight History)

Father: Alive or Deceased (circle one) Medical Problem: _____ Medical Problem: _____

Mother: Alive or Deceased (circle one) Medical Problem: _____ Medical Problem: _____

Siblings: # Brothers____ # Sisters____ Medical Problem: _____ Medical Problem: _____

Children: # Children ____ Medical Problem: _____ Medical Problem: _____

Social History

Are you currently employed? YES or NO Are you currently Disabled? YES or NO Why? _____

Current Employer (if employed) _____ Position: _____

Marital Status:(check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Caffeine - Regular Pop: Quantity_____ Diet Pop: Quantity_____ Coffee: Quantity_____ Tea: Quantity_____

Alcohol Consumption: # of Drinks per week ☐ 1-5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ More than 20 a week

Smoking: ☐ Never ☐ Current **Chewing Tobacco**: ☐ Never ☐ Current

Drug Use: Current or Past (circle one), what type: _____ Medical Marijuana Card? YES or NO

Are you currently involved in an exercise program? (Please describe) _____

Previous Medical Testing

Have you had any recent labs done? YES or NO, If yes: Date _____and location_____

Sleep Study Date: _____ Doctor: _____ C-pap? YES or NO C-Pap setting _____

Echocardiogram Date: _____ Doctor: _____ Results: _____

Heart Stress Test Date: _____ Doctor: _____ Results: _____

Heart Catheterization Date: _____ Doctor: _____ Results: _____

Breathing Test (PFT's) Date: _____ Doctor: _____ Results: _____

Upper Endoscopy (EGD) Date: _____ Doctor: _____ Results: _____

Colonoscopy Date: _____ Doctor: _____ Results: _____

Ultrasound of Gallbladder Date: _____ Doctor: _____ Results: _____

PATIENT LAST NAME: _____

Previous Medical Testing Cont.

DEXA Scan Date: _____ Doctor: _____ Results: _____

Mammogram Date: _____ Doctor: _____ Results: _____

Pap & Pelvic exam (women) Date: _____ Doctor: _____ Results: _____

Prostate exam (men) Date: _____ Doctor: _____ Results: _____

Current Medical Conditions

(Check all that apply)

General		**Neurological**		**GU**	
	Fever		Numbness		Urine Incontinence
	Chills		Tingling		Painful Urination
	Night Sweats		Weakness		Blood in Urine
	Fatigue		Fainting		Hesitancy
HEENT		**Hematological**			Night-time Urination
	Headaches		Easy Bruising	**Abdominal**	
	Vision Changes		Easy Bleeding		Pain
	Dizziness		Blood Clots		Nausea
Skin		**Musculoskeletal**			Vomiting
	Rash		Joint Pain or Swelling		Diarrhea
	Jaundice		Muscle Pain		Constipation
	Ulcers (leg or sacrum)	**Cardiac**			Bloody Stool
Pulmonary			Chest Pain		Heartburn/Reflux
	Cough		Palpitations		Difficulty Swallowing
	Wheezing		Shortness of Breath w/ Activity	**Endocrine**	
	Snoring		Shortness of Breath w/o Activity		Abnormal Hair growth
	Daytime Sleepiness		Waking up short of breath		High Blood Sugar
	Stop breathing in sleep		Leg Swelling		Thyroid Problems

Any additional medical information you want GHP to know: _____

_____

_____

PLEASE REMEMBER IF YOU'VE HAD AN EKG, EGD, LABS DRAWN, OR CARDIAC TESTS DONE PLEASE BRING THE RESULTS WITH YOU TO YOUR APPOINTMENT.