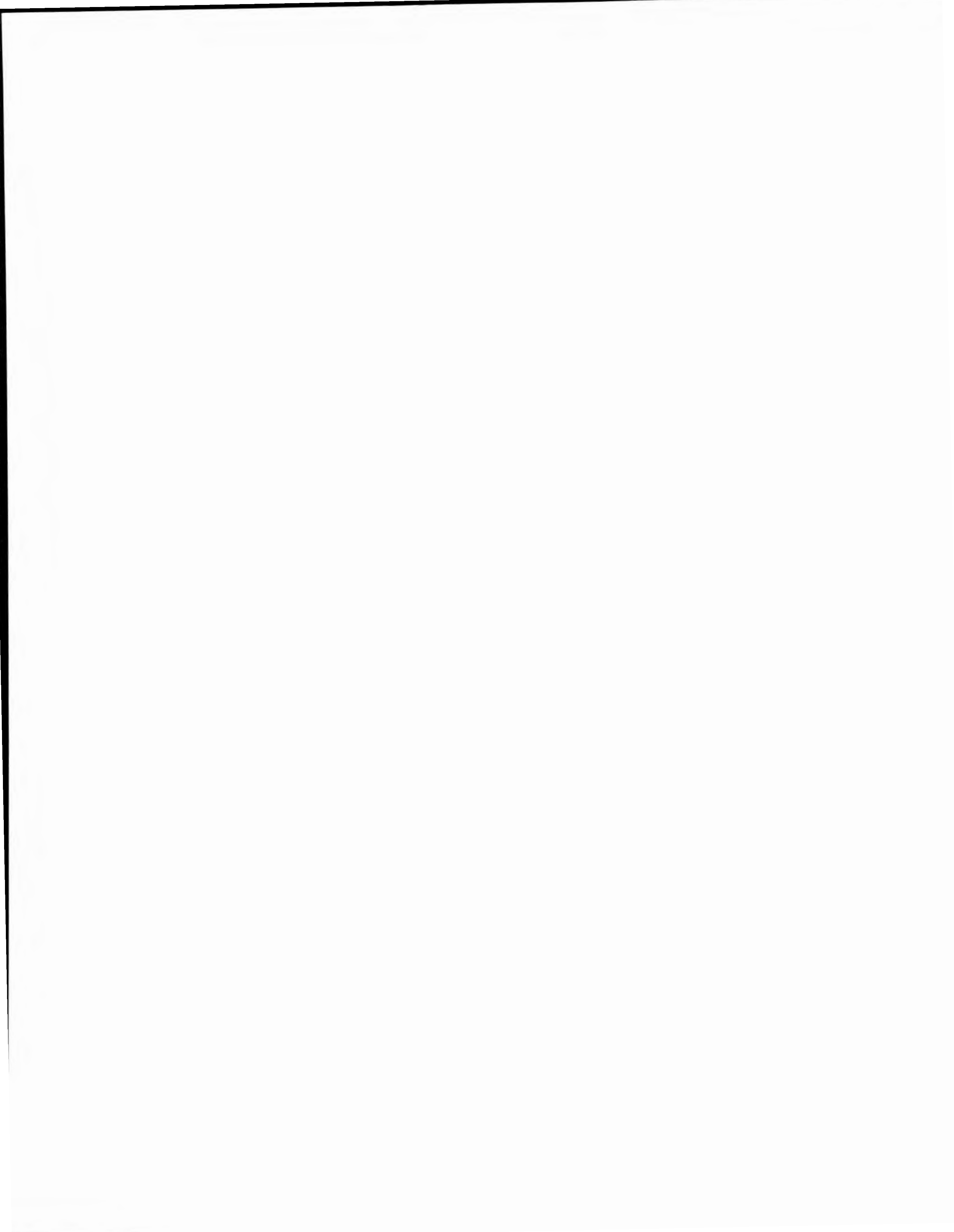
NAME: ______________________

How Did You Find Out About Us?

- Patient of Practice
- Medical Doctor Referral
- Word of Mouth
- Billboard
  - **Before & After**
  - **Obera (balloon)**
- Print Ads
- Employee of Practice
- Google
- Website
- Social Media (facebook/Instagram)
- Other ______________________________



East Cooper
Bariatric Surgery
EAST COOPER MEDICAL GROUP

Name: ______________________ **Date:** ______________________

Are you **Allergic or Sensitive** to any medications or any radiographic dye? (please list medication and reaction)

☐ **Allergies:** ______________________

☐ **I have no allergies**

List all your **current medications** with **dosages** including **supplements**

(example: Lipitor 10 mg daily, Saw Palmetto Herbs)

Name	Dosage	Frequency

☐ **I take no medications**

Past Surgical/Procedure History

☐ **No Surgeries**

Please list all operations including dates.

____

____

Previous problems with anesthesia? ☐ Yes ☐ No

If yes, please describe:

____

____

Family History:

List all serious illnesses in your immediate family which started younger than age of 70.

Family Members	Age	Significant Illness	Deceased?	Cause of Death
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Siblings				

Social History:

Do you use tobacco? ☐Yes ☐No ☐Never ☐Quit ____years ago
Type of tobacco product used: ______________________How many packs/day? _______

Do you drink alcohol? ☐Yes ☐No ☐Never ☐Quit ____ years ago
If yes, how often do you drink? ☐Daily ☐Weekly ☐Occasionally ☐Rarely
How many glasses per week? _______

Do you use drugs? ☐Yes ☐No ☐Never ☐Quit __________ years ago
Type of drug used: _______________________________________ How often? ____________

Diet/Weight loss History:

When did weight problems begin? ____________________________________

Why did you become concerned about your weight? _______________________________________

In your opinion, what contributes to your excess weight? ________________________________

What Diets have you tried?

Name of Program/Medication	Start Date	End Date	Weight Lost	Weight Regained

Past Medical History:

Please select all conditions that you currently have or had in the past:

- ☐ **I have no medical problems**
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots/DVT
- ☐ Cancer type: _______________
- ☐ Cholecystitis/gallstones
- ☐ Cirrhosis
- ☐ COPD
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease/IBS
- ☐ Cushing's disease
- ☐Colonoscopy
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Emphysema
- ☐ Fatty Liver
- ☐ Fibromyalgia
- ☐ Gastritis/Ulcer
- ☐ Gastroparesis
- ☐ GERD/Reflux/Heartburn
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Hernia/Type: ___________
- ☐ High Cholesterol
- ☐ High Triglycerides
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Incontinence
- ☐ Infertility
- ☐ Irregular Heart Rhythm
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Lupus
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Pancreatitis
- ☐ Parkinson's
- ☐ Polycystic Ovarian Syndrome
- ☐ Pseudotumor Cerebri
- ☐ Pulmonary Embolism
- ☐ Reynaud's
- ☐ Restless Leg Syndrome
- ☐ Rheumatoid Arthritis
- ☐ Sciatica
- ☐ Seizures
- ☐ Sleep Apnea: CPAP/BIPAP setting: _________
- ☐ Stroke/TIA
- ☐ Tuberculosis
- ☐ Ulcerative Colitis
- ☐ Urine Infections
- ☐Vascular Disease
- ☐ Depression
- ☐ Anxiety
- ☐ ADD/OCD
- ☐ Sexual Abuse
- ☐ Obsession
- ☐ Hyperactivity
- ☐ Alcoholism

Other:

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