LifeWeigh Bariatrics
Healthy Living Through Teamwork

PATIENT PERSONAL HISTORY FORM
GENERAL SURGERY

Please take time to update the following information for our files. This information is treated with strict confidentiality and will help us obtain a comprehensive assessment of your health care needs.

NAME	BIRTHDATE	DATE

CHIEF COMPLAINTS: (Please list current symptoms)	
1.	**3.**
2.	**4.**

PAST MEDICAL HISTORY: Hospitalizations and Surgeries			
Reason/Diagnosis/Procedure	Date	Reason/Diagnosis/Procedure	Date

MEDICAL ILLNESSES OR CONDITIONS: (Conditions you now have or have had in the past.)					
Condition	Onset Date	Condition	Onset Date	Condition	Onset Date
☐ Migraine headaches	________	☐ Stomach or duodenal ulcer	________	☐ Goiter	________
☐ Seizures or convulsions	________	☐ Hepatitis	________	☐ Gonorrhea	________
☐ Stroke	________	☐ Cirrhosis	________	☐ Syphilis or VD	________
☐ Polio	________	☐ Gall stones	________	☐ HIV infection	________
☐ Glaucoma	________	☐ Colon or bowel trouble	________	☐ Herpes infection	________
☐ Cataracts	________	☐ Dysentery or serious diarrhea	________	☐ Chicken pox	________
☐ Blindness	________	☐ Rectal trouble	________	☐ Mumps	________
☐ Recurrent ear infections	________	☐ Hemorrhoids	________	☐ Measles	________
☐ Deafness	________	☐ Recurrent urinary infections	________	☐ Recurrent boils	________
☐ Hay fever, allergic nose	________	☐ Kidney stones	________	☐ Skin problems	________
☐ Recurrent sinusitis	________	☐ Other kidney disease	________	☐ Serious depression	________
☐ Asthma	________	☐ Arthritis	________	☐ Serious emotional problems	________
☐ Chronic bronchitis	________	☐ Gout	________	☐ Nervous breakdown	________
☐ Emphysema	________	☐ Broken bones	________	☐ Other ____________________	
☐ Tuberculosis	________	☐ Varicose veins	________	☐ Other ____________________	
☐ Heart murmur	________	☐ Phlebitis or blood clots	________	*Women*	
☐ Heart attack	________	☐ Bleeding problems	________	☐ Menstrual difficulties	
☐ Angina	________	☐ Anemia	________	☐ Abnormal PAP	
☐ Enlarged heart	________	☐ Cancer (Type: ___________)	________	☐ Ovarian cyst(s)	
☐ Rheumatic fever	________	☐ Diabetes	________	☐ Breast lump(s)	
☐ High blood pressure	________	☐ Overactive thyroid	________	*Men*	
☐ Hiatal hernia / chronic heartburn	________	☐ Underactive thyroid	________	☐ Prostate trouble	

CURRENT MEDICATIONS: (Include non-prescription products)		**ALLERGIES:** (Include drugs foods, chemicals, insects, etc.)	
Drug Name	Dose	Item	Type of Reaction

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IMMUNIZATIONS & PREVENTIVE SERVICES: ***(Check all that apply and provide date you last received each.)***

☐ MMR	__________	☐ TB skin test	__________	☐ PAP smear	__________
☐ Tetanus	__________	☐ Hearing test	__________	☐ Mammogram	__________
☐ Pneumonia vaccine	__________	☐ Eye exam	__________	☐ Bone density test	__________
☐ Hepatitis B vaccine	__________	☐ Sigmoid or colon exam	__________	☐ PSA	__________

FAMILY HISTORY: ***Please complete the following information on your relatives.***

	Living	Dead	Age	Chronic condition(s)/Cause of Death
Father				
Mother				
Brothers (No.______) & Sisters (No.______)				
Spouse				
Children (No.______)				

Please check all conditions identified in your relatives and note which relatives are affected:

Condition	Relation	Condition	Relation	Condition	Relation
☐ Migraine headaches	__________	☐ High blood pressure	__________	☐ Bleeding problems	__________
☐ Seizures or convulsions	__________	☐ Stomach or duodenal ulcer	__________	☐ Anemia	__________
☐ Stroke	__________	☐ Liver disease	__________	☐ Sickle cell disease	__________
☐ Glaucoma	__________	☐ Gall stones	__________	☐ Cancer, including leukemia	__________
☐ Allergies	__________	☐ Colon or bowel trouble	__________	☐ Diabetes	__________
☐ Asthma	__________	☐ Kidney stones	__________	☐ Thyroid problems	__________
☐ Emphysema	__________	☐ Other kidney disease	__________	☐ Mental illness	__________
☐ Tuberculosis	__________	☐ Arthritis	__________	☐ Suicide	__________
☐ Heart trouble	__________	☐ Gout	__________	☐ Birth defects	__________

SOCIAL/PERSONAL HISTORY: Please complete the following information about yourself.

Current occupation: ____

Education completed:

☐ Grade: _________ ☐ High School ☐ College: _________ years, degree/major _________ ☐ Post-graduate: ________

Marital status: ☐ Single ☐ Married (Date: _________) ☐ Separated (Date: _________) ☐ Divorce (Date: _________)

Married ______ time(s): #1 ______yrs, ______children #2 ______yrs, ______children #3 ______yrs, ______children

Personal habits: *(check all that apply)*

☐ Currently uses tobacco: Type: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless tobacco Amount/day: ______ Years: ______

☐ Former smoker: Amount/day: ______ Years: ______ Quit Date: ___________

☐ Exposed to second-hand smoke

☐ Consume alcohol: Type: __________________________ Amount/day: ____________________

☐ Use recreational drugs: Type: __________________________ Amount/day: ____________________

☐ Consume caffeine: Beverage: _______________________ Amount/day: ____________________

☐ Exercise regularly: Type: __________________________ Frequency/week: __________________

☐ Wear my seatbelt: Frequency (%): ___________________

Sexual history: ☐ Multiple sex partners ☐ Prefer opposite sex ☐ Prefer same-sex relationships

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Name: ________________________ **Birthdate:** ____________ **Date:** ______________

REVIEW OF SYSTEMS: ***(Please check any item which describes recent or ongoing symptoms)***

General: ☐ *None apply*

☐ Significant weight loss ☐ Loss of feeling of well-being ☐ Fatigue or loss of energy ☐ Difficulty sleeping
Comment: ____________________

Eyes: ☐ *None apply*

☐ Blurred vision ☐ Double vision ☐ Spots in front of your eyes ☐ Eye pain/irritation ☐ Need for corrective lenses
Comment: ____________________

Ear-Nose-Throat: ☐ *None apply*

☐ Chronic headaches ☐ Hearing loss ☐ Ringing in ears ☐ Dizziness ☐ Chronic nasal congestion ☐ Recurring sinus infections
☐ Nose bleeds ☐ Nasal obstruction ☐ Bleeding gums ☐ Sore throat ☐ Toothache ☐ Breath odor ☐ Hoarseness
Comment: ____________________

Respiratory: ☐ *None apply*

☐ Shortness of breath ☐ Cough ☐ Chest congestion ☐ Wheezing ☐ Coughing up blood ☐ Choking ☐ Noisy breathing
☐ History of pneumonia ☐ History of Tuberculosis (TB)
Comment: ____________________

Cardiovascular: ☐ *None apply*

☐ Chest pain ☐ Heart fluttering/racing ☐ Heart murmur ☐ Decreased exercise tolerance
☐ Awakened due to shortness of breath ☐ Difficulty breathing while lying down ☐ Leg swelling
☐ Pain in buttocks or legs with exercise ☐ Sensitivity of hands/feet to temperature changes
Comment: ____________________

Breast : ☐ *None apply*

☐ Breast lump ☐ Breast pain ☐ Nipple discharge
Comment: ____________________

Gastrointestinal : ☐ *None apply*

☐ Stomach pains ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Frequent heartburn ☐ Indigestion
☐ Belching/sour taste ☐ Difficulty swallowing ☐ Bloating ☐ History of hepatitis ☐ History of yellow jaundice

Rectal:
☐ Rectal bleeding ☐ Rectal pain or irritation ☐ Swelling or hemorrhoids
Comment: ____________________

Genitourinary (Men): ☐ *None apply*

☐ Frequent urination (☐ often at night) ☐ Frequent urge to pee ☐ Pain on urination ☐ Bloody urine ☐ Discharge from penis
☐ Trouble starting urination ☐ Interruption of urine stream ☐ Dribbling ☐ Loss of bladder control
☐ Pain or swelling of penis ☐ Pain or swelling of scrotal sac ☐ Pain or swelling in groin
☐ Decline in sexual desire ☐ Difficulty having erections or reaching climax
Comment: ____________________

Genitourinary (Women): ☐ *None apply*

☐ Frequent urination (☐ often at night) ☐ Frequent urge to pee ☐ Pain on urination ☐ Bloody urine ☐ Frequent urinary infections
☐ Pressure in vagina ☐ Vaginal wall weakness/protrusion ☐ Frequent loss of urine
☐ Vaginal discharge ☐ Vaginal irritation ☐ Vaginal dryness ☐ Vaginal redness ☐ Vaginal pain
☐ Painful intercourse ☐ Decline in sexual desire ☐ Difficulty in sexual response
☐ Hot flashes ☐ Change in periods (menstrual flow, frequency) ☐ Mother took DES while pregnant with me
☐ Painful periods ☐ Troublesome symptoms before/during period ☐ Other pelvic pain

Please indicate:
Number of pregnancies ________ Number of deliveries ________ Number of miscarriages/abortions ________
Age of onset of periods ________ Periods occur every _______ of days and last _____ days Onset of last period ________
Comment: ____________________

Lymphatic/Hematologic: ☐ *None apply*

☐ Unusual lymph node swelling (in neck, armpit, or groin) ☐ Painful lymph nodes
☐ History of anemia ☐ Blood clots ☐ Bruise easily ☐ Unusual bleeding
Comment: ____________________

Musculoskeletal: ☐ *None apply*

☐ Limb or joint pains ☐ Limb or joint deformity ☐ Limb or joint swelling/stiffness/redness ☐ Muscle weakness
☐ Loss of muscle bulk ☐ Muscle spasms or twitching ☐ Recurring back/neck pain ☐ Back/neck injury
Comment: ____________________

Neurologic: ☐ *None apply*

☐ Seizures ☐ Tremors/shakiness ☐ Unusual clumsiness ☐ Limb weakness ☐ Numbness/tingling ☐ Stroke
☐ History of significant head injury ☐ Altered consciousness or black-outs
Comment: ____________________

Psychologic: ☐ *None apply*

☐ Lapses in memory ☐ Periods of confusion/disorientation ☐ Difficulty concentrating
☐ Troublesome depression ☐ Worry about things ☐ Mood swings ☐ History of mental illness
☐ Unusual stress ☐ History of physical or mental abuse
Comment: ____________________

Skin: ☐ *None apply*

☐ Itching ☐ Rash ☐ Unusual dryness ☐ Changes in hair ☐ Changes in pigmentation
Comment: ____________________

Endocrine: ☐ *None apply*

Unexpected changes in: ☐ Tolerance to heat ☐ Tolerance to cold ☐ Unusual thirst
Comment: ____________________

Allergy/Immunologic: ☐ *None apply*

☐ Seasonal allergies ☐ Sensitivity to specific items: ____________________
☐ Frequent or unusual infections
Comment: ____________________