



the DENVER CENTER
for BARIATRIC SURGERY

4600 Hale Parkway Suite 340 Denver, CO 80220

Phone: 303-280-0900 Fax : 303-280-3858

www.denverbariatrics.com

New Patient Questionnaire Bring to First Appointment

Name: _____ Date: _____

How did you hear about us? (check all that apply)

- Referring Physician: _____ Bariatric Pal YouTube
 Denver Center for Bariatric Surgery website
 Friend/Family/Word of Mouth Facebook
 Obesity Help Twitter
 Other healthcare facility: _____ Other Source: _____

Please list the names of your current medical providers:

Primary Care Provider Name: _____

Address: _____

Phone: _____

Other Provider: _____

Phone: _____ Specialty: _____

Other Provider: _____

Phone: _____ Specialty: _____

Other Provider: _____

Phone: _____ Specialty: _____

Patient Name: _____

Patient DOB: _____

Medical History

Any additional information, please continue on the back of the page.

Please list your prescribed, over-the-counter, or herbal medicines, including doses and number of times per day taken

#	Name	Strength	Take	Frequency	Start Date	End Date
1.						
2.						
3.						
4.						
5.						
6.						
7.						

Please list any current medical conditions and date of diagnosis (if known)

#	Condition	Date of Diagnosis
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Please list any allergies

#	Agent/Substance	Reaction
1.		
2.		
3.		
4.		

Patient Name: _____

Patient DOB: _____

Please list the date of last mammogram (women)

Date of Last Mammogram (women)	
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Please list any previous surgeries and dates

#	Date (Mo/Yr)	Surgery
1.		
2.		
3.		
4.		
5.		

Please list any previous hospitalizations and dates

#	Date (Mo/Yr)	Reason
1.		
2.		
3.		
4.		
5.		

Patient Name: _____

Patient DOB: _____

Please check if any of your blood relatives have a history of any of the following:

Family Members	Alive Deceased	Obesity	Bleeding Tendency	Blood Clots	Cancer	Diabetes	Heart Attack	Stroke	High Blood Pressure	Reaction to Anesthesia
Mother										
Father										
Sister(s)										
Brother(s)										
Daughter(s)										
Son(s)										
Paternal Grand Father										
Paternal Grand Mother										
Maternal Grand Father										
Maternal Grand Mother										

Other significant family history: _____

Patient Name: _____

Patient DOB: _____

Social History

Do you drink alcohol? Yes ____ No ____ How often/How much _____

Do you have a history of alcoholism? Yes ____ No ____

Do you smoke? Yes ____ No ____

If you smoked previously, when did you quit: _____

Do you chew? Yes ____ No ____

Have you ever had recreational drug abuse? Yes ____ No ____

Drug(s) _____

Are you: Single ____ Married ____ Partnered ____ Living with a significant other ____

What is your occupation? _____

Patient Name: _____

Patient DOB: _____

Review of Systems

Please check if you have experienced any of the following:

C/V: High blood pressure	_____	Heart disease/Heart attack history	_____
CHF	_____	Chest Pain	_____
Chest pain with activity	_____	Irregular heart beat/murmur	_____
Stroke	_____	TIA	_____
High cholesterol	_____	High triglycerides	_____
Blood clots in legs	_____	Blood clots in lungs	_____

Resp: Sleep apnea	_____	CPAP _____	Settings _____
Home oxygen use	_____	During day _____	At night _____
Snoring	_____	Shortness of breath	_____
Asthma	_____	COPD/Emphysema	_____
Difficulty breathing w/exertion	_____		

GI: Heartburn/Reflux	_____	Stomach ulcers	_____
Problem eating/swallowing	_____	Abdominal pain	_____
Inflammatory bowel Disease	_____	Irritable bowel disease	_____
Rectal bleeding/Blood in stool	_____	Pain with fatty foods	_____
Gallstones	_____	Hiatal hernia	_____
Gallbladder surgery	_____	Liver or pancreas problems	_____
Diarrhea	_____	Constipation	_____
Change in bowel habits	_____		
Upper Endoscopy/scope (when)	_____	Colonoscopy/Lower scope (when)	_____

Endo: Diabetes I / II (circle one)	_____	Insulin _____	Oral meds _____
Low thyroid	_____	Hirsutism (Increased hair)	_____
# of pregnancies	_____	# of children	_____
Oral contraceptives used	_____	Irregular periods	_____
Hot flashes	_____	Sexual dysfunction	_____
Polycystic ovarian syndrome (PCOS)	_____	Other _____	_____

Musc: Joint pain	_____	Where? _____
Arthritis	_____	Where? _____
Leg swelling	_____	Varicose veins _____
Leg ulcers	_____	Peripheral vascular disease _____

GU: Urinary stress incontinence	_____	Losing urine _____
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Patient Name: _____

Patient DOB: _____

Kidney stones	_____	Prostate problems	_____
Blood in urine	_____	Pain with urination	_____
Erectile dysfunction	_____	Urination frequency	_____

Heme: Anemia (low blood count)	_____	Bruising	_____
Blood clots	_____	Bleeding or Clotting problems	_____
Embolism to lungs	_____	Low iron levels	_____
History of transfusions	_____		

Com: HIV/AIDS	_____	Hepatitis A/B/C (circle one)	_____
TB	_____		

Neur: Seizures/Convulsions	_____	Neuropathy/Numbness	_____
Migraines	_____	Headaches	_____
Fatigue	_____	Confusion	_____
Dizziness	_____	Difficulty walking	_____
Weakness	_____		

CA: Any type of cancer	_____	Where? _____
Last mammogram (women)	_____	

Psy: Depression	_____	Anxiety/Panic	_____
Other mood disorders	_____	Thought disorders	_____
Low motivation	_____	Memory changes	_____
Stress	_____	Suicidal thoughts	_____
Other psychiatric problems	_____	On psychiatric medicines	_____
Required hospitalization	_____	Eating disorder	_____
Sexual abuse (optional)	_____		

Nutrition

Number of meals eaten per day	_____	Snacks	_____
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Number of sodas per day	_____	Diet or regular	_____
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Number of coffees per day	_____	Sports drinks	_____
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Number of fast food meals per week	_____
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Food cravings _____

Are you a: sweet eater _____ volume eater _____ emotional eater _____

Patient Name: _____

Patient DOB: _____

Weight History

When your weight first became a problem to you:

Always ____ In high school ____ As young adult ____ After children ____ Later in life ____

Maximum weight _____

Please circle all weight loss plans attempted:

Fen-Phen Phentermine Redux Xenical Meridia

Other prescription: _____ Physician monitored diet Alli

MediFast Diet centers Nutrisystem Weight Watchers

Jenny Craig Metabolife Herbalife Atkins Zone

LA Weight Loss Sugar Busters Slim4Life South Beach Qsymia

Hypnosis Acupuncture Psychotherapy Overeaters anonymous

Richard Simmons Body for Life Hydroxycut Ephedra

Grapefruit diet Calorie counting Ornish diet FullBar Biggest Loser

Other diets attempted: _____

Exercise programs: Gym Membership(s) Weight lifting Jogging/Running

Walking Yoga Pilates Trainer Spin Biking

Other exercise programs attempted: _____