4600 Hale Parkway Suite 340 Denver, CO 80220
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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: _____________________________

Revised 04-2015

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)	

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	_______

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	________
Number of sodas per day	________	Diet or regular	________
Number of coffees per day	________	Sports drinks	________
Number of fast food meals per week	________		

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/Runnning	
Walking	Yoga	Pilates	Trainer	Spin Biking

Other exercise programs attempted: ____