Patient Medical History Questionnaire
Sparrow Medical Group Bariatric Surgery/Sparrow Weight Management Services
(PLEASE PRINT)

Last Name: ___________________________________ First: _____________________ MI: ____

Date of Birth: ___________________

Home: ____________________ Cell: ____________________ Work: ______________________

E-Mail Address: ____

Race: (please circle) White Black or African American Asian
American Indian or Alaska Native Native Hawaiian or other Pacific Islander
Other: ____

Hispanic Ethnicity: (please circle) Yes No Unknown

Preferred Language: (please circle) English Spanish Other: _____________

Your Primary Care Physician

Physician Name: ____

Phone: ____

List all **allergies and the reaction:** (drugs, latex, tape, food, environmental)

____

____

____

List all **medication names and dosages:** (include non-prescription i.e. vitamins, aspirin, fish oil, etc.)

1. ________________________________ 7. ___________________________________

2. ________________________________ 8. ___________________________________

3. ________________________________ 9. ___________________________________

4. ________________________________ 10. ___________________________________

5. ________________________________ 11. ___________________________________

6. ________________________________ 12. ___________________________________

List previous **surgeries** and what **year** they were performed:

1. ________________________________ 3. ___________________________________

2. ________________________________ 4. ___________________________________

Please list the last date you had the following **test(s)** and **where** they were completed. If you have never had one, indicate with "N/A":

Colonoscopy: _____/_____/_____ Where: ________________________________

EKG: _____/_____/_____ Where: ________________________________

Sleep Study: _____/_____/_____ Where: ________________________________

Women Only:

OB-GYN/Pap Smear: _____/_____/_____ Where: ________________________________

Mammogram: _____/_____/_____ Where: ________________________________

Do you use birth control? □ Yes □ No

If yes, select type: oral IUD condom diaphragm injection

Other: ____

Any chance you are pregnant? □ Yes □ No

Men Only: PSA Test: _____/_____/_____ Where: ________________________________

Social History: (Please circle one)

Current Smoker Never Smoked Former smoker
packs/day: _________ quit date: ________________________

Do you use smokeless tobacco? □ Yes □ No
If yes, please circle type: snuff chew e-cigarette (name/brand) ________________________

Do you drink alcohol? □ Yes □ No
If yes:

_________ Glasses of wine/week _________ Shots of liquor/week

_________ Cans of beer/week _________ Drinks w/ 0.5oz of alcohol/week

Do you use recreational drugs: □ Yes □ No
If yes, what type: ____

Do you use a hookah pipe or smoke hookah? □Yes □ No

To your knowledge, do you have now or have **you ever had** any of the following:

YES	NO		YES	NO	
____	___	Cancer	____	___	Arthritis
____	___	Diabetes	____	___	AIDS/HIV Positive
____	___	Liver Disease/Hepatitis	____	___	Tuberculosis
____	___	MRSA/VRE Infection			

Review of System/Medical History Questionnaire Medical Information:
Please check any of the following conditions from the past or present

General
______ fever ______ chills ______ night sweats ______ fatigue

HEENT
______ glasses or contacts ______ hearing issues ______ congestion ______ trouble swallowing

Pulmonary
______ cough ______ wheezing ______ snoring ______ stop breathing while sleeping
______ shortness of breath ______ emphysema/COPD ______ asthma
______ sleep apnea If yes, do you use CPAP or BIPAP? ◻ Yes ◻ No

Neurological
______ numbness ______ tingling ______ weakness ______ seizures/epilepsy ______ fainting
______ stroke/CVA/TIA ______ lightheadedness/dizziness ______ headaches

Cardiac
______ chest pain or pressure ______ heart disease/failure ______ palpitation
______ heart murmur ______ high blood pressure ______ shortness of breath while lying down
______ heart attack If yes, date ____________ (circle) bypass stent angioplasty

Abdominal
______pain ______ nausea/vomiting ______ diarrhea ______ constipation
______ blood in stool ______ GERD/reflux/heartburn/indigestion ______ difficulty swallowing
______ stomach ulcer

Genito-urinary
______ urine incontinence (unintentional loss of urine) ______ blood in urine
______ painful urination ______ night time urination ______ urgency/frequency
______ kidney disease ______ history of kidney stones

Hematological
______ easy bruising ______ easy bleeding ______ bleeding disorder
______ blood clots/DVT/phlebitis ______ blood transfusion

Musculoskeletal
______ joint pain Please circle all that apply: knee hip ankles wrist hands
______ chronic low back pain ______ muscle pain
______ mobility assistance If yes, which? cane walker wheelchair/scooter

Skin

_____ rash _____ jaundice _____ ulcers (leg or sacrum) _____ cancer _____ cellulitis

Endocrine

_____ abnormal hair growth _____ heat intolerance _____ cold intolerance
_____excessive thirst _____ thyroid disease

Psychological Diagnosis (past or present)

_____ anxiety _____ depression _____panic attacks _____ bipolar disorder
_____ eating disorder _____alcohol abuse _____ substance abuse
_____ history of self-harm/suicide attempt/homicidal thoughts

Previous Bariatric Surgery

_____ Gastric Bypass Date: ___________________ Surgeon: ______________________
Location: ____
_____ Sleeve Gastrectomy Date: ___________________ Surgeon: ______________________
Location: ____
_____ Lap Band placement Date: ___________________ Surgeon: ______________________
Location: ____

Family History:

Have any of **your blood relatives** had any of the following: (please check yes or now, and then indicate: M=mother, F=father, S=Sister, B=brother, D=daughter, Sn=son)

Obesity	□ Yes □ No	M F S B D Sn
Diabetes	□ Yes □ No	M F S B D Sn
Cancer	□ Yes □ No	M F S B D Sn
Heart Disease	□ Yes □ No	M F S B D Sn
Stroke	□ Yes □ No	M F S B D Sn
High Blood Pressure	□ Yes □ No	M F S B D Sn
DVT/Blood Clot	□ Yes □ No	M F S B D Sn

Additional information for Physician:

____
____
____

I hereby certify that all statements and answers provided by me in this questionnaire are true to the best of my knowledge:

Patient Signature: ____ Date: __________________