BARIATRIC AND METABOLIC INSTITUTE
GOOD SAMARITAN MEDICAL CENTER

PATIENT INFORMATION
Please complete entire form

Name (Last, First),_____**DOB**_____**Age**_____
Height _____**Weight** _____**BMI** _____ **Social Security#** _____**Race**_____
Email _____**Employment Status**_____
Address_____**City**_____**State**_____**Zip**_____
Cell#_____
Work#_____ **Marital Status**_____ **Name of Spouse/Significant Other**_____
Emergency Contact Name_____**Emergency phone** _____
Relationship to Patient _____
Employer Name _____**Employer Address** _____
Employer Phone_____ **Occupation** _____**Employment Status**_____

PATIENT'S ASSIGNED PROVIDERS

Primary Physician _____**Phone** _____
Cardiologist_____ **Phone**_____
Pulmonologist_____ **Phone**_____
Endocrinologist _____**Phone**_____
Psychiatrist_____ **Phone**_____

INSURANCE INFORMATION

Bring your insurance cards & driver's license to the consult with surgeon.

Name of Primary Insurance Company _____

Name of Insured exactly as it appears on card_____

Insurance Billing address_____

Policy holder's Date of Birth _____ **Policy#** _____ **Group Number**_____

Subscriber's Full Name _____**Subscriber's DOB** _____**Relationship**_____

Subscriber's Employer name _____**Subscriber's Employer Status**_____

Subscriber's Employee Address _____**Employer Phone**_____

How did you hear about us? □ **Internet** □ **Referral** □ **Friend**

Past weight loss surgery? □ **Yes** □ **No** **Interest in Medical Weight Loss?** □ **Yes** □ **No**

Surgery Interest? □ **Gastric Bypass** □ **Sleeve Gastrectomy** □ **Band Removal** □ **Conversion Sleeve to Bypass**

Which Surgeon? □ **Dr. Betancourt** □ **Dr. Follwell** □ **Dr. Lopes** □ **Dr Parra Davila** □ **No Preference**

Medical History

	Stent		**Lymphedema**
	High Blood Pressure		**Brain Aneurysm**
	Vascular Disease		**Stroke**
	Heart Disease		**High Cholesterol**
	COPD		**Joint Disease**
	Depression		**Gynecological Problems**
	Sleep Apnea		**Irritable Bowel Syndrome**
	C-PAP		**Acid Reflux/Heartburn/Ulcer**
	Lung Disease		**DVT/PE**
	Kidney Disease		**Fibromyalgia**
	Bleeding Problem		**Arthritis**
	Diabetes (Type I or II)		**Rheumatoid Arthritis**
	Hiatal Hernia		**Cancer**
	Psychiatric Disorder (bipolar, schizophrenia, anxiety)		**Gallstones**

PAST SURGICAL HISTORY

Please list all previous surgeries and date of surgery

Surgery	Date

Have you ever had a problem with anesthesia? _____ If yes explain _____

Have you had a COVID Vaccine?_____

SOCIAL HISTORY

Do you use tobacco products/Vape? _____ What type? _____

How many years? _____

Do you drink alcohol? _____ What type? _____ How often? _____

Do you use recreational drugs? _____ What type? _____How often? _____

Do you consume caffeine? _____ How much? _____

Please list all ALLERGIES and reactions

Allergy	Reaction

MEDICATIONS

List all medications and vitamins you currently are taking

Medication	Dose	Frequency	Reason for Taking

FAMILY HISTORY

Include parents, sibling, children

Relation	Alive?	Diabetes	Heart Attack	High Blood Pressure	Cancer	Stroke	Obesity

PreOperative Nutrition Assessment

WEIGHT HISTORY:

What is your highest adult weight? _____

What is your lowest adult weight? _____

What do you consider a healthy weight for you? _____

At each age below, please check where you would describe your weight:

AGE	OBESE	OVERWEIGHT	AVERAGE	BELOW AVERAGE
5				
10				
20				
30				
40				
50				
60				
70				

What do you think was the reason for weight gain? _____

_____

_____

EATING HABITS. DIETARY DOWNFALLS. Please check all that apply.

Lack of Fullness Signal		Overeating on regular basis		Skipping Meals	
Poor Planning		Eating when not Hungry		Inconsistent Eating	
Poor Food Choices		Snacking/Grazing		Lack of Fruits	
Eating out Frequently/Fast Food		Desserts/Sweets		Lack of Vegetables	
Rapid Eating		Sweetened Beverages		Closet Eating out of embarrassment	
Lack of Time		Milk Consumption		Alcohol Intake	

CULTURAL FACTORS

Do you feel there are any cultural and/or social factors affecting your eating habits and weight?

Please explain:_____

_____

MEAL/SNACK PATTERNS

Do you plan your meals? YES NO

Do you plan grocery lists? YES NO

Do you pack meals/snacks for work & travels? YES NO

Who does the grocery shopping? _____

How many meals do you eat daily, on a regular basis? _____

How many snacks do you consume daily? _____

Do you skip meals? YES NO

If yes, which meal(s) ? _____

How many meals do you eat out in a week? _____

Do you tend to eat the same food at meals and snacks? YES NO

Do you consume a variety of fruits and vegetables? YES NO

Do you eat more than (3) food groups at your meals? YES NO

Are you in tune to hunger and fullness signals? YES NO

Are you an emotional eater? YES NO

What are your emotional triggers that would cause you to eat? _____

BEVERAGE CONSUMPTION

How many ounces/day do you consume of the following beverages?

____oz Water
____oz Diet Soda
____oz Regular Soda
____oz Coffee
____oz Tea
____oz Energy drinks

____ oz Milk
____ oz Juice
____ oz Sports Drink
____ oz Liquor
____ oz Beer
____ oz Wine

DIETARY RECALL

Please describe a typical day, including specific portions

TIME	FOOD	AMOUNT
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

DIET HISTORY

Please check off ALL diet programs you have tried for weight loss

WEIGHT LOSS PROGRAM	YEAR	WEIGHT LOSS/WEIGHT REGAINED
Atkins		
Body by Vi		
Exercise		
Herbal Life		
Hypnosis		
HCG		
Jenny Craig		
Keto		
LA Weight Loss		
LapBand		
Nutrisystem		
Optifast		
Overeaters Anonymous		
Physician-Supervised		
Portion Control		
Quick Weight Loss		
Richard Simmons		
Slimfast		
Weight Loss Medications (which one(s) _____)		

Weight Watchers		
Worked with Dietitian		
21 Day Fix/Beach Body		

_____

PHYSICAL ACTIVITY

What types of recreational activities, exercise, sports are you currently participating in and how many hours per week?

_____
_____

Are there any activities you have always wanted to try, but felt your weight affected your ability to?

_____
_____

Do you have any physical limitations affecting the ability to exercise?

_____
_____

KNOWLEDGE OF BARIATRIC SURGERY DIETARY CHANGES

How long have you been considering bariatric surgery? _____

What are your weight loss expectations after surgery?_____

What do you know about the required dietary changes after bariatric surgery? _____
_____
_____