SOUTHWEST BARIATRIC SURGEONS, PLLC

PATIENT HEALTH INFORMATION

NAME OF PATIENT: _____ DATE OF BIRTH: _____ DATE: _____

REASON FOR VISIT: _____

PAST MEDICAL HISTORY

PREVIOUS SURGERIES				PREVIOUS HOSPITALIZATIONS			
TYPE:		DATE:		REASON:		DATE:	
TYPE:		DATE:		REASON:		DATE:	
TYPE:		DATE:		REASON:		DATE:	
TYPE:		DATE:		REASON:		DATE:	

MEDICAL ILLNESSES

	PATIENT YES	PATIENT NO	FAMILY YES	FAMILY NO	Family Member & / or Additional Information:
DIABETES	☐	☐	☐	☐	
HIGH BLOOD PRESSURE	☐	☐	☐	☐	
HEART DISEASE	☐	☐	☐	☐	
KIDNEY DISEASE	☐	☐	☐	☐	
CANCER	☐	☐	☐	☐	

SPECIFY TYPE OF CANCER _____

OBSTRUCTIVE SLEEP APNEA ☐ ☐ DOES PATIENT USE CPAP/BIPAP MACHINE? YES ☐ NO ☐

PREVIOUS DVT (DEEP VEIN THROMBOSIS) ☐ ☐

OTHER ILLNESSES _____

_____

CURRENT MEDICATIONS (Including HERBS, VITAMINS, SUPPLEMENTS & OVER-THE-COUNTER MEDICINE)

NAME: _____ DOSAGE: _____	NAME: _____ DOSAGE: _____	NAME: _____ DOSAGE: _____	NAME: _____ DOSAGE: _____
NAME: _____ DOSAGE: _____	NAME: _____ DOSAGE: _____	NAME: _____ DOSAGE: _____	NAME: _____ DOSAGE: _____
NAME: _____ DOSAGE: _____	NAME: _____ DOSAGE: _____	NAME: _____ DOSAGE: _____	NAME: _____ DOSAGE: _____
NAME: _____ DOSAGE: _____	NAME: _____ DOSAGE: _____	NAME: _____ DOSAGE: _____	NAME: _____ DOSAGE: _____

PREFERRED PHARMACY NAME: _____

ADDRESS (or Cross Street/Intersection): _____

CITY: _____ PHONE: _____

DRUG & FOOD ALLERGIES

DRUG & FOOD ALLERGIES				DRUG & FOOD ALLERGIES			
DRUG/FOOD:		REACTION:		DRUG/FOOD:		REACTION:	
DRUG/FOOD:		REACTION:		DRUG/FOOD:		REACTION:	
DRUG/FOOD:		REACTION:		DRUG/FOOD:		REACTION:	

HABITS

Have you ever smoked tobacco? _____ If yes: How long / how much? _____ When did you quit? _____

How often do you consume alcohol? _____ How much caffeine do you consume? _____

Have you ever used IV street drugs? _____ How often do you exercise? _____

SOCIAL

Occupation: _____ ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Level of Education: _____

_____

SIGNATURE DATE

Rev. 04.28.16 TRC