University Bariatrics Application (non-bariatric surgery)

1.

Thank you for choosing University Bariatrics. Please take your time and fill out this application in full. You may forward the completed questionnaire to us via mail, fax, or email:

University Bariatrics
425 Haaland Drive. #203
Thousand, Oaks, CA 91302
Fax : (805) 379-6700
coordinator@universitybariatrics.com

If you have any questions, please do not hesitate to contact us at (805) 379-9796 or via email. We look forward to seeing you soon.

For the University Bariatrics Team
Amir Mehran, MD

1. Your full name

2. Your date of birth?

3. Mailing address:

4. Telephone number(s) where we can leave private messages

5. Email address(es) where you can receive personal private emails.

6. Emergency contact information

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7. Providing CORRECT and up-to-date primary care MD information is mandatory prior to consideration for surgery. Providing COMPLETE information will be significantly helpful in expediting your surgery by allowing us to easily and reliably communicate with your PCP. Please include full name, address, phone and fax, and if known, email address

***8. Please provide the name, specialty, and contact information for your other physicians and healthcare providers.**

9. Please provide the primary reason you would like to see us for, including a brief explanation if possible.

10. How did you hear about University Bariatrics?

- ☐ PCP referral
- ☐ Other physician or healthcare provider such as NP or psychologist
- ☐ Friend or family member or coworke
- ☐ Advertisement in print media
- ☐ Google
- ☐ Other internet search enginesa such as Bing, Yahoo, etc
- ☐ LaPeer (website or banner ads)
- ☐ Social internet sites such as Facebook, Twitter etc
- ☐ Obesityhelp.com website
- ☐ Other

Other (please specify)

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11. Cardiac history: Please mark all that apply.

- ☐ High blood pressure (including medication controlled)
- ☐ Heart attack
- ☐ Congestive heart failure
- ☐ Abnormal heart rhythms
- ☐ I have or have had a pacemaker
- ☐ Murmurs
- ☐ Pulmonary hypertension
- ☐ Known abnormal EKGs
- ☐ Swelling of the legs during the day
- ☐ None of the above
- ☐ Other

If other (please specify)

12. Pulmonary History: Please mark all that apply.

- ☐ Known obstructive sleep apnea
- ☐ Tuberculosis
- ☐ History of pneumonia
- ☐ Emphysema
- ☐ Asthma
- ☐ Shortness of breath on exertion eg going up stairs
- ☐ Lung or other airway cancer
- ☐ None of the above
- ☐ Other:

If other (please specify)

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13. Gastrointestinal history: Please mark all that apply.

- ☐ Heartburn (gastric reflux disease)
- ☐ Gastroparesis
- ☐ Barretts esophagitis
- ☐ Pernicious anemia
- ☐ Gastric polyps
- ☐ Biliary colic (gallbladder pains)
- ☐ Diarrhea
- ☐ Constipation
- ☐ Diagnosis of irritable bowel syndrome
- ☐ Celiac sprue
- ☐ Lactose intolerance
- ☐ Inflammatory bowel disease(ulcerative colitis or Crohns)
- ☐ Rectal bleeding
- ☐ Colon or small intestine polyps
- ☐ Fatty liver
- ☐ Liver cirrhosis
- ☐ Any gastrointestinal cancer
- ☐ None of the above
- ☐ Other:

If other (please specify)

14. Endocrine history: Please mark all that apply.

- ☐ Insulin treated diabetes
- ☐ Oral medication treated diabetes
- ☐ Hyperlipidemia (cholestrol and/other lipids)
- ☐ Hyperthyroidism (overactive)
- ☐ Hypothyroidism (underactive)
- ☐ Endocrine cancers such as thyroid, adrenal, pituitary, etc
- ☐ None of the above
- ☐ Other:

If other (please specify)

15. Urinary history: Please mark all that apply

- ☐ Stress urinary incontinence
- ☐ "Suspension surgery" for stress incontinence
- ☐ Benign prostatic hypertrophy
- ☐ Any prostate surgery
- ☐ Frequent urinary tract infections
- ☐ Kidney failure history (now or in past)
- ☐ Dialysis dependent
- ☐ Urological cancers
- ☐ None of the above
- ☐ Other:

If other (please specify)

16. GYN history (women only): Please mark all that apply

- ☐ Menopause
- ☐ Irregular periods/vaginal bleeding not related to menopause
- ☐ Endometriosis
- ☐ Polycystic ovarian disease
- ☐ Infertility
- ☐ Tubal ligation
- ☐ Hysterectomy
- ☐ GYN hormones (eg birth control pills, depo shots)
- ☐ Any GYN cancer
- ☐ None of the above
- ☐ Other:

Other (please specify)

17. Hematological history: Please mark all that apply

- ☐ Religious or cultural opposition to blood transfusion even if it means saving one's life
- ☐ Abnormal bleeding (ie do not clot easily)
- ☐ Hemophilia
- ☐ Known clotting disorders (ie hypercoagulable diseases)
- ☐ History of pulmonary embolus
- ☐ IVC filter
- ☐ History of blood transfusion
- ☐ Any form of immunodeficiecy such as HIV
- ☐ Hepatitis A or B or C
- ☐ Leukemia
- ☐ Lymphoma
- ☐ None of the above
- ☐ Other:

If other (please specify)

18. Neurological history: Please mark all that apply

- [ ] Stroke
- [ ] Migraines or other severe headaches
- [ ] Pseudotumor cerebri
- [ ] Tumors
- [ ] None of the above
- [ ] Other:

Other (please specify)

19. Musculoskeletal history: Please mark all that apply

- [ ] Early arthritis
- [ ] Severe arthritis or joint loss requiring orthopedic surgery
- [ ] History of orthopedic surgeries
- [ ] None of the above
- [ ] Other:

If other (please specify)

20. Other history:

- [ ] Skin cancers or precancerous lesions
- [ ] Hair loss
- [ ] Psoriasis
- [ ] Eczema
- [ ] Blindness in one eye
- [ ] HIV or other immunodeficiency
- [ ] None of the above
- [ ] Other:

Other (please specify)

21. Other past medical or surgical history or hospitalizations not mentioned above. Please include approximate dates and write on SEPARATE lines for each event.

22. If you have had general anesthesia before, i.e. have been put to complete sleep for a surgical procedure, please check the appropriate box.

- ○ I have never had general anesthesia
- ○ I have had general anesthesia in the past and had no problems
- ○ I have had general anesthesia in the past and had problems

If had problems, please elaborate:

23. COMPLETE list of prescription medications, preferably with dosing and frequency

24. COMPLETE list of non-prescription, over-the-counter, or herbal medications and supplements.

25. Drug or other chemical allergies

- ☐ No drug, chemical , or food allergies
- ☐ Food allergies
- ☐ Latex allergy
- ☐ IV dye allergy (eg for CT scans or other xray tests)
- ☐ Allergies to other medications or chemicals

Please specify EACH allergy on a SEPARATE line and include what kind of reaction (eg nausea, rash, stop breathing, etc))

26. Family history: Please mark all that apply.

- ☐ Obesity
- ☐ Cancer
- ☐ Blood clots and embolism
- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Hyperlipidemia
- ☐ Strokes
- ☐ Neurological disorders eg Parkinsons, Alzheimers, etc
- ☐ Anesthesia problems
- ☐ Other:

Other (please specify)

27. Current alcohol history:

	none	Less than five drinks per week	More than 6 drinks per week
Beer	○	○	○
Wine	○	○	○
Other liquor	○	○	○

28. Current tobacco/nicotine history:

	None	Less than pack/roll/box a day	More than one pack/roll/box a day
Cigarettes	○	○	○
Cigar	○	○	○
Chewable tobacco	○	○	○

If past user and have quit: please indicate when

29. I currently use drugs including medical marijuana. If yes, please elaborate type and amount.

- ○ Yes
- ○ No

If yes, please specify type and amount

30. What is your current occupation

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31. This application has been filled out by myself or with the help of someone else under my guidance. In either case, by writing my name, signing and dating below, I attest that all the information is accurate to the best of my abilities.