Institute for Metabolic and Bariatric Surgery and Medicine | JOSEPH E. CHEBLI, MD

NEW PATIENT REGISTRATION FORM

MRN: _____ **DATE:** _____

Patient Name: (first) _____ (last) _____ (m.i) _____
Date of Birth: _____ /_____/ _____ **Age:** _____

Previous Diagnostic Procedures

Please check any of the following diagnostic procedures that have been performed in *the last year* and indicate where we can retrieve them.

- ☐ EKG _____
- ☐ Stress Test _____
- ☐ Chest X-Ray _____
- ☐ Abdominal Ultrasound _____
- ☐ Echocardiogram _____
- ☐ Heart Cath _____
- ☐ Upper Endoscopy _____
- ☐ Upper GI Series _____
- ☐ Colonoscopy _____
- ☐ CT Scan _____
- ☐ Pulmonary Function Test _____
- ☐ Sleep Study _____
- ☐ Other _____

Surgical History

Have you or a relative ever had bariatric surgery? [ ] YES [ ] NO

Name & Relationship: _____

What procedure? _____ By which surgeon? _____

Please list any surgical procedures you have had. Include the year performed and the reason(s) for the procedure(s). Please specify if the procedure was performed *laparoscopic* or *open*.

Surgery	Reason	Year	Laparoscopic / Open

MEDICAL HEALTH INFORMATION

Please indicate if any of the following conditions have ever been significant problems for you. Please specify the year diagnosed and the physician who is currently managing the diagnosis.

CARDIAC

Coronary Artery Disease ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

MI (Heart Attack) ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Elevated Cholesterol ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Chest Pain ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Congestive Heart Failure ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Valvular Heart Disease ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Rheumatic Fever ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Heart Murmur ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Heart Arrythmia ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

High Blood Pressure / Hypertension ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

PULMONARY

Asthma ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Pneumonia ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Bronchitis ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

COPD (Emphysema) ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Tuberculosis ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Diagnosed Sleep Apnea ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Obesity Hypoventilation Syndrome ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Pulmonary Hypertension ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

ENDOCRINE

Diabetes Mellitus ☐ **Yes** ☐ **No**

If yes, how is your Diabetes managed?

- ☐ Insulin
- ☐ Oral medication
- ☐ Combination of both
- ☐ Neither

Year Diagnosed: _____ Physician: _____

Hyperthyroid ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Hypothyroid ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Adrenal (Cushing's) ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

GASTROINTESTINAL

Reflux Disease (Heartburn) ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Peptic Ulcer Disease ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Gallbladder Disease ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Liver Disease ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Inflammatory Bowel Disease ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Hiatal Hernia ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Irritable Bowel Syndrome ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

CANCER

☐ **Yes** ☐ **No**

Type / Organ Affected:

_____

Year Diagnosed: _____ Physician: _____

RENAL

Kidney Disease ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Urinary Stress Incontinence ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Kidney Stones ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

PERIPHERAL VASCULAR DISEASE

Arterial Vascular Disease ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Pulmonary Embolism ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

DVT (Phlebitis) ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Superficial Phlebitis ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Peripheral Edema (swelling of legs/ankles) ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Leg Ulcers ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Varicose Veins ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

CENTRAL NERVOUS SYSTEM

Stroke ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Seizure ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Cerebral Aneurysm ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Arteriovenous Malformation ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Pseudo Tumor Cerebri ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Multiple Sclerosis ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

PSYCHIATRIC DISORDERS

Bipolar Depression ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Anxiety ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Schizophrenia ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Eating Disorder ☐ **Yes** ☐ **No**

Type: _____ Year Diagnosed: _____ Physician: _____

Are you receiving therapy or medications? ☐ **Yes** ☐ **No**

Depression ☐ **Yes** ☐ **No**

Severity: ☐ Mild, no treatment ☐ Moderate, with treatment ☐ Severe, with intensive treatment ☐ Severe, requiring hospitalization

Year Diagnosed: _____ Physician: _____

MUSCULOSKELETAL DISORDERS

Gout ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Fibromyalgia ☐ **Yes** ☐ **No**

Treatment: ☐ exercise ☐ Narcotic Medications ☐ Non-Narcotic Medications ☐ No Symptoms

Year Diagnosed: _____ Physician: _____

Abdominal Skin / Pannus ☐ **Yes** ☐ **No**

Symptoms: ☐ Irritation ☐ Interferes with Ambulation ☐ Recurrent Cellulitis and Ulceration ☐ No Symptoms

Year Diagnosed: _____ Physician: _____

Functional Status Limited ☐ **Yes** ☐ **No**

☐ Requires Wheelchair ☐ Able to walk 200ft with cane / crutch ☐ Unable to walk 200ft without cane / crutch

Lower Back Pain ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Osteoarthritis / DJD ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Osteoporosis ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Joint Pain ☐ **Yes** ☐ **No**

Year Diagnosed: _____ Physician: _____

Autoimmune Disease ☐ **Yes** ☐ **No**

Explain Further:
(Ex: Lupus, Rheumatoid Arthritis, Connective Tissue, etc.) _____

_____

Year Diagnosed: _____ Physician: _____

OBSTETRICAL/GYNECOLOGICAL

Menstrual Irregularities ☐ **Yes** ☐ **No**
Explain: _____

Polycystic Ovarian Syndrome ☐ **Yes** ☐ **No**
Year Diagnosed: _____ Physician: _____

History of Breast Cancer ☐ **Yes** ☐ **No**
Year Diagnosed: _____ Physician: _____

Indicate if you are ☐ **Pre-Menopausal** ☐ **Post-Menopausal**

Hysterectomy ☐ **Yes** ☐ **No** Year: _____
How was it performed? ☐ **Vaginal** ☐ **Abdominal**
Were Ovaries removed? ☐ **Yes** ☐ **No**

Tubal Ligation ☐ **Yes** ☐ **No** Year: _____
How was it performed? ☐ **Open** ☐ **Laparoscopic**

Number of Pregnancies to term: _____

Number of deliveries: _____

SOCIAL HISTORY

Occupation: _____

☐ **Full Time** ☐ **Part Time** ☐ **Retired** ☐ **Disabled**
Please indicate cause: _____

What category best describes your highest level of education?

☐ **High school** ☐ **College** ☐ **Graduate School** ☐ **Vocational** ☐ **Other**

What is your religious affiliation?

☐ **Atheist** ☐ **Christian** ☐ **Catholic** ☐ **Jehovah Witness** ☐ **Jewish** ☐ **Other**

Do you have any children? ☐ **Yes** ☐ **No**
If yes, how many? _____

What are their names and ages?

_____ _____
_____ _____
_____ _____
_____ _____

TOBACCO / NICOTINE HISTORY

Do you currently use tobacco or nicotine products? ☐ **Yes** ☐ **No**

Have you ever used tobacco or nicotine products? ☐ **Yes** ☐ **No**

What type?

☐ **Cigarettes** ☐ **Vapor** ☐ **Chew / Snuff** ☐ **Cigar**

How many per day? _____

Start Age: _____ **Stop Age:** _____ **Total years used:** _____

DRUG HISTORY

Have you ever used illicit drugs? ☐ **Yes** ☐ **No**

What type?

☐ **Marijuana** ☐ **Cocaine** ☐ **Heroin** ☐ **Amphetamine**

How long ago?

☐ **Less than 5 months** ☐ **6 months – 1 year** ☐ **Over 1 year**

ALCOHOL HISTORY

Do you currently drink alcohol? ☐ **Yes** ☐ **No**

What type?

☐ **Wine** ☐ **Beer** ☐ **Liquor** ☐ **Mixed**

How many drinks do you currently consume?

Daily: _____ **Weekly:** _____ **Monthly:** _____ **Yearly:** _____

Have you ever had a problem with alcohol abuse in the past? ☐ **Yes** ☐ **No**

Indicate how long: _____ Treatment: _____

What type did you drink?

☐ **Wine** ☐ **Beer** ☐ **Liquor** ☐ **Mixed**

FAMILY HISTORY

In this section, please complete this chart to the best of your knowledge.

Has anyone in your family ever had a blood clot in their legs or lungs? ☐ **Yes** ☐ **No**

Has anyone in your family ever had a stroke? ☐ **Yes** ☐ **No**

Family Member	Deceased	Present Age	Medical Problems
FATHER	☐		
MOTHER	☐		
PATERNAL GRANDFATHER	☐		
PATERNAL GRANDMOTHER	☐		
MATERNAL GRANDFATHER	☐		
MATERNAL GRANDMOTHER	☐		
SIBLINGS	☐		
	☐		
CHILDREN	☐		
	☐		