

Institute for Metabolic and Bariatric Surgery and Medicine
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NEW PATIENT REGISTRATION FORM

MRN: _____ DATE: _____

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

Have you or a family member had bariatric surgery? Yes No

Name/Relation: _____ Procedure: _____ Surgeon: _____

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 _____

Patient Care Team

Preferred Imaging & Radiology Facility: _____

Preferred laboratory: _____

Primary Care Physician: _____ Phone: (_____) _____ - _____

Cardiologist: _____ Phone: (_____) _____ - _____

Gastroenterologist: _____ Phone: (_____) _____ - _____

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** Year Diagnosed: _____ Physician: _____

If yes, how is your Diabetes managed?

- Insulin
- Oral medication
- Combination of both
- Neither

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

Type / Organ Affected **Yes** **No** 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** Year Diagnosed: _____ Physician: _____

(If Yes) Type of Disorder: _____

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

(If Yes) Type of Disorder: _____

- Depression** **Yes** **No** Year Diagnosed: _____ Physician: _____

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

MUSCULOSKELETAL DISORDERS

Gout **Yes** **No** Year Diagnosed: _____ Physician: _____

Fibromyalgia **Yes** **No** Year Diagnosed: _____ Physician: _____

Treatment: exercise Narcotic Medications Non-Narcotic Medications No Symptoms

Abdominal Skin / Pannus **Yes** **No** Year Diagnosed: _____ Physician: _____

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

Functional Status Limited **Yes** **No** Year Diagnosed: _____ Physician: _____

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** Year Diagnosed: _____ Physician: _____

Explain Further:

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

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

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	<input type="checkbox"/>		
MOTHER	<input type="checkbox"/>		
PATERNAL GRANDFATHER	<input type="checkbox"/>		
PATERNAL GRANDMOTHER	<input type="checkbox"/>		
MATERNAL GRANDFATHER	<input type="checkbox"/>		
MATERNAL GRANDMOTHER	<input type="checkbox"/>		
SIBLINGS	<input type="checkbox"/>		
	<input type="checkbox"/>		
CHILDREN	<input type="checkbox"/>		
	<input type="checkbox"/>		