



Advanced Surgical
& Bariatrics of NJ, PA

Ragui Sadek, MD, FACS
Associate Director of Bariatric Surgery
Robert Wood Johnson University Hospital

49 Veronica Ave.
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Phone: 732-640-5327
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Medical History Form

LAST NAME: _____ FIRST: _____ MI: _____ AGE: _____

DATE OF BIRTH: _____ MARITAL STATUS: M ___ S ___ D ___ W ___

Sex: ___ Male ___ Female SS# _____

Home address: _____
(Cannot accept P.O. Box as home address) *Street Apt#/Bldg# City State Zip code*

Mailing address: _____
Street Apt#/Bldg# City State Zip code

Home phone: _____ Work phone: _____ Cell phone: _____

E-mail address: _____ Can we contact you via e-mail? ___ Yes ___ No

Occupation: _____

Employer: _____

Work address: _____

Insurance carrier: _____

Insurance Address: _____

Insurance Phone: (_____) _____ / Effective date: _____

Insured: _____ Insured's DOB: _____

ID: _____ Group: _____ Copay: _____

Reason for consultation _____

Referring physician _____ **Primary care physician** _____

Past Medical History

Check all that apply and list details/diagnoses

- Myocardial Infarction
 Diabetes
 High Blood Pressure
 Emphysema
 Irregular Heartbeat
 High Cholesterol
 Thyroid Problems
 Asthma
 Stroke
 Coagulation Disorder (you may take Plavix or Coumadin for)
 Heart Failure
 Sleep Apnea
 Cancer
 Other _____

Other Medical Problems and details:

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, aspirin or blood thinners:

Medication	Dose	Times per day

Medication	Dose	Times per day

SURGICAL HISTORY: Including Defibrillators, Pacemakers or Stents

Operation	Date

Operation	Date



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ALLERGIES or REACTIONS: None Latex

Medication	Reaction or Side Effect

FAMILY HISTORY:
 Please check all that apply.

Medical Condition	Mom	Dad	Sister	Brother	Daughter	Son	Other
Anesthesia Problem							
Asthma							
Bleeding Problems							
Breast Cancer							
Colon Cancer							
Melanoma							
Thyroid Cancer							
Parathyroid Cancer							
Prostate Cancer							
Diabetes							
Heart Attack							
High Blood Pressure							
Kidney Disease							
Leukemia							
Lupus							
Lymphoma							
Stroke							
Vascular Disease							

SOCIAL HISTORY

Tobacco Use

Cigarettes

- Never Current Smoker: packs/day _____ # of years _____
 Quit: Date _____ How many years did you smoke? _____

Other Tobacco:

- Pipe Cigar Snuff Chew

Alcohol Use

- No Yes: # drinks/week _____

PLEASE INDICATE BELOW IF YOU ARE CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS:

General, constitutional			Musculoskeletal		
Does your job require heavy lifting	no	yes	Joint Pain	no	yes
Recent weight change	no	yes	Joint stiffness or swelling	no	yes
Fever	no	yes	Weakness of muscles/joints	no	yes
Fatigue	no	yes	Muscle pain or cramps	no	yes
			Back pain	no	yes
Eyes and vision			Cold extremities	no	yes
Eye disease or injury	no	yes	Difficulty in walking	no	yes
Wear glasses or contact lenses	no	yes			
Blurred or double vision	no	yes	Skin and Breasts		
Glaucoma	no	yes	Rash or itching	no	yes
			Change in skin color	no	yes
Ears, nose, throat			Change in hair or nails	no	yes
Hearing loss	no	yes	Varicose veins	no	yes
ringing in the ears	no	yes	Breast pain	no	yes
Earaches or drainage	no	yes	Breast lump	no	yes
Sinus problems	no	yes	Breast discharge	no	yes
Nose bleeds	no	yes			
Mouth sores	no	yes	Neurological		
Bleeding gums	no	yes	Frequent or recurrent headaches	no	yes
Bad breath or bad taste	no	yes	Light headed or dizzy	no	yes
Sore throat or voice change	no	yes	Convulsions or seizures	no	yes
Swollen glands in neck	no	yes	Numbness or tingling sensations	no	yes



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Heart and Cardiovascular		
Heart trouble	no	yes
Chest pains	no	yes
Swelling of feet, ankles, hands	no	yes
Respiratory		
Frequent coughing	no	yes
Spitting up blood	no	yes
Shortness of breath	no	yes
Asthma or wheezing	no	yes
Gastrointestinal		
Loss of appetite	no	yes
Change in bowel movements	no	yes
Nausea or vomiting	no	yes
Frequent diarrhea	no	yes
Painful bowel movements or constipation	no	yes
Genitourinary		
Frequent urination	no	yes
Burning or painful urination	no	yes
Blood in urine	no	yes
Change in force or strain with urination	no	yes
Incontinence or dribbling	no	yes
Kidney stones	no	yes
Sexual difficulty	no	yes
Painful periods	no	yes
Irregular periods	no	yes

Paralysis	no	yes
Stroke	no	yes
Head injury	no	yes
Psychiatric		
Nervousness	no	yes
Depression	no	yes
Sleep problems	no	yes
Endocrine		
Thyroid disease	no	yes
Diabetes	no	yes
Excessive thirst or urination	no	yes
Heat or cold intolerance	no	yes
Dry skin	no	yes
Change in hat or glove size	no	yes
Hematologic/Lymphatic		
Slow to heal after cuts	no	yes
Easily bruise or bleed	no	yes
Anemia	no	yes
Phlebitis	no	yes
Transfusion	no	yes
Swollen glands	no	yes

Patient Signature: _____

Date: _____