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

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Somerset, NJ 08873
Phone: 732-640-5327
Fax: 800-689-2361

MEDICAL AND SOCIAL HISTORY

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:____

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Insurance carrier: ____

Insurance Address::____

Insurance Phone; :(___) _____________/ Effective date: _____________

Insured; _____________ Insured's DOB: _____________

ID: _____________ Group: _____________ Copay: _____________

HEIGHT: _____ WEIGHT: _____ HOW LONG AT CURRENT WEIGHT? ___________
GOAL WEIGHT: _______

ARE YOU A SMOKER? YES ______ NO ______ *IF YES, HOW MANY PER DAY? __________________________

DO YOU DRINK? YES ______ NO ______ *IF YES, HOW OFTEN AND HOW MUCH? _______________________

RACE: CAUCASIAN ____ AFRICAN AMERICAN _____ ASIAN _____ HISPANIC _____
OTHER______________

How Did you hear about us? __________________________

*THE INFORMATION YOU PROVIDE WILL HELP YOUR SURGEON PLAN YOUR TREATMANT AND INSURANCE APPROVAL PROCESS.

PRIMARY HEALTHCARE PROVIDER

ALL PATIENTS NEED TO HAVE A PRIMARY CARE PHYSICIAN

Primary care physician's name: __________________________
ADDRESS:
____

PHONE: ____________________________ HOW LONG HAS HE/SHE BEEN YOUR PCP?
____

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DATE OF LAST PHYSICAL EXAM BY YOUR PCP?____

DO YOU HAVE OR HAVE YOU HAD	YES	NO	DON'T KNOW
DIABETES			
HIGH BLOOD PRESSURE			
HIGH CHOLESTEROL			
HIGH TRIGLYCERIDES			
ANGINA/CORONARY ARTERY DISEASE			
HEART ATTACK			
HEART ARRHYTHMIA			
SLEEP APNEA			

PLEASE LIST ANY OTHER PHYSICIANS TREATING YOU:
____

HAVE YOU EVER BEEN UNDER THE CARE OF A PSYCHIATRIST OR PSYCHOLOGIST? YES_____ NO______

*IF YES, WITH WHOM AND WHEN
____

BEING OVERWEIGHT HAS AFFECTED YOU IN WHICH OF THE FOLLOWING WAYS:

- ❑ FAMILY LIFE
- ❑ SOCIAL LIFE
- ❑ EMOTIONALLY
- ❑ UNABLE TO FIND A JOB
- ❑ EXERCISE OR SPORTS

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MEDICATIONS

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

NAME OF MEDICATIONS	STRENGTH	REASON FOR MEDICATION	HOW OFTEN

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES ______ NO ______

PLEASE LIST: ____
______

DO YOU HAVE A LATEX ALLERGY? YES ______ NO______ *IF YES, YOU WILL NEED TO SEE AN ALLERGIST TO CONFIRM THIS.

Advanced Surgical & Bariatrics of NJ, PA

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LIST ANY MAJOR ILLNESSES

ILLNESS	DATE	TREATMENT	OUTCOME

LIST ANY SURGERIES

SURGERY	DATE	REASON

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FAMILY HISTORY:

MOTHER, FATHER, SIBLINGS	AGE NOW OR AT DEATH	CAUSE OF DEATH	WEIGHT: THIN, NORMAL, SLIGHTLY OVERWEIGHT, OVERWEIGHT OR OBESE	HEALTH PROBLEMS (please describe)

WHAT OTHER FAMILY MEMBERS ARE OBESE?

____

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FERTILITY OR GYNECOLOGIC PROBLEMS

HAVE YOU BEEN TREATED FOR INFERTILITY? YES______ NO______ IF YES, BY WHOM?_______________

DO YOU HAVE AN OB/GYN PHYSICIAN? YES______ NO______ IF YES, WHO? ___________________________

DATE OF MOST RECENT PELVIC EXAM____________ DATE OF MOST RECENT MAMMOGRAM___________

URINARY PROBLEMS

DO YOU EVER INVOLUNTARILY LOSE YOUR URINE? YES______ NO______

IF YES, WHAT CAUSES YOU TO LOSE URINE? COUGHING______ JUMPING______ SNEEZING______

WALKING______ BENDING FORWARD______ OTHER____

HEARTBURN AND/OR INDIGESTION

DO YOU HAVE INDIGESTI0N OR HEARTBURN? YES______ NO______ IF YES, FOR HOW LONG?__________

HAVE YOU EVER HAD AN ENDOSCOPY? YES______ NO _______ IF YES, DATE OF PROCEDURE__________

HAVE YOU EVER HAD A COLONOSCOPY? YES______NO_______IF YES, DATE OF PROCEDURE__________

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DO YOU EVER HAVE ANY TYPE OF PAIN IN THE ABDOMEN? YES______ NO______ IF YES, FOR HOW

LONG? _________________ Type of pain: _________________

WHEN DOES THE PAIN BEGIN? (BEFORE, DURING OR AFTER EATING) ________________________________

HOW LONG DOES IT LAST?____

WHAT HELPS RELIEVE THE PAIN?____

ANY CHANGES IN BOWEL MOVEMENTS? YES______ NO______ IF YES, PLEASE DESCRIBE:

____

ANY BLOODY STOOLS? YES______ NO______
|
CHRONIC DIARRHEA? YES______ NO______

CHRONIC CONSTIPATION? YES______ NO______

BREATHING PROBLEMS

HAVE YOU BEEN EVALUATED BY A PULMONOLOGIST? YES______ NO______ IF YES, COMPLETE THE FOLLOWING:

NAME OF PHYSICIAN: ____

ADDRESS: ____

PHONE NUMBER: ____

DO YOU EXPERIENCE SHORTNESS OF BREATH WITH PHYSICAL ACTIVITY? YES______ NO______

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HOW LONG HAVE YOU BEEN AWARE OF THIS (BE SPECIFIC)?
____

WHEN WALKING UP STAIRS, HOW MANY STEPS OR FLIGHTS CAN YOU CLIMB BEFORE NOTICING

SHORTNESS OF BREATH? ____________________ STEPS/FLIGHTS (PLEASE CIRCLE ONE)

DO YOU SNORE? YES______ NO______

HAVE YOU BEEN DIAGNOSED WITH SLEEP APNEA? YES______ NO______

DO YOU USE A C-PAP OR BI-PAP MACHINE? YES______ NO______

DO YOU EVER STOP BREATHING WHILE ASLEEP? YES______ NO______

DO YOU HAVE OR HAVE YOU HAD ASTHMA? YES______ NO______

DO YOU SUFFER WITH CHRONIC BRONCHITIS? YES______ NO______

BONE OR JOINT PROBLEMS

DO YOU HAVE ANY OF THE FOLLOWING? PLEASE INDICATE:

LOCATION	SWELLING	PAIN	STIFFNESS	POPPING/CRACKLING
ANKLES				
KNEES				
HIPS				
BACK				
OTHER				

HAVE YOU EVER BEEN TOLD YOU HAVE DEGENERATIVE CHANGES OR EARLY ARTHRITIC CHANGES IN YOUR JOINTS? YES______ NO______ *IF YES, PLEASE EXPLAIN:

____

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HAVE YOU EVER BEEN TREATED FOR BONE OR JOINT PROBLEMS? YES______ NO______ IF YES, PLEASE INDICATE (INCLUDE PHYSICAL THERAPY AND CHIROPRACTIC) ________________________________

REVIEW OF SYMPTOMS

	NO	YES	DETAILS/COMMENTS
HIGH BLOOD PRESSURE READINGS			
ELEVATED BLOOD SUGAR READINGS			
FREQUENT OR SEVERE FATIGUE			
FREQUENT OR SEVERE WEAKNESS			
FEVER, CHILLS, OR NIGHT SWEATS			
FREQUENT OR SEVERE HEADACHES			
ANY HISTORY OF HEAD INJUURY WITH LOSS OF CONSCIOUSNESS			
EYEGLASSES OR CONTACT LENSES			
VISUAL PROLEMS THAT AREN'T CORRECTABLE			
HEARING PROBLEMS			
EAR PAIN			
CHRONIC SINUS CONGESTION			
FREQUENT BLOODY NOSE			
DENTAL PROBLEMS			
DENTURES			
WHEEZING			
COUGHING			
BREAST LUMPS, PAIN OR DISCHARGE			
HEART MURMUR			
CHEST PAIN WITH EXERCISE OR ACTIVITY			

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HISTORY OF HIV INFECTION			
HISTORY OF LIVER PROBLEMS			
HISTORY OF HEPATITIS (STATE TYPE)			
USE OF BIRTH CONTROL			
INFERTILITY			
ANEMIA			
ANY HISTORY OF BLOOD TRANSFUSION			
BLEEDING TENDENCY			
CONVULSION SEIZURES			
PARALYSIS			

REVIEW OF SYMPTONS CONTINUED

	NO	YES	DETAILS/COMMENTS
NUMBNESS OR TINGLING			
DEPRESSION			
ANXIETY			
DRUG OR ALCOHOL ABUSE			
CHRONIC SKIN RASH OR HIVES			
CHRONIC SKIN INFECTIONS OF LOWER LEGS			
CHRONIC SKIN INFECTIONS UNDER BREASTS			
CHRONIC SKIN INFECTIONS UNDER ABDOMINAL SKIN CREASE			
VARICOSE VEINS OF LEGS			
MIGRAINES			
FIBROMYALGIA			
LUPUS			

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RHEUMATOID ARTHRITIS			
GOUT			

PLEASE LIST ANY OTHER MEDICAL CONDITIONS NOT LISTED CURRENTLY ON THE QUESTIONNAIRE. PLEASE BE SPECIFIC:

____

COMPREHENSIVE DIETARY HISTORY

NAME: _________________________ HEIGHT: ____________________ CURRENT WEIGHT: _____________

PLEASE COMPLETE THIS INFORMATION AND BE AS SPECIFIC AS POSSIBLE. THIS WILL BE SENT TO YOUR INSURANCE COMPANY AS PART OF THE DETERMINATION PROCESS.

DIET PROGRAMS MEDICALLY SUPERVISED

PROGRAM	**SUPERVISED BY**	**WHEN AND FOR HOW LONG**	**WEIGHT LOSS AND WEIGHT REGAINED**
❑ DIETICIAN			
❑ MEDI-FAST			
❑ OPTI-FAST			
SHOTS ❑ B-12			

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❑ B-6 ❑ OTHER			
DIET PILLS ❑ FEN-PHEN ❑ REDUX ❑ AMPHETAMINES ❑ OTHER ___________________ __ _____________________			

SURGICAL WEIGHT LOSS

HAVE YOU EVER HAD ANY TYPE OF WEIGHT LOSS SURGERY IN THE PAST?
YES_______ NO_______

IF YES, COMPLETE THE FOLLOWING:

SURGEONS NAME: _________________________________ ADDRESS:
____

PHONE NUMBER: __________________________ DATE OF SURGERY:
____

TYPE OF SURGERY:
____

NON MEDICALLY SUPERVISED DIETS

PROGRAM	**WHEN AND HOW LONG**	**WEIGHT LOSS**	**WEIGHT REGAINED**
WEIGHT WATCHERS			

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WEIGHT LOSS FOREVER			
ATKINS			
NUTRA SYSTEM			
JENNY CRAIG			
DIET CENTER			
OVEREATERS ANONYMOUS			
SLIMFAST			
METABOLIFE			
SWEET SUCCESS			
LIQUID PROTEIN			
LOW CALORIE			
METRACAL			
LOW FAT			
HIGH PROTEIN			
SELF IMPOSED FAST			
RICHARD SIMMONS			
SUSAN POWTER			
HERBAL LIFE			
SUGAR BUSTER			
ZONE DIET			
OVER THE COUNTER DIET PILLS_____________ _________________________			
OTHER_________________ _________________________ _________________________			

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COMPREHENSIVE DIETARY HISTORY CONTINUED

WHAT AGE DID YOU FIRST DIET?____

WHAT WAS YOUR GREATEST SINGLE WEIGHT LOSS AND HOW LONG DID YOU SUSTAIN THE WEIGHT?

____
____

HOW DID YOU LOSE THIS WEIGHT?____

HOW MANY TIMES HAVE YOU LOST OVER 25 POUNDS?____

HOW LONG HAVE YOU BEEN OVERWEIGHT?____

HOW LONG HAVE YOU BEEN AT YOUR CURRENT WEIGHT?____

ARE YOU CURRENTLY UNDER A PHYSICIANS CARE FOR WEIGHT LOSS?
YES______ NO_______

IF YES, PLEASE GIVE THE PHYSICIANS NAME, ADDRESS, PHONE NUMBER AND HOW LONG YOU HAVE BEEN UNDER HIS/HER CARE:

____

____

PLEASE LIST ANY OTHER DIET INFORMATION THAT IS NOT LISTED ON THIS QUESTIONNAIRE:

____
____

EXERCISE

DO YOU EXERCISE? YES______ NO______ IF YES, PLEASE COMPLETE THE FOLLOWING:

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HOW OFTEN DO YOU EXERCISE?____

WHAT TYPE OF EXERCISE PROGRAM ARE YOU CURRENTLY ON?_________________________________

- ❑ HEALTH CLUB
- ❑ VCR TAPES
- ❑ WALKING
- ❑ OTHER____
  ____

WHAT PHYSICAL ACTIVITIES DO YOU FIND ENJOYABLE?____

WHAT TYPE OF EXERCISE PROGRAM ARE YOU PLANNING FOR AFTER SURGERY?____
____

____
____

WOULD YOU BE INTERESTED IN GROUP EXERCISE PROGRAMS? _________YES _________NO

WOULD YOU BE INTERESTED IN EXERCISE COUNSELING? __________YES ___________NO

DATE: ___________________________ SIGNATURE OF Patient