Phone 1-855-991-5300
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www.golightbariatrics.com
info@golightbariatrics.com

Toll Free 855-991-5300 • Outside US 619-456-0052 • Fax 855-457-1400

Go Light Bariatrics

Patient Name: D.O.B.: Age:

Address:

Occupation: Work:

Phone #: Email:

Emergency Contact

First Name: Last Name:

Relationship to you: Phone ( ) -

Who referred you to us?

Family History

Heart disease	Yes	No
Pulmonary edema	Yes	No
Diabetes Mellitus	Yes	No
High blood pressure	Yes	No
Alcoholism	Yes	No
Liver problems	Yes	No
Lung problems	Yes	No
Bleeding disorder	Yes	No
Gallstones	Yes	No
Mental Illness	Yes	No
Malignant hyperthermia	Yes	No
Cancer	Yes	No

Type

☐ Breast ☐ Uterine ☐ Ovarian ☐ Prostate ☐ Colon

Other

Weight Related Data

Weight: Height: BMI:

Previous Weight Reduction Data

Have you ever had weight loss surgery? Yes No

Have you ever been consulted about weight loss surgery? Yes No

If yes, please list surgeon's name, type of weight loss surgery done, and date the surgery was done.

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Surgeon's Name	Type of Surgery/Consultation	Date of Surgery/Consultation

Past Medical History

List all medical conditions and hospitalizations. Please list names, addresses, and phone numbers of all your doctors (including your primary care physician, heart doctor, psychiatrist, therapist, or any other physician(s) you see on a regular basis).

Physician/Medical Condition	Address	Phone Number

Check those which apply:

- ☐ Reflux Disease
- ☐ High Blood Pressure
- ☐ Degenerative Joint Disease
- ☐ Urinary Stress Incontinence
- ☐ High Cholesterol
- ☐ Venous Stasis (Leg Swelling)
- ☐ Irregular Menstrual Period
- ☐ Diabetes. Do you use insulin? ○ Yes ○ No
- ☐ Sleep Apnea. Do you C-pap? ○ Yes ○ No

Comments:

Bi-pap? ○ Yes ○ No

Review of Systems

Cardiovascular

Heart attack	○ Yes	○ No
Angina (chest pain with activity)	○ Yes	○ No
Rhythm Disturbance/Palpitations	○ Yes	○ No
Congestive Heart Failure	○ Yes	○ No
High Blood Pressure	○ Yes	○ No
Ankle Swelling	○ Yes	○ No
Varicose Veins	○ Yes	○ No
Hemorrhoids	○ Yes	○ No
Phlebitis	○ Yes	○ No
Ankle/Leg Ulcers	○ Yes	○ No
Heart Bypass/Valve Replacement	○ Yes	○ No
Pacemaker	○ Yes	○ No
Clogged Heart Arteries	○ Yes	○ No
Rheumatic Fever/Valve Damage	○ Yes	○ No
Heart Murmur	○ Yes	○ No
Irregular Heart Beat	○ Yes	○ No
Cramping in legs when walking	○ Yes	○ No
Other symptoms	○ Yes	○ No

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Respiratory

Asthma	Yes	No
Emphysema	Yes	No
Bronchitis	Yes	No
Pneumonia	Yes	No
Chronic Cough	Yes	No
Short of Breath	Yes	No
Use of CPAP or oxygen supplement	Yes	No
Tuberculosis	Yes	No
Pulmonary Embolism	Yes	No
Hypoventilation Syndrome	Yes	No
Cough up Blood	Yes	No
Snoring	Yes	No
Sleep Apnea	Yes	No
Lung Surgery	Yes	No
Lung Cancer	Yes	No

Endocrine

Hypothyroid (low)	Yes	No
Hyperthyroid (high/overactive)	Yes	No
Goiter	Yes	No
Parathyroid	Yes	No
Elevated Cholesterol	Yes	No
Elevated Triglycerides	Yes	No
Low Blood Sugar	Yes	No
Diabetes (managed by diet or pills)	Yes	No
Diabetes (needing insulin shots)	Yes	No
“Prediabetes” with elevated blood sugar	Yes	No
Gout	Yes	No
Endocrine Gland Tumor	Yes	No
Cancer of Endocrine Gland	Yes	No
High Calcium Level	Yes	No
Abnormal Facial Hair Growth	Yes	No

Gastrointestinal

Heartburn	Yes	No
Hiatal Hernia	Yes	No
Ulcers	Yes	No
Diarrhea	Yes	No
Blood in Stool	Yes	No
Change in Bowel Habit	Yes	No
Constipation	Yes	No
Irritable Bowel	Yes	No
Colitis	Yes	No
Crohns	Yes	No
Hemorrhoids	Yes	No
Fissure	Yes	No
Rectal Bleeding	Yes	No
Black, Tarry Stools	Yes	No
Polyps	Yes	No
Abdominal Pain	Yes	No
Enlarged Liver	Yes	No
Cirrhosis/Hepatitis	Yes	No
Gallbladder Problems	Yes	No
Jaundice	Yes	No
Pancreatic Disease	Yes	No
Unusual Vomiting	Yes	No
Surgery	Yes	No
Cancer	Yes	No

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Gynecologic (for women only)

Problems Conceiving (Infertility)	Yes	No
Are You Pregnant?	Yes	No
Uterine/Ovarian Cancer	Yes	No
Surgery	Yes	No
Menstrual Irregularity	Yes	No
Menstrual Pain	Yes	No
Excessively Heavy Periods	Yes	No
Do you plan to have more children?	Yes	No
Are you post menopausal?	Yes	No

Date of menopausal onset:	/	/	
Date of last pap smear:	/	/	
Date of last menstrual period:	/	/	
Age started menses:			
How many pregnancies have you had?			
How many children have you had?			
How many miscarriages or abortions have you had?			

Musculoskeletal

Arthritis	Yes	No
Neck Pain	Yes	No
Shoulder Pain	Yes	No
Wrist Pain	Yes	No
Back Pain	Yes	No
Hip Pain	Yes	No
Knee Pain	Yes	No
Ankle Pain	Yes	No
Foot Pain	Yes	No
Cancer	Yes	No
Heel Pain	Yes	No
Ball of Foot/Toe Pain	Yes	No
Plantar Fasciitis	Yes	No
Carpal Tunnel Syndrome	Yes	No
Lupus	Yes	No
Scleroderma	Yes	No
Sciatica	Yes	No
Autoimmune Disease	Yes	No
Muscle Pain Spasm	Yes	No
Fibromyalgia	Yes	No
Broken Bones	Yes	No
Joint Replacement	Yes	No
Nerve Injury	Yes	No
Muscular Dystrophy	Yes	No
Surgery	Yes	No

Head and Neck

Wear Contacts/Glasses	Yes	No
Vision Problems	Yes	No
Hearing Problems	Yes	No
Sinus Drainage	Yes	No
Neck Lumps	Yes	No
Swallowing Difficulty	Yes	No
Dentures/Partial	Yes	No
Oral Sores	Yes	No
Hoarseness	Yes	No
Head/Neck Surgery	Yes	No
Cancer	Yes	No

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Neurologic

Migraine Headaches	Yes	No
Balance Disturbance	Yes	No
Seizure or Convulsions	Yes	No
Weakness	Yes	No
Stroke	Yes	No
Alzheimer's	Yes	No
Pseudo Tumor Cerebral	Yes	No
(loss of vision from high pressure In the brain)	Yes	No
Multiple Sclerosis	Yes	No
Frequency Severe Headaches	Yes	No
Knocked Unconscious	Yes	No
Surgery	Yes	No
Cancer	Yes	No

Breast (for women only)

Lumps	Yes	No
Pain	Yes	No
Fibrocystic Disease	Yes	No
Nipple Discharge	Yes	No
Surgery	Yes	No
Cancer	Yes	No

Skin

Rashes under Skin Folds	Yes	No
Keloids (excessively raised scars)	Yes	No
Poor Wound Healing	Yes	No
Frequent Skin Infections	Yes	No
Surgery	Yes	No
Cancer	Yes	No

Blood

Anemia (Iron Deficient)	Yes	No
Anemia (Vitamin B12 Deficient)	Yes	No
HIV	Yes	No
Low Platelets (Thrombocytopenia)	Yes	No
Lymphoma	Yes	No
Swollen Lymph Nodes	Yes	No
Superficial Blood Clot in Leg	Yes	No
Deep Blood Clot in Leg	Yes	No
Blood Clot in Lungs (Pulmonary Embolism)	Yes	No
Bleeding Disorder	Yes	No
Blood Transfusion	Yes	No
Blood and Thinning Medicine Use	Yes	No

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Psychiatric

Anxiety	Yes	No
Depression	Yes	No
Anorexia (starvation to control weight)	Yes	No
Bulimia (excessive vomiting to control weight)	Yes	No
Bipolar Disorder ("manic-depression")	Yes	No
Alcoholism	Yes	No
Drug Dependency	Yes	No
Schizophrenia	Yes	No
Other Psychiatric Problems	Yes	No
Hospitalization for Psychiatric Problems	Yes	No
Have you ever been in a psychiatric hospital?	Yes	No
Have you ever attempted suicide?	Yes	No
Have you ever been physically abused?	Yes	No
Have you ever been sexually abused?	Yes	No
Have you ever seen a psychiatrist or counselor?	Yes	No
Have you ever taken medications for psychiatric problems or for depression?	Yes	No
Have you ever been in a chemical dependency program?	Yes	No

Constitutional

Fevers	Yes	No
Night Sweats	Yes	No
Anemia	Yes	No
Weight Loss	Yes	No
Chronic Fatigue	Yes	No
Hair Loss	Yes	No

Social History

Tobacco Use:

Do you smoke now?	Yes	No
If yes, how many cigarettes and/or packs per day?		
Do you use snuff or chew?	Yes	No
If yes, how frequently do you use snuff/chew?		
For how many years have/did you use tobacco?		
If you have quit, how long ago?		

Alcohol Use:

Do you consume alcohol now?	Yes	No
If yes, how many times a week?		
If yes, how many drinks each time?		
For how many years do/did you drink alcohol?		
If you have quit, how long ago?		
Is anyone concerned about the amount you drink?	Yes	No

Drug Use:

Do you use street drugs now?	Yes	No
If yes, which drugs?		
If yes, how frequently do you use these drugs?		
If you have quit, how long ago?		

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Caffeine Use:

Do you drink coffee or other caffeine-containing beverages? ○ Yes ○ No
If yes, how many cups per day? _____ cups. Other _____
Do you drink carbonated beverages? ○ Yes ○ No
If yes, how many? _____ cans per day. Other _____

Past Surgical History

List all surgeries you have had, including place and date of surgery, and surgeon.

Type of Surgery	Surgeon	Hospital	Date

Medications

List all prescription and over-the-counter medications you currently take.

Medications	Dose	How Often Medication Is Taken	Reason for Taking Medication

Allergies

List any allergy/reaction to medication, food, and latex products.

Medication/Food/Latex	Type Of Reaction

Occupation: _____ Employer _____

Education:

☐ Less than high school ☐ High School ☐ Votech/Technical ☐ College ☐ Post Graduate

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Diet Program	When and How Long?	Total Weight Loss	Pounds Regained
Overeaters Anonymous			
Fasting			
Weight Loss Forever			
Nutra System			
Jenny Craig			
Herbal Life			
Metabolife			
Weight Watchers			
American Weight Loss			
Optifast			
Atkins			
Slimfast			
Hypnosis			
Xenical			
LA Weight Loss Center			

Please complete the following food diary as honestly as possible. Include one weekday and one weekend day, food, amount consumed, and how the food was prepared. Include snacks and beverages (with amounts consumed):

Day 1 (Weekday)	Day 2 (Week-end day)

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Psychological General Well-Being Index (PGWBI)

1. Have you been bothered by nervousness or your "nerves"? (during the past month)

0. ☐ Extremely so – to the point where I could not work or take care of things
1. ☐ Very much so
2. ☐ Quite a bit
3. ☐ Some – enough to bother me
4. ☐ A little
5. ☐ Not at all

2. How much energy, pop, or vitality did you have or feel? (during the past month)

5. ☐ Very full of energy – lots of pep
4. ☐ Fairly energetic most of the time
3. ☐ My energy level varied quite a bit
2. ☐ Generally low in energy or pep
1. ☐ Very low in energy or pep most of the time
0. ☐ No energy or pep at all – I felt drained, sapped

3. I felt downhearted and blue DURING THE PAST MONTH

5. ☐ None of the time
4. ☐ A little of the time
3. ☐ Some of the time
2. ☐ A good bit of the time
1. ☐ Most of the time
0. ☐ All of the time

4. Were you generally tense – or did you feel any tension? (during the past month)

0. ☐ Yes – extremely tense, most or all of the time
1. ☐ Yes – very tense most of the time
2. ☐ Not generally tense, but did feel fairly tense several times
3. ☐ I felt a little tense a few times
4. ☐ My general tension level was quite low
5. ☐ I never felt tense or any tension at all

5. How happy, satisfied, or pleased have you been with your personal life? (during the past month)

5. ☐ Extremely happy – could not have been more satisfied or pleased
4. ☐ Very happy most of the time
3. ☐ Generally satisfied – pleased
2. ☐ Sometimes fairly happy – sometimes fairly unhappy
1. ☐ Generally dissatisfied, unhappy
0. ☐ Very dissatisfied or unhappy most or all the time

6. Did you feel healthy enough to carry out the things you like to do or had to do? (during the past month)

5. ☐ Yes – definitely so
4. ☐ For the most part
3. ☐ Health problems limited me in some important ways
2. ☐ I was only healthy enough to take care of myself
1. ☐ I needed some help in taking care of myself
0. ☐ I needed someone to help me with most or all of the things I had to do

7. Have you felt so sad, discouraged, hopeless, or had so many problems that you wondered if anything was worthwhile? (during the past month)

0. ☐ Extremely so – to the point that I have just about given up
1. ☐ Very much so
2. ☐ Quite a bit
3. ☐ Some – enough to bother me
4. ☐ A little bit
5. ☐ Not at all

8. I woke up feeling fresh and rested DURING THE PAST MONTH?

0. ☐ None of the time
1. ☐ A little of the time
2. ☐ Some of the time
3. ☐ A good bit of the time
4. ☐ Most of the time
5. ☐ All of the time

9. Have you been concerned, worried, or had any fears about your health? (during the past month)

0. ☐ Extremely so
1. ☐ Very much so
2. ☐ Quite a bit
3. ☐ Some, but not a lot
4. ☐ Practically never
5. ☐ Not at all

10. Have you had any reason to wonder if you were losing your mind, or losing control over the way you act, talk, think, feel or of your memory? (during the past month)

5. ☐ Not at all
4. ☐ Only a little
3. ☐ Some – but not enough to be concerned or worried about
2. ☐ Some and I have been a little concerned
1. ☐ Some and I am quite concerned
0. ☐ Yes, very much so and I am very concerned

11. My daily life was full of things that were interesting to me DURING THE PAST MONTH?

0. ☐ None of the time
1. ☐ A little of the time
2. ☐ Some of the time
3. ☐ A good bit of the time
4. ☐ Most of the time
5. ☐ All of the time

12. Did you feel active, vigorous, or dull, sluggish? (during the past month)

5. ☐ Very active, vigorous every day
4. ☐ Mostly active, vigorous – never really dull, sluggish
3. ☐ Fairly active, vigorous – seldom dull, sluggish
2. ☐ Fairly active, vigorous – seldom dull, sluggish
1. ☐ Mostly dull, sluggish – never really active, vigorous
0. ☐ Very dull, sluggish every day

13. Have you been anxious, worried, or upset? (during the past month)

0. ☐ Extremely so – to the point of being sick or almost sick
1. ☐ Extremely so – to the point of being sick or almost sick
2. ☐ Quite a bit
3. ☐ Some – enough to bother me
4. ☐ A little bit
5. ☐ Not at all

14. I was emotionally stable and sure of myself DURING THE PAST MONTH?

0. ☐ I was emotionally stable and sure of myself DURING THE PAST MONTH?
1. ☐ A little of the time
2. ☐ Some of the time
3. ☐ A good bit of the time
4. ☐ A good bit of the time
5. ☐ All of the time

15. Did you feel relaxed, at ease, or high strung, tight, or keyed-up? (during the past month)

5. ☐ Felt relaxed and at ease the whole month
4. ☐ Felt relaxed and at ease most of the time
3. ☐ Generally felt relaxed but at times felt fairly high strung
2. ☐ Generally felt high strung but at times felt fairly relaxed
1. ☐ Felt high strung, tight, or keyed-up most of the time
0. ☐ Felt high strung, tight, or keyed-up the whole month

16. I felt cheerful, lighthearted DURING THE PAST MONTH?

0. ☐ None of the time
1. ☐ A little of the time
2. ☐ Some of the time
3. ☐ A good bit of the time
4. ☐ Most of the time
5. ☐ All of the time

17. I felt tired, worn out, used up or exhausted DURING THE PAST MONTH?

5. ☐ None of the time
4. ☐ A little of the time
3. ☐ Some of the time
2. ☐ A good bit of the time
1. ☐ Most of the time
0. ☐ All of the time

18. Have you been under or felt you were under any strain, stress, or pressure? (during the past month)

0. ☐ Yes, almost more than I could bear or stand
1. ☐ Yes, quite a bit of pressure
2. ☐ Yes, some – more than usual
3. ☐ Yes, some – but about usual
4. ☐ Yes, a little
5. ☐ Not at all

Now that you have completed our Health History form please take a moment to look it over one last time to make sure that all questions have been answered completely. It is very important that we have a complete understanding of your health status as we help you to prepare for surgery.

If while filling out this information you have any questions please feel free to contact our coordinators so that we can assist you.

Once you are sure that all questions are answered, please check the box below and submit the form.

☐ I verify that all the information I have provided is accurate to the best of my knowledge.

Date: