KC BARIATRIC, LLC

Stanley Hoehn, MD | G Brice Hamilton, MD | Robert Aragon, MD | Robert Cunningham, MD
23401 Prairie Star Parkway Suite B 300 Lenexa, KS 66227
Phone: 913. 677. 6319 Fax: 913. 677. 1540
www.kcbariatric.com

Patient Medical Assessment Form

Patient Name: _____ **Date of Birth:** _____

Email address: _____

Primary Care Physician & Preferred Pharmacy

PCP Name: _____ **Phone:** _____ **Fax:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Years of Care: _____

Pharmacy Name: _____ **Pharmacy Phone:** _____ **Location:** _____

Patient Medications & Supplements

Be sure to include all prescription medications, over-the-counter, diabetic, and vitamins.

Medication Name	Dosage Amount	# Taken Daily

Any Drug/Medication Allergies?

□ No

□ Yes, I am allergic to
_____ □ Unknown

Any Food Allergies?

□ No
□ Yes, I am allergic to
_____ □ Unknown

Do you have a Latex Allergy?

□ No □ Yes □ Unknown □ Other allergies _____

Weight History

Please provide your highest weight (pounds) in the last 5 years

Current Year _____ Year 1 Prior _____ Year 2 Prior_____ Year 3 Prior _____
Year 4 Prior _____

How many years have you been overweight? _____ How many years have you been trying to lose weight? _____

How long have you been researching or thinking about weight loss surgery? _____

Bariatric Surgery History

Have you had a previous bariatric surgery? □ No □ Yes □ Lap-band □ Sleeve □ Bypass

Past Medical History

Please mark all conditions current and/or past that applies

CARDIOVASCULAR

□ High Blood Pressure □ Congestive Heart Failure □ Ischemic Heart Disease □ Heart stress test

□ Heart attack □ Stents placed in Heart □ Heart catheterization □ Angina chest pain

□ Vascular Disease □ Stroke □ Lower Leg Edema / Swelling □ Blood clot in leg or lung □ Vena Cava heart filter

METABOLIC

□ Diabetes Mellitus, Type 1 □ Diabetes Mellitus, Type 2 □ Fasting Glucose > 99 mg/dL □ Oral medication for Diabetes

□ Insulin use □ Eye / Kidney problems □ High Cholesterol or Lipids □ Gout / High Uric Acid levels □ Thyroi

PULMONARY

□ Oxygen use at home □ Pulmonary Hypertension □ Asthma □ Inhaler use due to Asthma

GASTROINTESTINAL

□ Heartburn / Reflux / GERD □ Heartburn medication use □ Past anti-reflux surgery □ Barrett's Esophagus
□ Crohn's Disease or Colitis □ Gallstones □ Gallbladder removal □ Abnormal liver tests

MUSCULOSKELETAL

□ Back Pain □ Back Pain requiring medication □ Hip / Knee / Ankle pain □ Joint pain requiring medication
□ Fibromyalgia □ Joint replacement □ Back surgery

REPRODUCTIVE (female)

□ Polycystic Ovarian Syndrome □ Infertility □ Menstrual irregularities □ Hysterectomy

GENERAL

□ Stress urinary incontinence □ Sanitary pad use for leakage □ Pseudo tumor Cerebral □ Abdominal hernia

□ Hernia repair □ Cane / Walker use surgery □ Sores / rash in skin folds □ Previous weight loss
□ MRSA □ VRE □ Lupus / Autoimmune disease

PSYCHOLOGICAL

□ Anxiety □ Depression □ Bipolar disease □ Thoughts of suicide □ Suicide attempts

□ Psychiatric treatment □ Psychological counseling □ Hospitalized for psychological issue(s)

Past Surgical History

Please list any operations and dates of each.

SURGERY	**METHOD**-done laparoscopically?	**DATE**	**PHYSICIAN / LOCATION**

Family Medical History Assessment

Please mark any condition(s) that have been diagnosed in biological relation(s) such as parents, grandparents, siblings. Please check all that apply:

□ High Blood Pressure □ Stroke □ Heart Disease / Heart Attack □ Obesity

□ Bleeding Disorder □ Cancer □ Clotting Disorder □ Diabetes

Sleep Testing Assessment

Testing for Sleep Apnea may be required to obtain clearance for bariatric surgery. Please be sure to **FULLY COMPLETE** each question in this section. Answers should be **accurate**, as inaccurate or incomplete answers may delay our ability to process &/or obtain insurance authorization.

*Have you had a previous sleep study? □ Yes □ No

If yes, approximately when & where:

_____

*Have you had a prior diagnosis of Sleep Apnea? □ Yes □ No

*Do you currently use PAP therapy? □ Yes □ No

If yes: □ CPAP □ BiPAP □ AutoPAP □ Other: Pressure: __ cm H2O

*Who is your current Sleep Medicine Physician? _____

*Who provider your PAP therapy and supplies?

_____

Physical Exercise Assessment

Do you have any physical limitation(s) that make physical exercise difficult or impossible? □ Yes □ No □ Sometimes

If yes, please explain:

_____

Do you have difficulty with basic mobility or self-care? □ Yes □ No

Do you use assistive devices to transport? □ Yes □ No

Devices currently used (check all that apply)**:** □ Cane / Walker □ Wheelchair / Scooter □ Crutches / Brace □ Prosthetic Device □ Oxygen

History of falls within last 12 months: □ Yes □ No How did it happen?

_____

Social Assessment

Do you use tobacco products / nicotine?

□ No, never smoked □ No, I quit. Quit date: _____

□ Yes

If Yes, type: □ Cigarettes / _____ packs per day □ Chewing tobacco □ Smokeless such as vaping

Frequency: □ Rare, 1-2 times / month □ Occasionally, 3 or less / week □ Frequently, 4+ / week or daily

Do you drink alcohol? □ No □ Yes

If yes, type_____

Frequency: □ Rare, 1-2 times / month □ Occasionally, 3 or less / week □ Frequently, 4+ / week or daily

Do you use recreational drugs/medications/other substances?

□ No, never used

□ No, I quit. Quit date: _____ Type: _____

□ Yes

Type: _____

Frequency: □ Rare, 1-2 times / month □ Occasionally, 3 or less / week □ Frequently, 4+ / week or daily

Diet History

Please include all weight loss efforts attempted, including but not limited to the following: Doctor Supervised, commercial programs, prescription diet pills, behavior modification, unsupervised diets and over-the-counter diet aids.

DIET	MONTH/YEAR	DURATION	TOTAL WEIGHT LOSS