UnityPoint Health
Des Moines

UnityPoint Health - Des Moines
6600 Westown Parkway, Suite 220
West Des Moines, Iowa 50266
phone (515) 241-2250
fax (515) 241-2265

PLEASE PRINT CLEARLY

Patient name: First_____ Middle Initial_____ Last_____

List previous name(s):_____

Address_____

City_____ State_____ Zip Code_____

Phone numbers: Home_____ May we leave a message? YES / NO

Cell _____ May we leave a message? YES / NO

Social Security#_____ Age Race_____

Date of birth_____ Male or Female Marital status: M S D W

Employer_____

Occupation_____

Work Phone#_____ May we leave a message? YES / NO

Employment Status: Full-Time Part-Time Student Disabled

If disabled, please state reason_____

Name of Spouse/Partner _____

Spouse/Partner Employer_____ Phone#_____

Emergency Contact (not living at same address) Name:_____

Emergency Phone Number_____ Relationship to patient_____

Referring Physician or Primary Care Physician: ————————————————————

Physician 's Address_____

Physician's Phone# _____ Fax#_____

Insurance Information

Primary:_____ Secondary:_____

Billing Information

Responsible Party (If same as patient skip to bottom of page)_____

Relationship to patient_____ Social Security#_____

Date of birth_____ Phone#_____

Signature_____ Date:_____

Please indicate which number you would like us to call first.
Thank you,

Bariatric Questionnaire

Patient name_____

Pharmacy name_____

Pharmacy Address_____

Pharmacy Fax# _____ Phone # _____

How did you hear about us? (Internet, Primary Care Physician, Friend/Family, TV commercial, etc.)

_____

Did your medical provider, friend, family member, etc. recommend a surgeon? If yes, Dr. LaMasters or Dr. Cahalan? (circle one)

Considering Weight Loss Surgery

How long have you been considering weight loss surgery?

What have been your main sources of information about weight loss surgery?

Y / N Do you know other people that have had an operation for obesity?

Y / N Have those operations been successful?

Are your family and friends supportive of your decision to undergo an operation to help you lose weight? _____

_____

_____

What are your main reasons for considering an operation to help you lose weight?

_____

_____

_____

Weight History

Age of onset of obesity_____

Y / N Were you obese before puberty?

What is your lifetime maximum weight?_____When?_____

Allergies

List all medications/ medical products to which you have an **allergic** or bad reaction.

Medication/medical product	Type of reaction

Medications

List all the medications you take. Include those which do not require a prescription. (Also include any breathing device/machine such as CPAP/BiPAP)

Medication	Dosage/amount	Number of times taken Daily

YIN Have you taken steroids such as prednisone or cortisone in the last 6 months?

Medical History

Please place an "X" if you have now or have you ever had any of the following medical problems? Explain in the space next to problem.

___Abnormal bleeding or bruising
___Alcoholism
___Anxiety
___Arthritis or degenerative joint disease (Hips Knees Ankles Feet)
___Asthma
___Bipolar
___Blood clot or embolus
___Blood transfusion
___Cancer
___Crohns
___Congestive heart failure
___Depression treated with medications or counseling
___Diabetes
___Gallstones
___Gastroesphageal reflux disease or frequent heartburn
___Gout
___Heart attack or angina (chest pain, pressure or tightness)
___Hernia (umbilical, groin, incisional)
___High cholesterol
___High triglycerides
___History or physical or sexual abuse
___Hypertension (high blood pressure)
___Irregular heart rhythm or palpitations
___Irritable bowel syndrome
___Kidney or bladder problems
___Liver problems or hepatitis
___Low back pain
___Lupus
___Migraine headache
___Other lung or breathing problems
___Peripheral edema (swelling of the legs, ankles)
___Psychiatric illness
___Rheumatic fever
___Schizophrenia
___Seizure or epilepsy
___Sleep apnea
___Stress incontinence (leak urine with coughing or laughing)
___Stroke
___Substance abuse
___Thyroid problems
___Tuberculosis
___Ulcerative colitis
___Polycystic Ovarian Syndrome or problems with fertility
___Other(specify):_____

For Women:

Y / N Have you had problems with significant anemia?
Y / N Do you have a family history of osteoporosis?
Y / N Do you plan to become pregnant?
Y / N Are you post menopausal?

Surgical History

List any previous operations you have had:

Operation	Date	Problems

List any hospitalizations you have had for an illness or accident **not** requiring surgery:
1._____
2._____
3._____
4._____

Family History

Do any of your blood relatives have the following problems?
Explain which relative and type of problem in the space provided.
___Alcoholism _____
___Cancer _____
___Diabetes _____
___Heart disease _____
___Kidney disease _____
___Liver disease _____
___Lung disease _____
___Other illnesses than run in the family _____
___Rheumatoid arthritis _____
___Serious mental illness _____
___Stroke _____

Y / N Have you or any of your blood relatives had a serious problem with anesthesia?
Specific type: _____

Social History

Do you currently smoke? **Yes / No** History of tobacco use? **Yes / No**
Packs per day:_____# of years_____Quit date: _____

Do you drink alcohol? **Yes/No** #of years_____Drinks per week_____Quit date: _____
Describe your frequency: Occasional-Use / Moderate Consumption / Excessive Consumption

Do you use recreational or illegal drug? **Yes/No** _____
Specify type: _____

With whom do you live? _____
What is your occupation? _____
How many hours a day are you employed outside the home? _____
How many hours a day do you watch TV? _____
If you are disabled, it is because: _____
Could someone help care for you if you were seriously ill? _____
Are there people for whom you are the primary care giver? _____
What hobbies do you have that are important to you? _____

General symptoms

Do you have any of the following symptoms?
___Acid reflux
___Arthritis or severe joint pains
___Back pain
___Black or tarry stools
___Blackouts or periods of dizziness
___Blood in your sputum
___Burning with urination or frequent urination
___Chest pain
___Chronic cough or sputum (phlegm) production
___Diarrhea
___Difficulty swallowing
___Excessive bleeding following minor cuts or dental surgery
___Fever
___Frequent or new constipation
___Nausea
___Palpitations or irregular heart beat
___Pregnancy
___Shortness of breath when walking up one flight of stairs
___Swelling in the ankles
___Temporary weakness or numbness
___Temporary loss or blurring of vision
___Weight gain or loss greater than 10 pounds in the past 3 months

Thank you for completing this questionnaire.
It will help your doctor understand your health more thoroughly

----------FOR OFFICE USE ONLY----------

_____Current weight _____Height _____BMI

_____Blood Pressure Goal weight at BMI of 22.5_____
25_____
27_____
_____EBW 30_____