BAY BARIATRICS

Steven A. Tersigni, MD, FACS
1900 Woodland Drive
Coos Bay, Oregon 97420

Medical Information

Date: _____

Patient Information

First Name	MI	Last	Date of Birth	Gender ☐ Male ☐ Female
Address			Home Phone	Cell Phone
City	State	Zip	Email Address	
Employer	Work Phone		Emergency Contact and Phone	

Spouse Information (or parent if applicable)

First Name	MI	Last	Home Phone (If different)	Cell Phone
Employer	Occupation		Work Phone	Relationship to Patient

Other Contacts

Nearest relative/friend not living with you	Relationship	Phone Number

Referral Information

How did you hear about us? Physician, friend, patient, web, etc.	Primary Care Physician/Provider	Phone Number

Height and Weight

Height Feet: Inches:	Weight Pounds:

Allergy Information

List all medicine allergies	Do you have a Latex allergy or other allergies?

Medications (Please list dosing and frequency information)

1.	Dose	6.	Dose
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Previous Surgeries (List type and date)

1.	Date	6.	Date
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Personal Medical History

Have you ever had: (please check all that apply) or ☐ ALL NEGATIVE

☐ High blood pressure ☐ Lung disease ☐ Asthma ☐ Heart attack ☐ Stroke ☐ Liver disease ☐ High cholesterol ☐ Kidney disease

☐ Sleep apnea Do you Use C-PAP? ☐ Yes ☐ No ☐ Cancer Type:

☐ Diabetes Do you use Insulin? ☐ Yes ☐ No ☐ Pain Site: ☐ Back ☐ Hips ☐ Knees ☐ Ankles

Family Medical History

Does anyone in your family have: (please check and list who)

☐ High blood pressure ☐ Diabetes ☐ Heart disease ☐ Cancer Type: Who:

Social History (if yes, please check and/or explain)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Do you have children? ☐ Yes ☐ No How many?
Ethnicity: ☐ Caucasian ☐ Hispanic ☐ African American ☐ Asian ☐ Indian ☐ Other ☐ Declined	
Are you currently: ☐ Working ☐ Retired ☐ Disabled ☐ Homemaker	Occupation or Disability?
Do you smoke or use tobacco? ☐ Yes ☐ No Per day?	Have you quit? ☐ Yes ☐ No How long ago?
Alcohol? ☐ Yes ☐ No How frequent?	Drugs? ☐ Yes ☐ No Type: Quit? ☐ Yes ☐ No

General (please check all that apply) or ☐ ALL NEGATIVE

☐ Fever ☐ Chills ☐ Fatigue ☐ Weakness ☐ Appetite changes ☐ Weight loss ☐ Night sweats

Ears/Nose/Throat (please check all that apply) or ☐ ALL NEGATIVE

☐ Hearing loss ☐ Nasal congestion/discharge ☐ Sore/scratchy throat ☐ Hoarseness ☐ Difficulty swallowing

Cardiovascular System (please check all that apply) or ☐ ALL NEGATIVE

☐ Chest pain ☐ Palpitations ☐ Racing heart ☐ Lightheadedness ☐ Leg/ankle swelling ☐ Murmur ☐ Leg pain

Respiratory System (please check all that apply) or ☐ ALL NEGATIVE

☐ Shortness of breath ☐ Wheezing ☐ Sleeping upright ☐ Cough ☐ Bloody/discolored sputum ☐ Vomiting blood

Gastrointestinal System (please check all that apply) or ☐ ALL NEGATIVE

☐ Abdominal pain ☐ Bloating ☐ Cramps ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Rectal bleeding ☐ Blood in stools ☐ Gas
☐ Indigestion ☐ Heartburn ☐ Gastroesophageal Reflux (GERD)

Urinary System (please check all that apply) or ☐ ALL NEGATIVE

☐ Painful urination ☐ Frequency ☐ Urgency ☐ Blood in urine ☐ Inability to hold urine

Musculoskeletal (please check all that apply) or ☐ ALL NEGATIVE

☐ Joint pain ☐ Muscle aches ☐ Back pain ☐ Joint swelling/stiffness ☐ Back spasms ☐ Pain in other joints

Skin and Breasts (please check all that apply) or ☐ ALL NEGATIVE

☐ Rash ☐ Lesions ☐ Edema ☐ Skin ulcer ☐ Nodule ☐ Breast pain ☐ Breast lump/mass ☐ Breast discharge ☐ Hernia
Site?

Neurological (please check all that apply) or ☐ ALL NEGATIVE

☐ Headache ☐ Confusion ☐ Dizziness ☐ Paralysis ☐ Fainting ☐ Leg numbness ☐ Leg weakness ☐ Tingling ☐ Difficulty walking ☐ Seizures

Psychiatric (please check all that apply) or ☐ ALL NEGATIVE

☐ Insomnia ☐ Irritable ☐ Anxiety ☐ Depression ☐ Suicidal

Hematologic and Lymphatic (please check all that apply) or ☐ ALL NEGATIVE

☐ Swollen glands ☐ Swollen neck glands ☐ Easy bleeding ☐ Easy bruising ☐ Jaundice ☐ Anemia

Quality of Life

Do you have shortness of breath with normal activity?	☐ Yes ☐ No	Are you unable to participate in normal activities?	☐ Yes ☐ No
Are you embarrassed in public due to obesity?	☐ Yes ☐ No	Is your lifestyle inhibited due to obesity?	☐ Yes ☐ No
Do you have trouble bending over to tie your shoes?	☐ Yes ☐ No	Are you unable to participate in recreational activities?	☐ Yes ☐ No
Are you unable to participate in family activities?	☐ Yes ☐ No	Are you unable to exercise?	☐ Yes ☐ No
Do you have difficulty sleeping at night?	☐ Yes ☐ No	Do you ever wake up with snorting or shortness of breath?	☐ Yes ☐ No
Do you have arthritis? If so, which joints?	☐ Yes ☐ No	Do you have trouble climbing stairs?	☐ Yes ☐ No
Do you have trouble performing household duties?	☐ Yes ☐ No	Do you have difficulty cleansing yourself after using the restroom?	☐ Yes ☐ No
Do you have difficulty bathing?	☐ Yes ☐ No	Do you have trouble traveling?	☐ Yes ☐ No
Does your obesity interfere with your sex life?	☐ Yes ☐ No	Are you unable to go shopping?	☐ Yes ☐ No
Do you suffer from depression?	☐ Yes ☐ No	Do you have anxiety disorder?	☐ Yes ☐ No
Do you have a diagnosed mental disorder? If yes, what is the diagnosis?	☐ Yes ☐ No	If yes, are you currently under a physician's care? If yes, who?	☐ Yes ☐ No

Weight History

Height:	Current Weight:	Age you became obese?	
Lowest adult weight:	Year:	Highest adult weight:	Year:
Waist circumference:	Inches:	Hip circumference:	Inches:

Attempted Diets (Please specify amount lost, gained, and year)

Weight Watchers Lost: Gained: Year:	☐ Yes ☐ No	Slim Fast Lost: Gained: Year:	☐ Yes ☐ No
Nutri System Lost: Gained: Year:	☐ Yes ☐ No	Overeaters Anonymous Lost: Gained: Year:	☐ Yes ☐ No
Atkins Diet Lost: Gained: Year:	☐ Yes ☐ No	Cabbage Soup Diet Lost: Gained: Year:	☐ Yes ☐ No
Herbal Life Lost: Gained: Year:	☐ Yes ☐ No	Hollywood Diet Lost: Gained: Year:	☐ Yes ☐ No
TOPS Lost: Gained: Year:	☐ Yes ☐ No	Meridia Lost: Gained: Year:	☐ Yes ☐ No
Phentermine Lost: Gained: Year:	☐ Yes ☐ No	Redux Lost: Gained: Year:	☐ Yes ☐ No
Fen-Phen Lost: Gained: Year:	☐ Yes ☐ No	Pondimin Lost: Gained: Year:	☐ Yes ☐ No
Xenical Lost: Gained: Year:	☐ Yes ☐ No	Diet Workshop Lost: Gained: Year:	☐ Yes ☐ No
Optifast Lost: Gained: Year:	☐ Yes ☐ No	Other: Lost: Gained: Year:	☐ Yes ☐ No
HMR Lost: Gained: Year:	☐ Yes ☐ No	Other: Lost: Gained: Year:	☐ Yes ☐ No
Jenny Craig Lost: Gained: Year:	☐ Yes ☐ No	Other: Lost: Gained: Year:	☐ Yes ☐ No

Physical Activity

How much physical activity do you get per day? (Please check all that apply below)		How many days per week do you exercise? (Please check all that apply below)	
☐ Walking ☐ Jogging ☐ Swimming ☐ Bicycling ☐ Other Type:	Minutes:	☐ Gym ☐ Aerobics ☐ Home gym ☐ Videotapes ☐ Other Type:	Days: