Patient Name: _____ Date of Birth:_____

Drop off at our office, mail, Fax, or email to:

Office@bmisurgery.org

BMI Surgery, SC
Dr. Brian Lahmann
1890 Silver Cross Blvd. Pavilion A Suite 260
New Lenox, IL 60451
Ph: 815-717-8744 Fax: 815-717-8339

Please fill out completely and return to our office.

Patient Phone Number: _____

Patient Email: _____

Public Health and Travel:

1.) Have you been to an area known to at an elevated risk for COVID-19? Yes or No

2.) In the 14 days before symptom onset, have you had close contact with a laboratory-confirmed COVID-19 while that case was ill? Yes or No

3.) In the 14 days before symptom onset, have you had close contact with a person who is under investigation for COVID-19 while that person was ill? Yes or No

Substance Use:

4.) Do you or have you ever smoked tobacco?

-Never Smoker	-Smoker: Current Statues Unknown	-Not Indicated
-Former Smoker	-Unknown if ever smoked	
-Current Every day Smoker	-Not tolerated	
-Current Someday Smoker	-Patient Refused	

5.) How many years have you smoked tobacco? _____

6.) At what age did you start smoking tobacco? _____

7.) How much tobacco do you smoke?

-None	-1/4 pack per day	-2 packs per day
-1 pack per week	-1/2 pack per day	-3 or more packs per day
-2 packs per week	-1 pack per day	

Yes No

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8.) Do you or have you ever used any other forms of tobacco or nicotine?

9.) Do you or have you ever used e-cigarettes or vape?

10.) Do you or have you ever used smokeless tobacco?

-Never used electronic cigarettes

-Former user of electronic cigarettes

electronic cigarettes

-Never used smokeless tobacco	-Currently uses moist powdered tobacco
-Current snuff user	-Not tolerated
-Currently chews tobacco	-Not indicated
-Patient Refused	

11.) How much tobacco do you chew?

-None	-2-4/day
-1/ day	-5+/day

12.) What was the date of your most recent tobacco screening? _____ MM-DD-YYYY

13.) Has tobacco cessation counseling been provided?

Yes	No

14.) What is your level of alcohol consumption?

-None	-Moderate
-Occasional	-Heavy

15.) How many years have you consumed alcohol? _____

16.) Do you use any illicit or recreational drugs?

Yes	No

17.) Which illicit or recreational drugs have you used? _____

18.) What is your level of caffeine consumption?

-None	-Moderate
-Occasionally	-Heavy

Education and Occupation:

19.) What is the highest grade or level of school you have completed or the highest degree you have received?

-Never Attended/Kindergarten only	-Associate Degree: Occupational, Technical, or Vocational Program	-Doctoral Degree: (PhD, EdD)
-1st-12th grade, No Diploma	-Associate Degree: Academic Program	-Do not know
-High School Graduate	-Bachelor's degree: (e.g., BA, AB, BS)	-Refused
-GED or Equivalent	-Master's Degree: (e.g., MA, MS, MEng, Med, MSW, MBA)	
-Some College, No Degree	-Professional School Degree: (MD, DDS, DVM, JD)	

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20.) Are you currently employed? | Yes | No |

-Who is your employer? _____

-What is your occupation? _____

Activities of Daily Living:

21.) Are you able to care for yourself? | Yes | No |

22.) Are you blind or do you have difficulty seeing? | Yes | No |

23.) Are you deaf or do you have serious difficulty hearing? | Yes | No |

24.) Do you have difficulty concentrating, remembering, or making decisions? | Yes | No |

25.) Do you have difficulty walking or climbing stairs? | Yes | No |

26.) Do you have difficulty dressing or bathing? | Yes | No |

27.) Do you have difficulty doing errands alone? | Yes | No |

Home and Environment:

28.) What is your home situation?

-Both Parents	-Relatives	-Other
-Mother	-Adoptive Parents	
-Father	-Foster Parents	

29.) Have there been any changes to your family or social situation? | Yes | No |

Diet & Exercise:

30.) What type of diet are you following?

Regular	Vegetarian	Vegan	Gluten Free	Specific	Carbohydrate	Cardiac	Diabetic

31.) What is your exercise level?

None	Occasional	Moderate	Heavy

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32.) How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days?

Marriage and Sexuality:

33.) What is your relationship status?

-Unknown	-Divorced	-Domestic Partner
-Married	-Separated	-Other
-Single	-Widowed	

If married, Spouse's Name & Date of birth:

_____ _____ _____

Patient's Ethnicity:

34.) What is your Ethnicity: _____

Lifestyle:

35.) Do you feel stressed (tense, restless, nervous, or anxious, or unable to sleep at night)?

-Not at all	-Only a little	-To some extent
-Rather much	-Very much	

Advanced Directive:

36.) Do you have an advanced directive?

Yes	No

37.) Is blood transfusion acceptable in an emergency?

Yes	No

Adult:

38.) Name and Location of Primary Care Physician/Referring Physician: _____

Location and/or Phone #: _____

39.) Which surgery are you interested in? Band Gastric Bypass Sleeve Revision Other

41.) How many years have you been overweight? _____

42.) How did you hear about us? _____

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43.) How many years have you been overweight by 100 lbs. or more? _____.

44.) How Much weight have you lost with your most significant weight loss? _____.

45.) What weight loss method did you use for your most significant weight loss? _____.

46.) How many years were you able to sustain your weight loss? _____.

47.) Have you tried medications for weight loss? If so, what? _____.

48.) Do you eat large amounts of foods Yes or No

49.) Do you eat a lot of sweets Yes or No

50.) Do you Binge/Purge Yes or No

51.) Are you an emotional eater Yes or No

52.) Do you snack or graze Yes or No

53.) At what age did you first start to diet: _____.

54.) Have you done Low Carb Diet Yes or No

55.) Have you done South Beach Diet Yes or No

56.) Have you done Slim Fast Yes or No

57.) Have you tried Atkins diet Yes or No

58.) Have you tried Calorie Counting Yes or No

59.) Have you tried High Protein Diet Yes or No

60.) Jenny Craig Yes or No

61.) LA Weight Loss Yes or No

62.) TOPS Yes or No

63.) Nutri-Systems Yes or No

64.) Opti-fast/Medi-fast Yes or No

65.) Overeaters Anonymous Yes or No

66.) Tried fasting Yes or No

67.) Weight Watchers Yes or No

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other diets attempted _____.

68.) What exercises have you tried in the past to lose weight? _____.

69.) Do you have a support person? Yes or No

70.) Can you walk 200 ft with assistance (cane/walker) Yes or No

71.) Can you walk 200ft without assistance Yes or No

72.) CANNOT walk 200 ft with assistance Yes or No

73.) Requires Wheelchair Yes or No

74.) Bedridden Yes or No

75.) Number of Children _____.

76.) Ages of Children _____.

77.) Current Birth Control Method _____.

78.) Are you planning to have more children? Yes or No

79.) Are you currently attending BMI Surgery's monthly support group meetings? Yes or No

80.) Have you ever had a Pneumonia Vaccination? Yes or No

81.) Have you had a Flu shot this year? Yes or No

82.) Are you fully Vaccinated against COVID? Yes or No

If yes: Which vaccine? Pfizer Moderna Johnson & Johnson

83.) Have you had any problems with Anesthesia? Yes or No

If yes, please describe: _____

Medical History:

Please check only the conditions or diseases that apply. If none apply to you Check the No diseases or conditions. if

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- ☐ No diseases or conditions

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Barrett's Esophagus
- ☐ Bipolar Disease
- ☐ Bleeding Disorder
- ☐ Blood Clot in Leg Veins (DVT)
- ☐ COPD
- ☐ Cancer _____
- ☐ Chest Pain
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Diverticulitis
- ☐ Do you have a Heart Pacemaker
- ☐ Do you use Blood Thinners
- ☐ Fibromyalgia
- ☐ GERD/Reflux
- ☐ Gallstones / Gallbladder Disease
- ☐ Gout
- ☐ Have you ever had a Heart Cath
- ☐ Have you ever had a heart stent
- ☐ Heart Attack (MI)
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Infertility
- ☐ Irritable Bowel Disease
- ☐ Joint Pain- Name Site:

_____

- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Lower Back Pain
- ☐ Lower Extremity Edema
- ☐ Menstrual Irregularity
- ☐ Migraine Headaches
- ☐ Osteoporosis
- ☐ Peptic Ulcer Disease
- ☐ Polycystic Ovarian Syndrome
- ☐ Plantar Fasciitis
- ☐ Pulmonary Embolism
- ☐ Fibromyalgia
- ☐ Rheumatoid Arthritis
- ☐ Sleep Apnea
- ☐ Stroke or Stoke Risk
- ☐ Urinary Stress Incontinence
- ☐ Varicose Veins
- ☐ Other: _____

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Family History:

□ No diseases or conditions

□ Cerebrovascular accident

* Relation: _____Onset Age: _____Died of age: _____

□ Complication of anesthesia

* Relation: _____Onset Age: _____Died of age: _____

□ Congestive heart failure

*Relation: _____Onset Age:_____Died of age:_____

□ Coronary arteriosclerosis

*Relation: _____Onset Age:_____Died of age:_____

□ Diabetes Mellitus

*Relation:_____Onset Age: _____Died of age:_____

□ Family history of cancer

* Relation: _____Onset Age: _____Died of age:_____

□ Family history of stroke

* Relation: _____Onset Age:_____Died of age:_____

□ Hypercholesterolemia

*Relation: _____Onset Age:_____Died of age:_____

□ Hypertensive disorder

* Relation: _____Onset Age:_____Died of age:_____

□ Joint finding

* Relation: _____Onset Age:_____Died of age:_____

□ Obesity

* Relation: _____ Onset Age:_____ Died of age:_____

□ Renal failure syndrome

* Relation:_____ Onset Age:_____ Died of age:_____

□ Sleep apnea

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* Relation:_____ Onset Age:_____ Died of age:_____

PLEASE ATTACH A LIST OF YOUR MEDICATIONS *OR* COMPLETE THE FORM ON THE NEXT PAGE

THANK YOU!!

Medications: (Prescriptions, over the counter and supplements)

_____

_____

_____

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Please Note: If we do not have your insurance card(s) and Photo ID, Please attach a copy with this form and or email to office@bmisurgery.org Fax to: 815-717-8339 or upload through the patient portal. Once we have all or your information and have verified insurance we will call you to schedule a consultation. Thank you