Patient Name: ______________________________ Date of Birth:_________________________

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

**Health History Information** **Please fill out completely and return to our office**

## Social History

1. Occupation ________________________________
2. Are you currently employed? Yes No
3. Employer ________________________________
4. Education Level - Select - ________________________________
5. Marital status - Select - Married, Single, Divorced, Separated, Widowed, Partner
6. Name of Primary Care Physician/ Referring Physician: ___________________________
7. What type of bariatric surgery are you interested in? Band, Bypass, Sleeve, revision, other
8. Diet - Select - Regular, Vegan, Vegetarian, Gluten Free, Specific, Carbohydrate, Cardiac
9. Obese Yes No
10. Overweight Yes No
11. How many years have you been overweight
12. How many years have you been overweight by 100 lbs. or more
13. How did you hear about us? ________________________________
14. How Much weight have you lost with your most significant weight loss
15. What weight loss method did you use for your most significant weight loss
16. How many years were you able to sustain your weight loss
17. Have you tried medications for weight loss? If so what?
18. Do you eat large amounts of foods Yes No
19. do you eat a lot of sweets Yes No
20. Do you Binge/Purge Yes No
21. Are you an emotional eater Yes No
22. Do you snack or graze Yes No
23. At what age did you first start to diet
24. Have you done Low Carb Diet Yes No

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25. Have you done South Beach Diet ○ Yes ○ No
26. Have you done Slim Fast ○ Yes ○ No
27. Have you tried Atkins diet ○ Yes ○ No
28. Have you tried Calorie Counting ○ Yes ○ No
29. Have you tried High Protein Diet ○ Yes ○ No
30. Jenny Craig ○ Yes ○ No
31. LA Weight Loss ○ Yes ○ No
32. TOPS ○ Yes ○ No
33. Nutri-Systems ○ Yes ○ No
34. Opti-fast/Medi-fast ○ Yes ○ No
35. Overeaters Anonymous ○ Yes ○ No
36. Tried fasting ○ Yes ○ No
37. Weight Watchers ○ Yes ○ No
38. other diets attempted ________________________________________
39. Exercise level - Select - None, Occasional, Moderate or Heavy
40. What exercises have you tried in the past to lose weight?
41. General stress level - Select - Low, Medium, or High
42. Live alone or with others? - Select -
43. Do you have a support person ○ Yes ○ No
44. Smoking Status - Select - Smoker, Never Smoker, Former Smoker
45. Smoking - How much? - Select -
46. Has smoked since age
47. Tobacco-years of use
48. Chewing tobacco - Select -
49. Alcohol-years of use
50. How many days in the past year have you had a heavy drinking consumption?
51. Alcohol intake - Select - None, Occasional, Moderate, or Heavy
52. Caffeine intake - Select - None, Occasional, Moderate, or Heavy
53. Illicit drugs ________________________________________
54. Illicit drugs-years of use

55. Legally blind in one or both eyes? ○ Yes ○ No
56. Do you have a medical power of attorney/ Advance directive? ○ Yes ○ No
57. Hard of hearing or deaf in one or both ears? ○ Yes ○ No
58. Able to Care for Self ○ Yes ○ No
59. Home situation [- Select -] Both Parents, Mother, Father, Relative, Adoptive Parents, Foster Parents, Other
60. Long commute/limited mobility ○ Yes ○ No
61. Can you walk 200 ft without assistance ○ Yes ○ No
62. Can you walk 200 ft with assistance (cane/walker) ○ Yes ○ No
63. CANNOT walk 200 ft with assistance ○ Yes ○ No
64. Requires Wheelchair ○ Yes ○ No
65. Bedridden ○ Yes ○ No
66. Post-op home care? ○ Yes ○ No
67. Post-op transportation? ○ Yes ○ No
68. Is blood transfusion acceptable in an emergency? ○ Yes ○ No
69. Number of Children [ ]
70. Ages of Children [ ] ________________________________________
71. Current Birth Control Method [ ] ______________________________
72. Are you planning on having more children ○ Yes ○ No
73. Smokeless tobacco status: Choose all that apply (please Circle):
    - Never used
    - Former user
    - Current snuff user
    - Current chew tobacco user
    - Currently use moist powdered tobacco
74. E-Cigarette/ Vape status: Choose one (please circle):
    - Never Used
    - Former User
    - Current user
75. Have you ever had a Pneumonia Vaccination? ☐ YES ☐ NO
76. Have you had a Flu shot this year? ☐ YES ☐ NO

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## Medical History

**Please check only the conditions or diseases that apply, if none apply to you Check the No diseases or conditions**

- ☐ 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
- ☐ 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
- ☐
- ☐ Pulmonary Embolism
- ☐ Rheumatoid Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Urinary Stress Incontinence
- ☐ Varicose Veins
- ☐ Other: ____________________________
- ☐ Other:
- ☐ Other: ____________________________
- ☐ Other:____________________________

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## Family History

□ No diseases or conditions

□ CAD (Coronary Artery Disease)

* Relation: _____________________________Onset Age: ___________Died of age: ________

□ Cancer

* Relation: _____________________________Onset Age: ___________Died of age: ________

□ Diabetes

*Relation: _____________________________Onset Age:___________Died of age:_________

□ Heart Attack (MI)

*Relation: _____________________________Onset Age:___________Died of age:_________

□ High Cholesterol

*Relation:______________________________Onset Age: __________Died of age:_________

□ Hypertension

* Relation:_____________________________Onset Age:___________Died of age:_________

□ Obesity

* Relation: _____________________________Onset Age:___________Died of age:_________

□ Sleep Apnea

*Relation: _____________________________Onset Age:___________Died of age:_________

□ Renal Failure

* Relation: _____________________________Onset Age:__________Died of age:__________

□ Stroke

* Relation: _____________________________Onset Age:__________Died of age:__________

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

**THANK YOU!!**

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**Medication List**

| Medication Name | Dosage | How many times per day |
| --- | --- | --- |
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