

## Medical History Form

Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### Social History

Sex:  Male  Female

Responsible adult available to assist during the recovery period:  Yes  No

Relationship: \_\_\_\_\_

### Family History: Have any blood relatives ever had any of the following problems?:

Abnormal Bleeding  Yes  No Heart Surgery  Yes  No Kidney Disease  Yes  No  
Abnormal Clotting  Yes  No Diabetes  Yes  No Tuberculosis  Yes  No  
Heart Attack  Yes  No Hypertension  Yes  No Other Illness  Yes  No  
Breast Cancer  Yes  No Cancer  Yes  No

Have any of your family members or relatives had the following problems with anesthesia?

High Fever:  Yes  No Death:  Yes  No Other (please list):  Yes  No

### Please list any past surgeries:

Surgery	Date	Surgery	Date

Any problems with surgery? \_\_\_\_\_

### Personal History

Have you lost a significant amount of weight?  Yes  No How much?: \_\_\_\_\_

Did you have surgery to lose the weight?  Yes  No

Type of surgery:  Lap band  Open RnY bypass  Laproscopic RnY bypass

Primary Care Physician (Name): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Date last seen by Primary Care Physician: \_\_\_\_\_

### Women Patients Only

Number of pregnancies: \_\_\_\_ Number of children: \_\_\_\_ Did you breast feed?:  Yes  No

Have you had a mammogram? Date: \_\_\_\_\_ Result:  Normal  Abnormal

If you are considering breast surgery, what is your current bra size? \_\_\_\_\_

