

# MEDICAL HISTORY FORM

Walter J. Chlysta MD, Inc.

First name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Gender: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Telephone No: (Home) \_\_\_\_\_ (Bus/cell): \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

**PRIMARY INSURANCE:** \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_

Spouse's name: \_\_\_\_\_ Spouse's Birthdate: \_\_\_\_\_

Spouse's social security #: \_\_\_\_\_

**CONTACT PERSON:** \_\_\_\_\_

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

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

Telephone No: (Home) \_\_\_\_\_ (Bus): \_\_\_\_\_

**CURRENT WEIGHT** \_\_\_\_\_ **CURRENT HEIGHT** \_\_\_\_\_

**I am interested in (circle one):** **Laparoscopic Gastric Banding**  
**Laparoscopic Sleeve Gastrectomy**  
**Laparoscopic Roux-en-Y Gastric Bypass**

## REFERRAL INFORMATION

Referring Physician: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

# PERSONAL MEDICAL HISTORY

**ALLERGIES:** \_\_\_\_\_

**MEDICAL PROBLEMS**

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

**Have you ever suffered with any of the following health problems?**

Diabetes:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Asthma:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Respiratory/Breathing problems:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Arthritis or joint pain:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Back pain:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Kidney or urinary disorder:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Neurological:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Psychological/nervous disorder:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Blood clots/Deep vein clot:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Reflux or heartburn:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Gastric or duodenal ulcer:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Hepatitis or liver disease:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
High blood pressure:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Heart disease:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
High cholesterol:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Anemia or bleeding disorder	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Varicose veins or leg swelling	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Infectious disease	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Cancer	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Sleep apnea	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Are you on CPAP or BIPAP?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Settings: _____

## **MEDICATIONS**

Please list in detail all **CURRENT** medications that you are taking:

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

Additional medications: \_\_\_\_\_

## **SURGICAL HISTORY**

Please list all prior surgery (dates if possible) and any adverse reactions or events (ex. bleeding, high fever, etc.):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_

## **SOCIAL PROFILE**

### **FAMILY STRUCTURE:**

Children/Ages: \_\_\_\_\_  
\_\_\_\_\_

Friends/Support: \_\_\_\_\_  
\_\_\_\_\_

**ALCOHOL:**

Do you drink alcohol?    Never   •   Rarely   •   Regularly   •

How many standard glasses do you drink per day? \_\_\_\_\_

How many days do you drink per week? \_\_\_\_\_

Do you drink    Beer   •   Wine   •   Spirits   •

**SMOKING:**

Do you smoke?    • Yes   • No   • Never    If yes: how many per day? \_\_\_\_\_

Have you smoked in the past?    • Yes   • No    If so, how many per day? \_\_\_\_\_

For how many years \_\_\_\_\_    When did you stop smoking? \_\_\_\_\_

<b>FAMILY MEDICAL HISTORY</b>
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Do you have a family history of any of the following and if so, please indicate:

	<b>PARENT</b>	<b>SIBLING / CHILD</b>	<b>OTHER RELATIVES (cousins, aunts, grandparents etc)</b>	<b>NO FAMILY HISTORY</b>	<b>DON'T KNOW</b>
Diabetes					
Heart attack					
Hypertension					
Gout					
Gallstones					
Obesity					
Snoring / sleep apnea					
Asthma					
Allergies					
Hayfever					
Dermatitis / Eczema					
High Cholesterol					
Osteoporosis					
Cancer					

## WEIGHT HISTORY

Please indicate your weight at the following times. Please indicate whether you consider your weight was below average, average, above average or very heavy in the relevant boxes.

	<b>Below Average</b>	<b>Average Weight</b>	<b>Above Average</b>	<b>Very Heavy</b>
Birth Weight				
Weight at starting school (5-6 years)				
Weight at beginning of high school (10-12 yrs)				
Weight at end of high school (15-18 years)				
Weight at time of commencing work (21 years)				
Weight at time of marriage (if applicable)				

Heaviest weight and approximate time of heaviest weight: \_\_\_\_\_

## DIET HISTORY

Typical breakfast (food and beverage):

\_\_\_\_\_

Food or beverages consumed between breakfast and lunch (any snack even if it is only once a week):

\_\_\_\_\_

Typical lunch (food and beverage):

\_\_\_\_\_

Food or beverages consumed between lunch and dinner (any snack even if it is only once a week):

\_\_\_\_\_

Typical dinner (food and beverage):

\_\_\_\_\_

Food or beverages consumed after dinner (any snack even if it is only once a week):

\_\_\_\_\_

\_\_\_\_\_

## WEIGHT LOSS HISTORY

**It is very important to document all weight loss attempts and the length of the attempt. This information will be reviewed and used by your insurance company to help approve or deny coverage for your surgery.** All attempts are important (Slimfast, Dexatrim, Richard Simmon's tapes, etc.). They reflect your effort at weight loss.

Meridia: \_\_\_\_\_ Duration: \_\_\_\_\_

Xenical: \_\_\_\_\_ Duration: \_\_\_\_\_

Redux/Phen-Phen: \_\_\_\_\_ Duration: \_\_\_\_\_

Weight Watchers: \_\_\_\_\_ Duration: \_\_\_\_\_

Physicians Weight Loss: \_\_\_\_\_ Duration: \_\_\_\_\_

TOPS: \_\_\_\_\_ Duration: \_\_\_\_\_

LA Weight Loss: \_\_\_\_\_ Duration: \_\_\_\_\_

Jenny Craig/Nutrisystem/Gloria Marshall etc: \_\_\_\_\_

\_\_\_\_\_ Duration: \_\_\_\_\_

Hypnotherapy: \_\_\_\_\_ Duration: \_\_\_\_\_

Fad diets: \_\_\_\_\_ Duration: \_\_\_\_\_

OTC Appetite suppressants: \_\_\_\_\_ Duration: \_\_\_\_\_

Amphetamines: \_\_\_\_\_ Duration: \_\_\_\_\_

**Details of any other weight loss measures (including surgical):**

\_\_\_\_\_  
\_\_\_\_\_

**Was there any particular event that led to significant weight gain?**

\_\_\_\_\_  
\_\_\_\_\_

**ACTIVITY LEVEL** ~ What exercise do you do on a regular basis?

How many sessions of exercise (walking, sports, etc.)  
do you do per week for more than 30 minutes at a time? \_\_\_\_\_

Type of activity: \_\_\_\_\_

\_\_\_\_\_

## **AUTHORIZATION FOR PAYMENT AND RELEASE OF MEDICAL INFORMATION**

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, Medicaid or other government sponsored programs, private insurance and other health plans to Walter J. Chlysta, M.D., Inc. to release any and all information, medical or otherwise, necessary to secure payment including all charges incurred without a valid referral. I authorize Walter J. Chlysta, M.D., Inc. to initiate a complaint to the Ohio Department of Insurance on behalf of the patient for denied or late claims.

\_\_\_\_\_  
Patient (or guardian) signature

\_\_\_\_\_  
Date

Please mail your completed medical history form to:

Walter J. Chlysta MD, FACS  
400 Wabash Avenue  
Akron, OH 44307

If you are not contacted for an appointment within 7-10 days, please call our office at (330) 344-1100. Thank you.