Revive Bariatric Health
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Revive
BARIATRIC HEALTH

Patient Intake Form

Date (yyyy-mm-dd): _____

Patient Information

Full Name: _____

Date of Birth (yyyy-mm-dd): _____

Age: _____

Phone No: _____

Email: _____

Address: _____

_____

Insurance Information:

Ins Name: _____

Ins Phone No: _____

Ins ID: _____

Patient Physical Health:

Weight: _____ BMI: _____

Height: _____ Waist: _____

Emergency Contact:

Name: _____

Relation to you: _____

Phone No: _____

Other Conditions:

- ☐ High Cholesterol or Triglycerisdes
- ☐ Fatty Lever
- ☐ Thyroid Disease
- ☐ Acid Reflux (GERD)

Health History:

Diabetes:

- ☐ You have prediabetes treated with diet (no medication at the moment)
- ☐ Your diabetes is treated only with tablets
- ☐ Your diabetes is treated with insulin with or without tablets

Comments:

_____

Sleep Apnea:

- ☐ Possible if you have one of these symptoms (heavy snoring, drowsiness during the day frequent awakenings at night, fatigue upon waking)
- ☐ Diagnosed but not wearing prescribed device

Reason not to wear: _____

- ☐ Diagnosed and you are wearing the prescribed device (CPAP or BPAP)

Comments:

_____

Cardiac disease:

- ☐ A doctor has confirmed that you have angina
- ☐ A doctor has confirmed that you have heart rhythm problems
- ☐ You have already had heart surgery (bypass, valve replacement)
- ☐ You have had cardiac catheterization, dilations or stents
- ☐ Diagnosed with high blood pressure
- ☐ Other Heart Condition: _____

Comments:

_____

Orthopaedic problems:

- ☐ You are able to move around without a walking aid (e.g., cane, walker), manage daily activities independently, and able to climb stairs.
- ☐ You require a walking aid (cane, walker) or need help with daily activities or have had or still use infiltrations with narcotic or anti inflammatory medications to treat joint pain (back, knees, ankle, etc.)
- ☐ You have been diagnosed with total disability or are awaiting orthopaedic surgery (back, knees, hip) or you must use a wheelchair.

Comments:

_____

Have you had previous weight-loss surgery? ☐ Yes ☐ No

Do you have a Gallbladder? ☐ Yes ☐ No

If yes, please provide type, name of surgeon, date, weight outcomes: _____

_____

Medication History:

Medication Name	Dose	Route	Start Date	Reason/Indication	Notes (Allergy/Reaction)

Do you have any allergies? ☐ Yes ☐ No If yes, please list: _____

Diet / Food History

When did your weight challenges begin?
Age (years)

☐ 10 or less ☐ 11-19 ☐ 20 or older

Which diets have you tried?

_____

On which diet did you lose the most weight?

_____

How much weight did you lose? _____

Name of diet currently following, if any:

_____

Have you ever met with a Nutritionist/Dietitian?

☐ Yes ☐ No

if yes, indicate reason:

_____

Meal Pattern

Which meals do you eat everyday?

☐ Breakfast ☐ Lunch ☐ Dinner

Do you eat between meals? If yes, how many per day?

☐ Yes ☐ No _____

Do you ever have a second serving of food at a meal? ☐ Yes ☐ No

Do you ever eat at night? ☐ Yes ☐ No

Which do you eat EVERY day? Check all that apply.

☐ Sweet Desserts ☐ Dairy Products ☐ Meat

☐ Vegetables ☐ Sweet Desserts ☐ Starch (carbs)

☐ Chocolate ☐ Potato Chips ☐ Fruits

Please indicate your usual intake? Check all that apply.

☐ Soft drinks: _____ per day ☐ Coffee: _____ cups/day

☐ Juice: _____ per day ☐ Milk: _____ cups/day

☐ Gum: _____ per day ☐ Fast food: _____ times/week

Do you eat at Restaurants? ☐ Yes ☐ No If yes, list types and how often per week:

Psychosocial History:

Are you working? ☐ Yes ☐ No What is your job and where do you work? _____

Do you have a health plan? ☐ Yes ☐ No If yes, which company? _____

Marital status: _____

Do you Exercise? ☐ Yes ☐ No

If yes, list types of exercise/frequency OR if not, explain why:

_____

What do you feel are the 3 contributing factors to your obesity?

_____

What are the stressors in your life?

_____

Who are the supportive people in your life?

_____

Do they support your decision for Weight Loss Surgery?

_____

What are your expectations and motivations for undergoing weight-loss surgery, aside from weight loss?

_____

Substance Use

Please indicate your usual intake?
Check all that apply.

☐ Alcohol: ____ per day ____ per week

☐ Cigarettes: ____ per day ____ per week

☐ Cigars: ____ per day ____ per week

☐ Cannabis: ____ per day ____ per week

☐ Vapes: ____ per day ____ per week

☐ Drugs how often? _____

list type of drugs:

Please check one of the following:

☐ Yes, I want this surgery ☐ No, I do not want this surgery at this time

Any other information we should know:

Signature: _____ **Date (yyyy/mm/dd):** _____