MEXICO BARIATRIC TEAM

www.MexicoBariatricTeam.com
Calle C #148 Suite 201 Colonia Nueva, Especialidades Almater, Mexicali B.C.
Tel. (686) 553 5340 | Toll-Free: (888) 879-4081

PRE-SURGERY QUESTIONNAIRE

Please fill out and e-mail back or give to the doctor BEFORE surgery This is helpful for the doctor to have, especially if you have any other medical problems. You always want your surgeon to be well-informed.

If you want to expand in any area or have additional information that is important the doctor know, please add on to the form.

! YOUR SAFETY DEPENDS ON THE ACCURACY OF THE INFORMATION PROVIDED.

PERSONAL INFORMATION

Name: _____ Age: ____ Birth Date: _____

Email: _____ Male ☐ Female ☐

Address: _____ Phone: _____

Name of person to contact in case of emergency: _____ Phone: _____

DIET HISTORY

Current Weight: _____ Current Height: _____ BMI: _____

Max Weight: _____ Date of max weight: _____

Have you tried any special diet, or any other weight loss attempts, professionally supervised: ☐ Yes ☐ No

If yes, what kind of diet: ☐ 1200 calorie ☐ Low fat ☐ Low carbohydrate ☐ Other

Have you been on weight loss medications: ☐ Yes ☐ No If yes, please list: _____

MEDICAL HISTORY

ALLERGIES:

Are you allergic to any drug, food, or substance? ☐ Yes ☐ No

If yes, what happens when you take or are exposed to it?
(Example: Penicillin – rash)

_____

_____

MEDICATIONS:

Are you taking any medications, herbal supplements: ☐ Yes ☐ No If yes, please mark wich one and write the details below:

☐ Aspirin ☐ Water pill ☐ Blood pressure meds ☐ Blood thinning ☐ Heart rhythm meds

☐ Digitalis ☐ Steroids ☐ Over the counter ☐ Herbal ☐ Vitamin-Mineral supplements

☐ Other: _____

Specify name, dose, frequency: _____

_____

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PAST MEDICAL AND SURGERY HISTORY

Do you have, or have you had, any of the following?

- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Reflux (heart burn, indigestion)
- ☐ Heart failure
- ☐ Seizures
- ☐ Asthma
- ☐ Polycystic ovarian syndrome
- ☐ Crohn's disease
- ☐ Irritable bowel syndrome
- ☐ Depression
- ☐ Lupus, Rheumatoid arthritis
- ☐ Stomach ulcers
- ☐ Gallbladder trouble
- ☐ Radiotherapy
- ☐ Chemotherapy
- ☐ Fatty liver disease
- ☐ HIV
- ☐ Anxiety
- ☐ Kidney problems
- ☐ Cancer, what type: _____
- ☐ Thyroid disease, what: _____
- ☐ Hernia, what kind: _____
- ☐ Hepatitis B or C, Which one: _____
- ☐ Menopause, when: _____
- ☐ Heart attack or angina, when: _____
- ☐ Other medical condition: _____
- ☐ COPD (emphysema or chronic bronchitis)
- ☐ Blood problems (anemia or prolong bleeding from gums, cuts, easy bruising)
- ☐ Sleep apnea: If yes, do you use: ☐ CPAP ☐ BiPAP and, How many liters: _____

Have you had an endoscopy: ☐ Yes ☐ No Diagnosis: _____

Have you had any abdominal surgery: ☐ Yes ☐ No If yes: What and when: _____

_____

Have you had any other surgery (not abdominal) ☐ Yes ☐ No Specify: _____

Do you have any reaction to anesthesia: ☐ Yes ☐ No Specify: _____

Do you have any dentures or dental implants? ☐ Yes ☐ No Specify: _____

Have you had any pregnancies: ☐ Yes ☐ No Number: _____ Are you pregnant now: ☐ Yes ☐ No

Do you have heavy periods: ☐ Yes ☐ No

FAMILY HISTORY

Any family member (father, mother, brither or sister, grandparents) with:

- ☐ Heart disease, who: _____
- ☐ High blood pressure, who: _____
- ☐ Lung disease, who: _____
- ☐ Diabetes, who: _____
- ☐ Stroke, who: _____
- ☐ Kidney disease, who: _____
- ☐ Thyroid disease, who: _____
- ☐ Cancer, who and what type: _____
- ☐ Other, specify: _____

SOCIAL HISTORY

Do you smoke: ☐ Yes ☐ No How many per day: _____ When was the last cigarette: _____

Do you drink: ☐ Yes ☐ No What and how many per week: _____ Last one: _____

Do you use any recreational drugs: ☐ Yes ☐ No What and how often: _____ Last: _____