Tulane
Medical Center
**PLEASE PRINT**

**For Office Use Only: TBC NEW PATIENT INFORMATION**
Patient Name_____
MRN_____ Date _____
Dr. Levy



**Name:**_____**DOB**_____ **SS#:** _____

**Email Address:**_____ **Phone:** _____
We will not share your information with any third party outside of our organization.

**Primary Care Physician:** _____ **Phone:** _____

**Emergency Contact :**_____ **Phone:** _____

**Pharmacy Name and Phone Number**:_____

**1. Medical problems: (check all that apply)**

| | | | |
|---|---|---|---|
| ☐ High Blood Pressure | ☐ High cholesterol | ☐ Diabetes | ☐ COPD |
| ☐ Congestive Heart Failure | ☐ Heart Attack | ☐ Kidney Disease | ☐ Urinary Incontinence |
| ☐ Polycystic Ovaries | ☐ Back Pain | ☐ Joint Pain | ☐ Pseudotumor Cerebri |
| ☐ Asthma | ☐ Atrial Fibrillation | ☐ Chronic Fatigue | ☐ Heartburn (Acid Reflux) |
| ☐ Stomach Ulcers | ☐ Migraines | ☐ Stroke | ☐ Liver Disease |
| ☐ Gout | ☐ Deep Vein Thrombosis | ☐ Pulmonary Embolus | ☐ Depression |
| ☐ Anxiety | ☐ Sleep Apnea – CPAP/BiPaP settings_____ | | |

☐ Cancer (please specify type)_____
☐ Other_____

**2. Previous Surgeries/ procedures: (This includes all c-sections and hysterectomy, also include year of the procedure and if it was open or laparoscopic)**

_____

_____

_____

3. For women: Have you had a tubal ligation, Essure procedure or IUD implanted for pregnancy prevention?Yes/No ☐

4. Are you medications up to date in our computer system? Yes / No ☐

**5. Allergies – please include any drug allergies, and the type of reaction (for example, rash, or vomiting, or breathing difficulty) and level of severity (mild, moderate or severe):**

_____

**6. Have you been hospitalized or seen in the ER for any reason in the past year**? Yes / No ☐
If Yes, please explain why (for example: chest pain, or abdominal pain, or car accident, etc):

| **Date:** | **What Hospital?** | **Reason for visit/admission?** |
|---|---|---|
| | | |
| | | |

Tulane Medical Center
PLEASE PRINT

**For Office Use Only: TBC NEW PATIENT INFORMATION**
Patient Name_____
MRN_____ Date _____
Dr. Levy



**7. Have you been hospitalized or seen in the ER for any psychiatric reason in the past year**? Yes / No
If Yes, please explain why (for example: depression, panic attack, suicidal ideation, self harm, etc):

| Date: | What Hospital? | Reason for visit/admission? |
|---|---|---|
| | | |
| | | |
| | | |

**8. Social history:**

- Do you smoke/ have you smoked in the past?

Yes / No # packs/day_____ # of years _____ Quit date: _____

- Do you use tobacco products (dip, chew, e-cigarette)?

Yes / No How often_____ # of years_____ Quit date:_____

- Do you drink alcohol? Yes / No Amount_____ How often_____
- Who do you live with?_____
- What is your occupation?_____
- Disabled: Yes / No If yes, what is the nature of your disability?_____
- Are you able to read: No Yes with difficulty Yes without difficulty

**9. Family History: (check all that apply)**

☐ Morbid Obesity ☐ High Blood Pressure ☐ Heart Disease ☐ Lung Disease
☐ Diabetes ☐ Bleeding Problems ☐ Cancer ☐ Blood clot
☐ Other: _____

**10. Activity History**

- What is the most demanding physical activity you participate in?

_____

- Can you walk for 1 block or 50 yards without stopping? Yes / No
- Can you do light house work, like dusting or doing dishes, without stopping? Yes / No
- Can you climb a flight of stairs without stopping? Yes / No
- What limits your activity (for example, joint or back pain, chest pain, or shortness of breath, or balance limitations, or vision limitations)? _____
- Do you use any of the following devices for assistance?

☐**walker** ☐ **cane** ☐**wheelchair** ☐**other**_____

- Do you need assistance with any of the following activities?

☐ **eating** ☐ **bathing** ☐**walking** ☐ **dressing** ☐ **other**_____

Tulane
Medical Center
PLEASE PRINT

**For Office Use Only: TBC NEW PATIENT INFORMATION**
Patient Name_____
MRN_____ Date _____
Dr. Levy



## 11. Weight Loss Program History Form: *(PLEASE LIST ALL ATTEMPTS AT WEIGHT LOSS)*

| **Type of weight loss program** (for example: Weight Watchers ®, physician supervised diet, prescription diet pills, cutting calories etc): | **Number of times tried** | **How long did you follow the diet** | **What year(s) did you try the diet** | **What were the results (long-term and short-term?)** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## 12. Are you currently experiencing any of the following problems on a frequent basis?

| **Constitutional:** | | | **GI:** | | |
|---|---|---|---|---|---|
| Fevers | Yes ☐ | No ☐ | Nausea | Yes ☐ | No ☐ |
| Chills | Yes ☐ | No ☐ | Reflux Symptoms (Heartburn) | Yes ☐ | No ☐ |
| Night Sweats | Yes ☐ | No ☐ | Frequent Diarrhea | Yes ☐ | No ☐ |
| **SLEEP:** | | | Frequent Constipation | Yes ☐ | No ☐ |
| Daytime sleepiness | Yes ☐ | No ☐ | Black, tarry stools | Yes ☐ | No ☐ |
| Snoring | Yes ☐ | No ☐ | Bloody stools | Yes ☐ | No ☐ |
| Stop breathing during sleep | Yes ☐ | No ☐ | Abdominal pain | Yes ☐ | No ☐ |
| Morning headaches | Yes ☐ | No ☐ | **GU:** | | |
| **HEENT:** | | | Painful urination | Yes ☐ | No ☐ |
| Frequent headaches | Yes ☐ | No ☐ | Blood in urine | Yes ☐ | No ☐ |
| Difficulty eating or swallowing | Yes ☐ | No ☐ | **Musculoskeletal:** | Yes ☐ | No ☐ |
| **Cardiovascular:** | | | Joint pains | Yes ☐ | No ☐ |
| Chest pain | Yes ☐ | No ☐ | Back pain | Yes ☐ | No ☐ |
| Difficulty breathing while lying down | Yes ☐ | No ☐ | Frequent muscular pain | Yes ☐ | No ☐ |
| Shortness of Breath | Yes ☐ | No ☐ | **Neurologic:** | | |
| Palpitations | Yes ☐ | No ☐ | Dizziness | Yes ☐ | No ☐ |
| Lower extremity swelling | Yes ☐ | No ☐ | Seizures | Yes ☐ | No ☐ |
| **Respiratory:** | | | Numbness | Yes ☐ | No ☐ |
| Frequent cough | Yes ☐ | No ☐ | Weakness | Yes ☐ | No ☐ |
| Pain on inspiration | Yes ☐ | No ☐ | | | |
| Wheezing | Yes ☐ | No ☐ | | | |

Tulane
Medical Center
**PLEASE PRINT**

**For Office Use Only: TBC NEW PATIENT INFORMATION**
Patient Name_____
MRN_____ Date _____
Dr. Levy



| **Psychiatric:** | | | **Endocrine:** | | |
|---|---|---|---|---|---|
| Depression | Yes ☐ | No ☐ | Frequent urination | Yes ☐ | No ☐ |
| Anxiety | Yes ☐ | No ☐ | Frequent thirst | Yes ☐ | No ☐ |
| **Dermatologic:** | | | **Hematologic:** | | |
| Rashes | Yes ☐ | No ☐ | Easy bruising | Yes ☐ | No ☐ |
| Non-healing wounds | Yes ☐ | No ☐ | Bleeding of gums | Yes ☐ | No ☐ |
| | | | Frequent nose bleeds | Yes ☐ | No ☐ |

**13. How did you hear about Tulane Bariatric Center?**

- ☐ Referred by a doctor Doctor's Name _____ Doctor's Specialty _____
- ☐ Social media (please circle) Facebook Instagram
- ☐ Internet search
- ☐ Heard from a friend
- ☐ Other (Please describe) _____

**Patient Signature: _____Date: _____**

**For office use only: STOP BANG Questionnaire**

| | | |
|---|---|---|
| Snoring | Yes☐/ | No ☐ |
| Tired during the day | Yes☐/ | No ☐ |
| Observed apneas | Yes☐/ | No ☐ |
| Blood pressure (dx or being treated) | Yes☐/ | No ☐ |
| BMI (>35) | Yes☐/ | No ☐ |
| Age (> 50) | Yes☐/ | No ☐ |
| Neck circumference (>40 cm) | Yes☐/ | No ☐ |
| Gender (male) | Yes☐/ | No ☐ |

☐ **Pictures have been taken and uploaded into EWC**