Georgetown Bariatrics
& Advanced Surgical Services

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Transfer of Care

Please fill out packet and return with the records from your Bariatric surgery.

- Operative notes
- Office follow up notes
- Any testing
- Insurance card(s)

Thank you,

Patient Demographic and Medical History Questionnaire

Date Form Completed: _____ Date of Seminar Attended: _____

How did you hear about us? O Family/Friend O Doctor O Internet O TV O Magazine O Other _____

Have you ever started the process to have weight loss surgery in the past? YES O NO O

If yes, what year? _____ If yes, what program/city? _____

(If here at Georgetown, we will pull your chart and update your information)

If yes, did you undergo weight loss surgery? YES* O NO O

(*please provide further information when entering your surgical history in the applicable section)

If yes, but you did not proceed to surgery, for what reason(s) did you stop the process? _____

Are you able to read, write and communicate in the English Language? YES O NO O

If not, what is your primary language? _____

Please check any other barriers to communication applicable:

O Hearing Impaired (deafness or other) O Vision Impaired (blindness or other) O Cannot read and/or write

We will discuss with you accommodations to ensure you receive all of the information you need!

Patient Information:

First Name: _____ Middle Name: _____ Last Name: _____

Social Security Number: _____ Date of Birth: _____ Age: _____ Gender: Female O Male O

Marital Status: Single O Married O Divorced O Separated O Partnered O Widowed O

How many children do you have (include biologic and adopted/fostered and as blended family; please also list ages)?

_____

Patient Ethnicity: African American O Asian O Caucasian O Hispanic O Native American or Alaska Native O

Native Hawaiian or Other Pacific Islander O Choose not to specify O Other: _____

Patient's level of Education: _____ Religious Preference: _____

Address Information:

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

E-mail: _____ (We utilize e-mail addresses for contact when phone messages are not possible. We will also sign you up for our e mail patient notices and newsletters. If you wish to be excluded from the patient notices, check here: ☐

Home Phone #: _____ (OK to leave msg: Y or N) Work Phone #: _____ (OK to leave msg. Y or N)

Mobile Phone #: _____ (OK to leave msg. Y or N)

Preferred Procedure: Undecided O Roux-en-Y Gastric Bypass O Adjustable Gastric Band O Gastric Sleeve O

Adjustable Gastric Band with Plication O Laparoscopic Greater Curvature Plication (LGCP) (investigational; currently not covered by insurance) **Revision O** (Revision/conversion procedure of prior weight loss surgery; will discuss further with Bariatric Surgeon)

What is your height? _____ft _____in How much do you weigh? _____lbs. BMI (if known) _____

Transportation:

Reliable and punctual transportation is needed to all weight loss surgery center appointments as we must maintain a timely schedule in the center to ensure patients are seen by the providers. We apologize in advance for any inconvenience, but please be aware that late arrival will likely cause you to have to reschedule your appointment. If you rely on others for transportation, please tell us who provides that transportation.

Name: _____ Phone Number: _____

Authorization to discuss/review medical care plan:

"I hereby authorize the staff of the Bariatric Center at Georgetown Community Hospital to discuss my condition/treatment/plan of care, diagnostic test results and any scheduled appointments with the following named person(s), **and/or** further consent to the staff leaving messages for me on voicemail/answering machine":

Name: _____ Relation to you: _____

Name: _____ Relation to you: _____

Patient Signature: _____ Date: _____

Healthcare Provider Information:

Please complete the following information on all of your healthcare providers. We will share information about your process and completion of our weight loss surgery program with the healthcare providers for the purposes of continuity of care. If you do not have a specialty provider, write "N/A" in that area. **Note: You MUST have a Primary Care Provider to start our program.** If you need help finding a PCP in your area, please call us at 502-570-3720.

Primary Care Provider			
First Name:	Last Name:		○ MD ○ DO ○ APRN ○ PA
Street Address:			
City:	State:	Zip:	Phone:
Cardiologist			
First Name:	Last Name:		○ MD ○ DO ○ APRN ○ PA
Street Address:			
City:	State:	Zip:	Phone:
Nephrologist			
First Name:	Last Name:		○ MD ○ DO ○ APRN ○ PA
Street Address:			
City:	State:	Zip:	Phone:
Oncologist			
First Name:	Last Name:		○ MD ○ DO ○ APRN ○ PA
Street Address:			
City:	State:	Zip:	Phone:
Psychological Services			
First Name:	Last Name:		○ MD ○ DO ○ APRN ○ PA
Street Address:			
City:	State:	Zip:	Phone:
Other Specialist			
First Name:	Last Name:		○ MD ○ DO ○ APRN ○ PA
Street Address:			
City:	State:	Zip:	Phone:

Patient Employment/Mobility Information:

Employment status: **Full Time O** **Part Time O** **Student O** **Retired O** **Disabled O** **Homemaker O** **Unemployed O** **Leave of Absence O**

Patient's present or former occupation: _____

Patient's Current Employer: _____ Years Employed: _____

Patient's Employer's address: _____ State: _____ Zip: _____ Phone #: _____

Disabled? Yes O No O If Yes, specify the year and cause(s): Year: _____ Cause(s): _____

Can you walk at least 15 feet unassisted? Yes O No O

If you need assistance walking, what device(s) do you use (circle all that apply)?

Cane Walker Crutches Other: _____

Are you confined to a wheelchair and unable to stand at all? Yes O No O If yes, how long confined to wheelchair? _____ (months/years)

Spouse/Significant Other Employment Information:

Name: _____ Date of birth: _____ Phone #: _____

Employment status: Full Time O Part Time O Student O Retired O Disabled O Homemaker O Unemployed O Leave of Absence O

Occupation: _____ SSN: _____

Employer: _____ Years employed: _____

Employer's address: _____

Insurance Information: This section must be filled out in addition to enclosing a copy of your insurance card!

Payment Type: Insurance O Self Pay O

Primary Insurance:

Insurance Company: _____ Customer Service Number: _____

Policy Number: _____ Group #: _____

Subscriber Name: _____ Subscriber Date of Birth: _____ Subscriber Social Security # _____

Secondary Insurance (if applicable):

Insurance Company: _____ Customer Service Number: _____

Policy Number: _____ Group #: _____

Subscriber Name: _____ Subscriber Date of Birth: _____ Subscriber Social Security # _____

Emergency Contact:

First Name: _____ Last Name: _____

Relation to you: _____ Phone: _____

Do you have a designated Medical Surrogate, Health Care Power of Attorney or anyone who can legally make medical decisions for you? YES O NO O If yes, who is that person(s)? _____ Relationship to you? _____

Do you have a physician who can document your weight loss attempts for at least 6 months if required? Yes O No O

Can your long-term (>5 years) weight and health history be documented by a medical provider if required? Yes O No O

Blood Consent:
"I consent to accept blood or blood products during or after surgery if my condition is such that the physician deems it necessary"

Patient Signature: _____ Date: _____

Blood Products Refusal*: O I wish to complete the Blood/Blood Products Advance Directive form

(**if Jehovah's witness please* also check here: O)

Weight Loss History:

At what periods of your life have you been overweight? (may check more than one response)

O Childhood O Adolescence O Young Adulthood (age < 30) O Middle Adulthood (age < 60) O Pregnancy O Illness/Injury

If applicable, how long have you been 100 pounds or more overweight? _____Years

At what age did you start dieting? _____Age Check if no prior diet attempts of any kind O

What dieting method(s) were most successful in helping you lose weight? _____

What is the most weight you lost on a single attempt? _____ lbs. How long did you maintain the weight loss? _____ (months/years)

Please check all applicable weight loss methods you have previously tried from the list below:

Unsupervised Diet Attempts:

O Calorie Counting/Restriction
O High protein / Low Carbohydrate (ex: South Beach, Atkins, Body for Life)
O Low Fat
O Heart Healthy / DASH
O Diabetic Diet
O Supplements (ex: Herbal Life)
O Meal replacements (ex. Slim Fast)
O Other: _____

Supervised Diet Attempts/Organized Group Support:

O Nutri-System / LA Weight Loss
O Diet Center / Jenny Craig
O Optifast / HMR
O Weight Watchers
O TOPS / Overeaters Anonymous
O Nutritionist / Dietitian supervised
O Physician supervised
O Other: _____

Over-the-Counter or Prescribed Medications for Weight Loss:

O Dexedrine (dextroamphetamine)
O Didrex (benzphetamine)
O Accutrim / Dexatrim
O Phentermine
O Ionamin/Adipex
O Fastin/Pro-Fast
O Redux (dexfenfluramine)
O Pondimin (fenfluramine)
O Fen-Phen: # Months_____
O Tenuate (diethylpropion)
O Meridia (sibutramine)
O Xenical/Alli (orlistat)
O Antidepressants
O Diuretics ('fluid pills')
O Laxatives
O Byetta / Januvia
O Other: _____

Behavioral Treatments for Weight Loss:

O Hospitalization
O Psychological Therapy
O Hypnosis
O Physical Therapy
O Residential Programs
O Other: _____

Exercise:

O Walking / Treadmill
O Running
O Stationary cycle
O Weight Training
O Swimming / Water fitness
O Team Sports
O Other: _____

Have you used any of the following behaviors in the past to control your weight? (Check all that apply)

- O Bingeing and then Vomiting
- O Bingeing followed by food restriction
- O Vomiting purposefully after eating ('bulimia')
- O Excessive/Obsessive Calorie Restriction/Fasting ('anorexia')
- O Excessive/Obsessive Exercise

If so, when and how long was this period of behavior? _____

Do you currently use any of these methods for weight control? Yes O No O Please specify: _____

Current Eating:

Do you eat large meals in one sitting?	Yes O	No O
Do you frequently skip meals, or eat only 1-2 times per day?	Yes O	No O
Do you "graze" or snack frequently throughout the day/evening?	Yes O	No O
Do you eat or snack late in the evening or at night?	Yes O	No O

Taking into account your current lifestyle and schedule, please tell us if you prepare more meals at home or do eat more meals from take-out, fast-food and sit-down restaurants.

- O More meals prepared at home
- O More meals from restaurants

What is your preferred beverage of choice? (Please check all that apply.)

O Regular Soda O Diet Soda O Regular Coffee O Decaf Coffee O Sweet Tea
O Unsweetened Tea O Fruit Juice O Milk O Water O Other_____

Please check any triggers for overeating that impact you: Physical Hunger O Anxiousness O Boredom O
Makes me happy O Loneliness O Helps me handle stress O

What other factors do you feel contribute to your obesity disease? (Check all that apply)

Food choices:

- O Poor food and beverage choices/lack of nutritional knowledge
- O Poor environmental control (surrounded by temptations)
- O Lack of time for healthy food preparation
- O Cost of healthy foods
- O Dislike of healthy foods

Physical Activity:

- O Lack of knowledge or access to physical activity options
- O Physical condition(s) that limit physical activity
- O Lack of time for physical activity
- O Cost of physical activity options
- O Dislike of physical activity

Please explain in more detail any other issues that you feel contribute to your difficulty in losing weight and/or maintaining weight loss?

_____

_____

Why have you chosen to pursue weight loss surgery at this point in your life?

_____

_____

_____

_____

Patient Name: _____ Date of Birth: _____

Knowing your eating patterns and food choices must change; what, if any, lifestyle changes have you begun to make in preparation?

What support / accountability tools have you considered or begun to use to help achieve and maintain your weight loss success?

Medical History/Review of Symptoms: (Check all that apply)

General / Head and Neck: ☐ **I have no medical conditions listed in this section.**

☐ Cancer: (list year of diagnosis, area of body affected and treatment received):

☐	Glaucoma / Eye disease.	☐	Cataracts	☐	Hearing problem / Hearing aide
☐	Blindness				

Other symptoms (General):

☐	Fevers	☐	Hair loss	☐	Insomnia
☐	Chills / Night sweats	☐	Appetite change / Loss	☐	Fatigue / Tired / No energy
☐	Hot flashes	☐	Unexplained weight gain / loss	☐	Other_____

Other symptoms (Head and Neck):

☐	Wear contacts / glasses	☐	Sinus drainage	☐	Hoarseness
☐	Blurred / Double vision	☐	Seasonal allergies / Hay fever	☐	Sore throat
☐	Tinnitus (ringing in ears)	☐	Dentures / Partials	☐	Other_____
☐	Vertigo (room spinning)	☐	Gum problems / bleeding		
☐	Nose bleeds	☐	Dry mouth		
☐	Repeated ear infections	☐	Altered taste		

Cardiovascular: ☐ **I have no medical conditions listed in this section.**

☐ High Blood Pressure: ○ Borderline/No medication ○ Single medication ○ Multiple medications ○ Poorly controlled

☐ Poor circulation in legs/Peripheral vascular disease (PVD): ○ Medication ○ Surgery/revascularization

☐ Deep blood clot in leg (DVT): ○ resolved with anticoagulation ○ recurrent

☐ Blood clot in lungs (pulmonary embolism): ○ resolved with anticoagulation ○ recurrent ○ vena cava (Greenfield) filter placed

☐	Heart disease/Prior heart attack	☐	Pacemaker / Defibrillator	☐	Varicose veins
☐	Congestive heart failure (CHF)	☐	Atrial Fibrillation / Arrhythmia	☐	Venous insufficiency
☐	Heart murmur / 'leaky' valve	☐	Rheumatic Fever / Valve damage	☐	Prior stroke or TIA

Other symptoms:

☐	Ankle swelling / Edema: ○ Diuretic ('fluid pill')				
☐	Chest pain with activity	☐	Irregular heartbeat / Skipped beats	☐	Leg infections ('cellulitis')
☐	Shortness of breath with exercise	☐	Rapid heart rate	☐	Skin changes of legs ('stasis')
☐	Difficulty breathing when lying flat	☐	Very slow heart rate	☐	Cramping in legs when walking
		☐	Ankle / Leg ulcers	☐	Other_____

Patient Name:_____ Date of Birth:_____

Endocrine: ☐ **I have no medical conditions listed in this section.**

- ☐ Diabetes: ○ oral medication only ○ Insulin only ○ oral medication and insulin ○ complications (neuropathy/organ damage)
- ☐ Elevated Cholesterol / Triglycerides: ○ diet modification ○ single medication ○ multiple medications
- ☐ Gout: ○ no active symptoms ○ medication ○ joint destruction/disability

- ☐ Under / Overactive thyroid
- ☐ Parathyroid/ High calcium
- ☐ Endocrine gland tumor
- ☐ Pre-diabetes / "Insulin Resistance" with elevated blood sugars
- ☐ Gestational diabetes (during pregnancy)

Other symptoms:

- ☐ Goiter
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Heat or cold intolerance
- ☐ Low blood sugar
- ☐ Abnormal facial hair growth
- ☐ Excessive sweating
- ☐ Other_____

Respiratory: ☐ **I have no medical conditions listed in this section.**

- ☐ Asthma: ○ inhaler(s) ○ oral meds ○ not controlled ○ multiple hospitalizations required
- ☐ Obstructive Sleep Apnea: ○ symptoms but negative or no formal sleep study ○ diagnosed but no appliance ○ CPAP or BiPAP
- ☐ COPD/Emphysema: ○ supplemental oxygen
- ☐ Recurrent Bronchitis / Pneumonia
- ☐ Prior Tb
- ☐ Pulmonary hypertension/ right heart failure

Other symptoms:

- ☐ Chronic cough
- ☐ Shortness of breath at rest
- ☐ Coughing up blood
- ☐ Snoring
- ☐ Abnormal breathing pattern
- ☐ Wheezing
- ☐ Other_____

Gastrointestinal: ☐ **I have no medical conditions listed in this section.**

Date of last colonoscopy, if done: _____

- ☐ GERD/Heartburn: ○ no medication ○ intermittent medication ○ daily medication ○ prior surgery
- ☐ Gallbladder Problems/Gallstones: ○ intermittent symptoms ○ prior gallbladder removal ○ ongoing/unresolved complications
- ☐ Abnormal Liver findings / Elevated Liver Enzymes: ○ enlarged liver ○ elevated enzymes ○ NASH ○ Liver failure

- ☐ Barrett's esophagus
- ☐ Achalasia / motility disorder
- ☐ Hiatal hernia
- ☐ Stomach ulcer / +H. pylori
- ☐ Pancreatic disease
- ☐ Bile duct disease/blockage
- ☐ Cirrhosis / Hepatitis
- ☐ Ulcerative Colitis / Crohn's Disease
- ☐ Irritable bowel syndrome (IBS)
- ☐ Polyps
- ☐ Diverticulosis
- ☐ Hemorrhoids / Anal fissure
- ☐ Pilonidal cyst
- ☐ Incisional / Abdominal hernia

Other symptoms:

- ☐ Difficulty swallowing
- ☐ Belching / regurgitation
- ☐ Nausea / Vomiting
- ☐ Abdominal pain
- ☐ Jaundice
- ☐ Excessive gas or bloating
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in bowel habit
- ☐ Black, tarry stools
- ☐ Rectal bleeding/Blood in stool
- ☐ Frothy/mucousy stools
- ☐ Incontinence of stool
- ☐ Other_____

Bladder/Kidney: ☐ **I have no medical conditions listed in this section.**

- ☐ Leaking urine with cough/laugh/sneezing: ○ intermittent ○ daily; requires sanitary pad ○ disabling or prior surgery
- ☐ Kidney Stones: Treatment including (if applicable): ○ medication ○ prior surgical procedure or lithotripsy (ESWL)
- ☐ Kidney Failure / Renal Insufficiency

Other symptoms:

- ☐ Blood in urine
- ☐ Burning / Pain on urination
- ☐ Overall Loss of bladder control (global leakage)
- ☐ Trouble starting urine
- ☐ Urinary urgency/Frequency
- ☐ Decreased force of stream
- ☐ Incomplete emptying
- ☐ Terminal dribbling
- ☐ Other_____

Musculoskeletal / Autoimmune: ☐ **I have no medical conditions listed in this section.**

- ☐ Back Pain: ○ intermittent ○ non-narcotic treatment ○ narcotic medication ○ prior or recommended surgery ○ failed surgery
- ☐ Other Joint pain: ○ non-narcotic treatment ○ pain with walking ○ prior surgery ○ past or recommended surgery
- ☐ Fibromyalgia: ○ exercise ○ non-narcotic treatment ○ narcotic medication ○ surgery ○ disabling; treatment ineffective

- ☐ Degenerative arthritis / Degenerative disk disease
- ☐ Rheumatoid Arthritis
- ☐ Lupus / Scleroderma
- ☐ Carpal tunnel syndrome
- ☐ Plantar fasciitis

Other symptoms:

- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Elbow pain
- ☐ Wrist pain
- ☐ Hand/Finger(s) pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Ankle pain
- ☐ Foot/Heel pain
- ☐ Ball of foot/Toe pain
- ☐ Muscle pain/Spasm
- ☐ Other_____

Neurologic: ☐ **I have no medical conditions listed in this section.**

- ☐ Headaches
- ☐ Migraines
- ☐ Seizures or convulsions
- ☐ Multiple sclerosis
- ☐ Pseudotumor Cerebri (severe headaches with nausea, and possible loss of vision from high pressure in the brain)
- ☐ Neuropathy/Nerve damage
- ☐ Sciatica
- ☐ Restless legs syndrome (RLS)

Other symptoms:

- ☐ Frequent or recurrent headaches
- ☐ Balance disturbance
- ☐ Weakness
- ☐ Memory loss
- ☐ Dizziness / Vertigo
- ☐ Head Injury/Knocked unconscious
- ☐ Numbness/Tingling
- ☐ Other_____

Blood/Lymphatic: ☐ **I have no medical conditions listed in this section.**

- ☐ Anemia (iron deficient)
- ☐ Anemia (vitamin B12 deficient)
- ☐ HIV / AIDS
- ☐ Low platelets (thrombocytopenia)
- ☐ Lymphoma / Leukemia
- ☐ Superficial blood clot in leg / 'phlebitis'
- ☐ Bleeding/Clotting Disorder
- ☐ Prior blood transfusion
- ☐ Blood thinning medicine use

Other symptoms:

- ☐ Swollen lymph nodes
- ☐ Bruise easily
- ☐ Other_____

Testicular/Prostate (for men only): ☐ **I have no medical conditions listed in this section.**

Date of last prostate exam: _____

- ☐ BPH (benign prostate hypertrophy)
- ☐ Erectile dysfunction (ED)
- ☐ Testicular masses/asymmetry

Gynecologic (for women only): ☐ **I have no medical conditions listed in this section.**

Date of last PAP smear: _____ **Date of last bone density scan, if done:** _____

- ☐ Polycystic ovarian syndrome (PCOS): ○ no treatment ○ birth control pills ○ diabetic medication ○ combination therapy

How many pregnancies have you had? _____ Live births? _____ Miscarriages or abortions? _____

Are you currently pregnant? Yes ○ No ○ Do you plan to have more children? Yes ○ No ○

History of problems conceiving? Yes ○ No ○ History of pregnancy or delivery complications? Yes ○ No ○

Are you post menopausal? Yes ○ No ○ If so, age at Menopause onset: _____

Date of last menstrual period if premenopausal: _____ Current method of birth control if premenopausal: _____

- ☐ Menstrual irregularity / Abnormal periods
- ☐ Excessively heavy periods / Passage of clots
- ☐ No menses
- ☐ Menstrual pain
- ☐ Postmenopausal vaginal bleeding
- ☐ Cervical dysplasia
- ☐ Endometriosis
- ☐ Other_____

Psychiatric:

Please tell us honestly about any mental health diagnosis and/or related difficulty you have experienced in your lifetime. This information is needed to help provide you with the best possible support and treatment plan; it will be kept confidential.

- ☐ Alcoholism / Substance abuse
- ☐ Anxiety
- ☐ Attempted suicide
- ☐ Attention deficit disorder (ADD/ADHD)
- ☐ Bipolar disorder ('manic-depression')
- ☐ Depression
- ☐ Post Traumatic Stress Disorder (PTSD)
- ☐ Schizophrenia/Schizoaffective Disorder
- ☐ Sexual abuse
- ☐ Mental/Emotional abuse
- ☐ Physical abuse
- ☐ Other psychiatric illness or condition? Please describe here: _____

Have you ever had outpatient psychiatric counseling?

Yes ○ No ○

If yes, for what condition(s)?_____

Have you ever been hospitalized for psychiatric problems?

Yes ○ No ○

If yes, when? _____

Are you currently seeing a counselor/psychiatric professional?

Yes ○ No ○

If yes, for what condition(s)?_____

Have you ever been in a chemical dependency program?

Yes ○ No ○

If yes, when?_____

Are you currently taking medications for anxiety ('nerves') or other mental health problems? Yes ○ No ○

If yes, who is your prescriber?

_____

Provider Name

_____

Address

_____

Phone

Breast:

☐ **I have no medical conditions listed in this section.**

Date of last Mammogram: _____

- ☐ Breast skin changes
- ☐ Lumps / Fibrocystic disease
- ☐ Pain
- ☐ Nipple discharge
- ☐ Other_____

Patient Name:_____ Date of Birth:_____

Skin: ☐ **I have no medical conditions listed in this section.**

- ☐ Keloids (raised scars)
- ☐ Chronic abscesses or boils (hydradenitis suppurativa)
- ☐ Rosacea
- ☐ Eczema
- ☐ Psoriasis
- ☐ Prior MRSA infection or positive MRSA test

Other symptoms:

- ☐ Recurrent/chronic rashes/chafing ('heat rash' or 'galding') under skin folds
- ☐ Poor wound healing
- ☐ Frequent skin infections
- ☐ Skin ulcers
- ☐ Hair or Nail Changes / Fungus
- ☐ Other_____

Surgical Procedure(s):

	Year
Gallbladder: open laparoscopic	_____
Anti-reflux procedure/Nissen fundoplication	_____
Appendectomy: open laparoscopic	_____
Hysterectomy: abdominal vaginal	_____
○ Laparoscopic approach	
○ Ovaries also removed	
Other Ovary Surgery Describe	_____
Vasectomy	_____
Cesarean Section (if multiple, list all dates)	_____
Neck: Describe: _____	_____
Back: Describe: _____	_____
Hip: replacement fixation	_____
Knee: replacement arthroscopy	_____

	Year
Peripheral Vascular Procedure	_____
Heart surgery: CABG/Other: _____	_____
Breast Biopsy: diagnosis: _____	_____
Breast: lumpectomy mastectomy	_____
Breast Cancer Radiation	_____
Wisdom Teeth	_____
Tonsillectomy	_____
Hernia: Type: _____	_____
Tubal Ligation ('tubes tied')	_____
Bowel resection	_____
Vagotomy	_____
Other:_____	_____
Other:_____	_____

Anesthesia: ○ **No Problems**

Please tell us about any problems that you have had with anesthesia:

- ☐ Nausea
- ☐ Vomiting
- ☐ Difficulty Waking Up
- ☐ Woke up during procedure
- ☐ Heart Stopped
- ☐ Stopped Breathing
- ☐ Difficulty Urinating
- ☐ Other:_____

Previous Weight Loss Surgery (WLS) procedure: _____

(We will need a copy of the Operative Report from your previous weight loss surgery.)

Date of Surgery:_____ Surgeon: _____

List any complications of WLS: _____

Original Weight prior to Surgery: _____ ☐ Estimated ☐ Actual Lowest Weight Achieved: _____ ☐ Estimated ☐ Actual

Patient Name:_____ Date of Birth:_____

List Prescribed Medications*:	Taken for what condition:	Dosage/How Often:

*Also include prescription medications taken/used only *'as needed' or occasionally*

☐ I am currently not taking any medications

List any Over-the-Counter medications, herbal supplements or vitamins that you take on a regular basis.

Product:	Taken for what purpose:	Dosage/How Often:

Allergies:

Please **circle if allergic** and list your **Reaction**

Substance/Medication

○ **No history of allergies to these products**

Latex	Reaction:_____	Iodine	Reaction:_____
Tape (adhesives)	Reaction:_____	IV Contrast Dye	Reaction:_____

Medications: List any medications that you are allergic to and your reaction

○ **No Medication Allergies**

Foods: List any foods that you are allergic to and your reaction

○ **No Food Allergies**

Social History:
***Please note: you must be tobacco- and nicotine-free up to six (6) months prior to surgery depending on procedure; this includes cigarettes, cigars and pipe tobacco; snuff/smokeless tobacco and chewing tobacco; and nicotine replacement/step-down products**

Do you smoke now?* **Yes O** **NoO**

If yes, how many packs per day? Less than 1 pack/day O 1 to 2 O 2 to 3 O More than 3 O

Have you smoked in the past? Yes O NoO

If yes, how many packs per day did you smoke? Less than 1 pack/day O 1 to 2 O 2 to 3 O More than 3 O

For how many years did you smoke? ___Years If you have quit, how long ago? _____ weeks / months / years

Do you use snuff or chew?* Yes O NoO

If yes, how frequently do you use snuff chew? Less than once per week O Once per week O Several per week O
Less than once per day O Once per day O Several per day O

For how many years have you/did you use smokeless tobacco? _____Years If you have quit, how long ago? _____ weeks/months/years

Do you consume alcohol now? **Yes O** **NoO**

If yes, how many times per week? _____ How many drinks (on average) each time? _____

If yes, is anyone concerned about the amount you drink? Yes O NoO

For how many years have you/did you drink alcohol? _____Years If you have quit, how long ago? _____ weeks / months / years

Do you use street drugs now? **Yes O** **NoO**

If yes, what drugs? _____

If yes, how frequently do you use these drugs? Less than once per month O Once per month O Several per month O
Less than once per week O Once per week O Several per week O
Less than once per day O Once per day O Several per day O

For how many years have you/did you use street drugs? _____Years If you have quit, how long ago? _____ weeks / months / years

How many hours a day do you watch TV? Never O Rarely O 3-5 hours O 5+ hours O

What hobbies do you have that are important to you? _____

Do you routinely engage in planned physical activity or exercise now? Yes O No O

If yes, how frequently: daily O several times per week O weekly O Less than weekly O

Please list the types of planned physical activity you currently do: _____

On a scale of 1 to 5 (1 = least satisfied, 5 = very satisfied), rate the following situations in your life

Married Life/Romantic Partner?	1 O	2 O	3O	4O	5O
Present job/activities?	1 O	2 O	3O	4O	5O
Overall satisfaction with yourself?	1 O	2 O	3O	4O	5O

Describe your present life stressors(Check all that apply): Finances O Family O Illness O Work O Friends O
Other: _____

Describe your present support(s) (Check all that apply): Spouse O Family O Friends O Church O Co-Workers O Others O

Could someone help care for you if you were seriously ill? Yes O No O Who? _____

Are there people for whom you are the primary care giver? Yes O No O Who? _____

Have you required home health/nursing support, or formal PT/OT, in the past following hospitalizations or surgery? Yes O No O

Have you required special medical equipment at home in the past following hospitalizations or surgery? Yes O No O

Family Medical History: (Check all that apply)

Disease	Mother	Father	Siblings (specify brother or sister)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Morbid Obesity							
Diabetes (age of onset)							
High Blood Pressure							
Heart/ Cardiovascular Disease							
Heart Attack (age)							
Stroke (age)							
Cancer: List type and age of onset							
Elevated Lipids/ Cholesterol							
Gallstones / Gallbladder problems							
Sleep Apnea							
Asthma							
COPD/ Emphysema							
Schizophrenia							
Other (please list/describe):							
Death: List age and cause							
If still living, what age are they now?							

Reviewing Medical Provider Signature _____ **Date** _____

Thank you for taking the time to fill out our Patient Demographic and Medical History Questionnaire. Please also complete the attached Sleep Questionnaire and expanded Eating Questionnaire. Also, d*on't forget to include a* copy of the front and back of your insurance card(s) and your Insurance Review Form when mailing this information back to us!

Patient Name: _____ Date of Birth: _____