

SURGICAL WEIGHT MANAGEMENT PROGRAM

Patient name _____ Date of birth _____

Address _____ City _____ Zip Code _____

Telephone/Day _____ Evening _____ Email _____

Names of your doctors: *Please list the doctors you attend with.*

<i>Speciality</i>	<i>Name</i>	<i>When last seen</i>	<i>Address</i>	<i>Telephone</i>
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Primary physician: _____

Gynecologist: _____

Orthopedist: _____

Cardiologist: _____

Pulmonologist _____

Endocrinologist: _____

Counselor/
Psychologist: _____

Psychiatrist: _____

Other: _____

Have you been referred to Dr. Early and/or the Via Christi Surgical Program? No Yes
If yes, by whom? _____

Are you seeking evaluation for gastric bypass surgery for severe obesity? No Yes

Does your primary care physician know about your interest in obesity surgery? No Yes

Does your physician feel obesity surgery would be a good treatment for you? No Yes

Have you had obesity surgery in the past? No Yes

ALLERGY HISTORY

Have you ever had a reaction to any of the following? If so, please describe reaction.

____ *Milk or dairy products*

____ *Eggs or other foods*

____ *Vitamins*

____ *Drugs or medications*

____ *Latex*

WEIGHT AND DIETARY HISTORY

Name _____

How tall are you? _____ft _____in. How much do you weigh? _____lbs.

What is the most you have ever weighed? _____lbs

At what age did you develop a significant weight problem? _____

Approximate age when you first seriously dieted: _____

Are there events that are related to your weight gain? No Yes If yes, what are they?

In your opinion, what contributed to your excess weight?

___Portion sizes ___Eat too much fat & sugar ___Nervous Eating ___Compulsive eating
___Lack of exercise ___Stress ___Lack of knowledge about healthful eating and exercise

List diets, diet programs and weight loss medications that you have tried. Please be complete in you answers as this information is needed for insurance qualification for this surgery. Use back of page if needed.

Program or Diet	Date	How long?	MD supervised?	Maximum loss

If you took Phen/Fen, have you had an Echocardiogram since taking these medications? _____

Food Preferences

Indicate which foods you prefer or which food would most likely make you go off of a diet plan. Rank each selection between 1 through 4, with 1 being "Like very much" and 4 "Don't care".

___Soda/soft drinks	___French Fries	___Chips/salty snacks	___Steaks/chops
___Candy	___Chocolate	___Cookies	___Cakes/pies
___Fried foods	___Potatoes	___Pasta	___Pizza
___Salad dressings			

Do you have or have you been treated for an eating disorder such as anorexia, bulimia, binge-eating disorder, compulsive overeating? No Yes

If yes, please provide this information about your treatment.

Type of treatment program _____

Year(s) treated _____ Name of therapist _____

LIFESTYLE HISTORY

Name _____

Do you use tobacco? No Yes Amount? _____

Do you use alcohol? No Yes Amount? _____

Do you use marijuana or other recreational drugs? No Yes Amount? _____

Do you have or have you been treated for substance abuse? No Yes

If yes, please provide this information about your treatment.

Type of program _____

Year(s) treated _____ Name of therapist _____

Do you exercise regularly? No Yes

If yes, what type of exercise do you perform? _____

How many times a week do you exercise? _____ How long is each session? _____

Are there any issues of support from family or friends at the time of surgery or after that you feel may be a problem for you? No Yes *If yes, please describe.*

FAMILY MEDICAL HISTORY

Please include medical history of parents, grandparents, brothers and sisters.

Family Member Living or deceased? At Age Illnesses or cause of death

Father _____

Mother _____

Grandparents _____

Siblings _____

Please circle any family member who has a history of:

Obesity	GP	M	F	S	C	_____
High Blood Pressure	GP	M	F	S	C	_____
Diabetes	GP	M	F	S	C	_____
Heart Disease	GP	M	F	S	C	_____
High cholesterol	GP	M	F	S	C	_____
Stroke	GP	M	F	S	C	_____
Gallbladder disease	GP	M	F	S	C	_____
Cancer	GP	M	F	S	C	_____
Lung disease, asthma, or emphysema	GP	M	F	S	C	_____
Kidney disease	GP	M	F	S	C	_____
Bleeding tendency or blood disorder	GP	M	F	S	C	_____
Weight loss surgery (list procedure)	GP	M	F	S	C	_____

WEIGHT RELATED ILLNESSES

Name _____

Have you had or do you have any of the following illnesses or symptoms? If so please check the blank and complete the information requested.

____ **Heart Disease** Year diagnosed _____ Angina / MI / Bypass surgery / Abnormal ECG
Stress test / Palpitations / Congestive Heart Failure

____ **High Cholesterol** Year diagnosed _____ High triglycerides? _____

____ **High Blood Pressure** Year diagnosed _____ Treatment (Diet / Medication)

____ **Diabetes** Year diagnosed _____ Treatment (Diet / Pills / Insulin)
HgbA1C level _____ Neuropathy _____ Kidney disease _____ Eye disease _____

____ **Sleep Apnea** Year diagnosed _____ Sleep study _____ CPAP used? _____ @ setting _____ cm
Morning headaches / Daytime drowsiness / Restless sleep / Snoring
Night awakenings / Observed episodes of breathing stopped while asleep

____ **Asthma** Year diagnosed _____ # ER visits in the last 2 years _____ # Hospitalizations
in last 2 years _____ Have you used steroids in the last year? _____

____ **Shortness of Breath** Can walk _____ blocks on level ground or _____ # of stairs

____ **Obesity Hypoventilation Syndrome** Year diagnosed _____ Treatment _____

____ **Heartburn/Esophagitis/Hiatal Hernia** Year diagnosed _____ Upper GI series _____
Endoscopy _____ Medication taken _____ times per week or day / Rx _____ OTC _____

____ **Gallbladder Disease** Year diagnosed _____ Treatment _____

____ **Stress Incontinence** Year diagnosed _____ Wear a pad always / frequently / rarely

____ **Low Back Pain / Sciatica** Diagnosis _____
Seen by Chiropractor / Family doctor / Orthopedic surgeon
Take pain or antiinflammatory medication _____ times per day / week

____ **Pain in Hips / Knees / Ankles / Feet** Diagnosis _____
Seen by Chiropractor / Family doctor / Orthopedic surgeon
Take pain or antiinflammatory medication _____ times per day / week

____ **Venous Stasis Disease** Year diagnosed _____ Treatment _____
Blood clots in legs _____ or lungs _____ Treatment _____

____ **Thyroid Disease** Year Diagnosed _____ Treatment _____

____ **Weight-Related Injuries & Trauma** _____

____ **Depression** Year diagnosed _____ Treatment _____

PAST MEDICAL HISTORY**Name** _____*Have you had any of the following conditions? If so, please provide information requested*

ILLNES	AGE OR DATE AT ONSET	DATE OF HOSPITALIZATION OR SURGERY	COMMENTS
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Rheumatic fever

Heart Murmur

Bleeding Disorder

Appendectomy

Tonsillectomy

Hepatitis or other liver disease

Colitis or other bowel disease

Ulcer disease

Kidney disease

Psychiatric conditions
(e.g. Depression, Anxiety Disorder)

Blood transfusion

Refuse to accept blood transfusion

Abnormal bleeding

AIDS/HIV exposure

Thrombophlebitis

Varicose veins

Reaction to anesthesia

Gout

Seizures/convulsions

Accidents/injuries

Other

*Women: Obstetric and menstrual history**Number of pregnancies* _____*Number of live births* _____*Miscarriages or abortions* _____*Obstetric complications* _____*Age at first period* _____ *Date of last period* _____*Current method of birth regulation* _____*Do you take estrogen? No Yes*

SURGICAL HISTORY

Name _____

Please list any surgeries you have had and the year the surgery was done.

REVIEW OF SYMPTOMS

Please circle all symptoms which you have, or have had. Write in any additional problems.

HEAD, EYE, EAR NOSE & THROAT: Stuffy nose, runny nose, hay fever, sinus trouble, earache, headache, blurry vision, double vision, loss of night vision, buzzing in ears, ringing in ears, discharge from ear, loss of hearing, dizziness, vertigo, loss of balance, sore throat, lump in throat, trouble swallowing, pain with swallowing, hoarseness.

RESPIRATORY: Cough, wheezing, shortness of breath at night, use two pillows, blood in sputum, out of breath with exertion, wake up at night short of breath, wake up at night coughing or choking, emphysema, bronchitis.

CARDIOVASCULAR: Palpitations, pounding of heart, skipping of heartbeat, pains in chest, pains in neck, pains in arms, squeezing of chest, heart attack, abnormal electrocardiogram, irregular heartbeat, pain in legs, cold feet, blue toes, blue finger, loss of pulses.

GASTROINTESTINAL: Heartburn, nausea, vomiting, belching fluid in throat, burning in throat, food sticking in chest, pains in stomach, burning in stomach, acid stomach, diarrhea, constipation, pain with bowel movement, blood in stools, hemorrhoids, fissures, cramps, gasiness, irritable colon.

GENITOURINARY: Pain with urination, trouble starting urine, trouble stopping urine, small urine stream, blood in urine, kidney stones, bladder stones, kidney failure, nephritis, urinary tract infections, frequent urination, getting up at night to urinate, leakage of urine with cough or sneeze. **MEN:** Discharge from penis, loss of erection, painful erection.

WOMEN: Vaginal discharge, pain with intercourse, irregular periods, heavy or excessive menstrual flow, infertility.

ENDOCRINE (GLANDULAR): Low thyroid, hyperthyroid, goiter, Grave's disease, thyroid nodules, X-ray to thyroid, diabetes, adrenal gland tumor, frequent flushing, frequent heavy sweating.

MUSCULOSKELETAL: Pain in joints, swelling of joints, redness of skin over joints, warm joints, fluid in joints, arthritis, broken bones, sprains, low back pain, hip pain, knee pain, ankle pain, foot pain, flatfeet, slipped disk, herniated disk, sciatica.

NEUROLOGICAL: Dizziness, vertigo, falling to the side, falling at night, numbness, tingling, pins and needles feelings, weakness of any muscles, twitching of muscles, weakness of grip, shakiness, tremor, fainting, convulsions, fits, loss of consciousness.

