Surgical Weight Loss Center
at Odessa Regional Medical Center

*Your Name* _____ *Your Date of Birth* _____

***Medical Information Questionnaire***

Your height (inches) _____ Your weight (pounds) _____

How did you become interested in Bariatric Surgery, and how did you learn about our practice? _

_____

_____

What problems is obesity causing for you? _____

_____

What are your main motivating factors for surgery?_____

_____

How do you think Bariatric Surgery may help you? _____

_____

What was your weight at the following times in your life?

6th grade _____ At your wedding _____

High School Graduation _____ Birth of 1st child _____

Age 21 _____ Age 40 _____

Age 30 _____ Age 50 _____

What has been your maximum weight? _____

What has been your lowest weight (not due to illness) after age 21, which you have maintained for at least 1 year? _____ lbs at _____ yrs old, maintained for _____ yrs.

Was this weight reached after a weight loss effort? *(circle one)*..... yes/no

Check the statement that best describes you: "During the past 6 months my weight has ..."

- ❑ decreased more than 10 lbs
- ❑ decreased 5-10 lbs
- ❑ stayed about the same
- ❑ increased 5-10 lbs
- ❑ increased more than 10 lbs

**Physician Information:** Please list all doctors that you have seen and are helping in your care:

| **Name**<br>**MD or DO or other**<br>**( NP, PA)** | **Address** | **Phone** | **Specialty,**<br>**Primary, or other**<br>**Please list type** |
|---|---|---|---|
| **1.** | | | |
| **2.** | | | |
| **3.** | | | |
| **4.** | | | |
| **5.** | | | |

**Please list your medical problems and year diagnosed.**

| | | | |
|---|---|---|---|
| 1 | | 8 | |
| 2 | | 9 | |
| 3 | | 10 | |
| 4 | | 11 | |
| 5 | | 12 | |
| 6 | | 13 | |
| 7 | | 14 | |

*A list of common medical diagnoses is listed as a reminder for you:*

Diabetes
High Blood pressure (Hypertension)
Sleep Apnea, Pickwickian syndrome
Asthma, Reactive Airway Disease
Heart Failure
Angina, Coronary Artery Disease
Gallstones
GE Reflux disease ("GERD")
Arthritis
Back pain
Urinary incontinence
Menstrual irregularity, infertility
Hirsutism
Venous thrombosis (DVT) or PE
Cancer (type?)
Depression
High cholesterol, high lipids
Hypothyroidism
Other Endocrine problem
Other??

Have you been treated at a hospital (inpatient or outpatient) within the last year? _____

If yes, please provide further information: _____

_____

_____

**Please list your past surgical history and year surgery performed.**

| | | | |
|---|---|---|---|
| 1 | | 6 | |
| 2 | | 7 | |
| 3 | | 8 | |
| 4 | | 9 | |
| 5 | | 10 | |

Have you undergone any surgical procedure for obesity in the past? _____ *If so:*

Name of Procedure: _____ When performed: _____

Name of Surgeon: _____ Office location: _____

Your weight prior to that procedure _____

Maximum weight lost, or lowest weight after surgery: _____

Reason you are seeking another surgical evaluation: _____

More than one prior surgical procedure for weight loss? _____

Have any of your family members or close friends undergone weight loss surgery? If yes, please describe:

_____

_____

Are you **allergic** to any medications? Yes No

If yes, please list: *please describe your reaction to the medications listed*

**Please list all medications that you are currently taking:**

| | Medication | Strength | How many at one time | How many a day |
|---|---|---|---|---|
| | Example: TYLENOL | 250 mg | 2 | twice a day |
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |
| 11 | | | | |
| 12 | | | | |
| 13 | | | | |
| 14 | | | | |

Do you take birth control pills, or any hormone related medications? _____

Do you use any non-prescription (over-the-counter) drugs, vitamins, or herbal remedies? Please describe:

***General Symptom Review:***

Circle a number that corresponds with your general energy level:

*(1 = lowest, 5 = highest)*

1 2 3 4 5

Have you experienced more than one week of fever in the last year? ..... yes/no

Do you have severe headaches? ..... yes/no

Have you experienced any visual changes in the last year? ..... yes/no

Do you fall asleep unexpectedly? ..... yes/no

Do you snore loudly? ..... yes/no

Do you wake frequently at night? ..... yes/no

How many times? _____

Do you experience shortness of breath with exercise? ..... yes/no

Do you experience chest pain with exercise? ..... yes/no

How many flights of stairs can you climb without stopping? _____

How many times per week do you have heartburn? _____

Do you experience abdominal pain or nausea after eating fatty foods? ..... yes/no

Do you have difficulty swallowing, or feel a "catching" sensation when eating thick or bulky foods?..... yes/no

Do you have difficulty with leaking of urine when you cough or laugh? ..... yes/no

Have you had more than one urinary infection in the last year? ..... yes/no

Do you have persistent skin irritation, rash, ulcers? ..... yes/no
Where? _____

Do you have severe joint pain? ..... yes/no
What joints are worst? _____

Do you have persistent ankle or foot pain? ..... yes/no

Have you noticed any changes in your hair in the last year? ..... yes/no

Have you noticed any changes in your energy level in the past year? ..... yes/no

Has your thyroid function been checked by your physician in the past? ..... yes/no

Do you feel depressed or hopeless? ..... yes/no

Have you ever had a blood clot in your legs or lungs? ..... yes/no

***Family History:***

Has anyone in your immediate family had any of the following diseases? *(use: M = mother, F = father, S = sister, B = brother, G = grandparent)*

Diabetes _____

Hypertension _____

Severe Obesity _____

Cancer (what type?) _____

Blood Clotting _____

***Social History:***

Are you married? Yes/No/Divorced If married, how long? _____

If you have children, please list their names and ages below.

Where do you work? What does your job involve? How long have you had this job?

_____

_____

Do you smoke now? _____ How much? _____ How many years? _____

Did you ever smoke? ___ *If yes:*

How many packs/day? _ How many years? _____

When did you quit? _____

Do you drink alcohol? _____ If so, how much? _____

Do you use drugs like marijuana, cocaine, etc? _____

What do you aim for your weight to be, five years from now? _____

***Diet History:***

List the supervised diet plans you have tried in your life (supervised diets include the following: Physician/dietitian supervised diet, Weight Watchers, Medifast, Optifast, LA Weight Loss center, Jenny Craig and others). Do not list unsupervised diets like Atkins, Slimfast, or anything else that you have done on your own.

| Year | Supervised | Diet Name | Duration 3,6,9 months etc. | Wt. Lost | Wt. Regained Y or N | Documentation Available Y or N |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Please list below any medication you have tried including: Phen-fen, Phenteramine, Meridia, Redux, Xenicol, or Metabolife.

| Year | Supervised | Diet Name | Duration 3,6,9 months etc. | Wt. Lost | Wt. Regained Y or N | Documentation Available Y or N |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

What is the most weight you have lost during any diet program? _____

## Dietary History:

1. Are you a vegetarian? Yes No

   If yes, what type? Vegan Lacto-ovo

Answer each question to the best of your ability. Circle your responses in both the frequency and time frame sections

| How Often Do You: | Frequency Circle One | | | | | | | | Time Frame Circle One |
|---|---|---|---|---|---|---|---|---|---|
| 1. Drink 100% juice | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 2. Drink other fruit drink | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 3. Drink regular soda | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 4. Drink diet soda | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 5. Drink coffee | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 6. Drink tea | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 6. Drink alcohol | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 7. Drink milk (any kind, i.e, whole, skim, soy, etc.) | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 8. Eat yogurt | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 8. Drink water (#of glasses) | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 9. Have meal replacement drinks | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 10. Eat beef | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 11. Eat pork | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 12. Eat chicken | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 13. Eat turkey | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 15. Eat fish | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 16. Eat cheese | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 17. Eat cottage cheese | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 18. Eat eggs | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 19. Eat fruits | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 20. Eat vegetables | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 21. Eat fried foods | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 22. Eat fast food | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 23. Eat at restaurants | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 24. Use artificial sweetener | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 25. Binge eat | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 26. Purge(make your self vomit) | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 27. Take a vitamin supplement | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 28. Take a herbal supplement Name Type(s)_____ | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |

**Dietary History (cont.):**

2. How many meals do you eat per day?_____ How many snacks? _____

3. Do you have any food allergies? Yes No If yes please list _____

_____

4. Do you have any food intolerances? Yes No. If yes please list _____

_____

Please use this space to provide any other information that you think is important to understanding you and/or your weight and your successful participation in the program.

# PATIENT REGISTRATION

*Please fill out this form completely.*

Patient Name: _____ Today's Date:_____

Address: _____City: _____State: _____ Zip: _____

Evening: (  ) _____ Day Phone: (  ) _____Cell: (  ) _____

Date of Birth: _____ Soc Sec# _____Age: _____Sex _____Ht: _____ Wt: _____

Marital Status: ____ Single ____ Married ____Divorced ____ Separated_____ Widowed _____

Race: __ White: ___African American __ American Indian __ Alaska Native __ Pacific Islander __Choose to not answer

Email Address: _____

Occupation: _____Employer:_____

Employee Address: _____City: _____ St: _____

Zip: _____Employer Phone: _____

Primary Care Physician: _____Phone #: _____Fax _____

## HOW DID YOU HEAR ABOUT US?

TV (which program): _____ Doctor: _____

Radio (which station): _____ Internet: _____- which website/search engine: _____

Newspaper (which one) _____ Newspaper (which one): _____

Billboard: _____ Word of Mouth: _____ Friend: _____Patient: _____

Self –Pay or Financed Patient _____

## INSURANCE INFORMATION

Primary Insurance: ____ Medicare ____ Medicaid _____ HMO _____ PPO _____POS _____Other

Primary Card Holder's Name _____Primary Card Holder's SSN#_____

Relationship to patient: _____ Insurance Name: _____ Phone: _____

Policy #: _____ Group #: _____ ID# _____

Claims Address: _____

**Secondary Insurance: ____ Medicare ___ Medicaid ___ HMO ___ PPO ___POS ____Other**

Primary Card Holder's Name _____Primary Card Holder's SSN#_____

Relationship to patient: _____ Insurance Name: _____ Phone: _____

Policy #: _____ Group #: _____ ID# _____

Claims Address: _____

**Emergency Contact: _____ Relationship: _____**

**Emergency Contact Phone number: _____**

Would it be best to contact you by ____ phone or ____ email? If by phone when is the best time of day to reach you (between 9:00 am and 5:00 p.m.)? _____ At what number? _____ A specific day of the week? _____

I, the undersigned, certify that the above information given by me is correct.

Patient Signature _____ Date: _____