BAPTIST HEALTH BARIATRIC SURGERY
100 PROFESSIONAL DRIVE, SUITE 2
LONDON, KY 40741
PHONE (606) 330-4175 FAX (606) 330-4178
DR. JAHAN MIREMAMI

PATIENT INFORMATION PACKET

Preferred Procedure:

◯ **Laparoscopic Sleeve Gastrectomy**

Are you able to read, write, and communicate in English language? ◯ **YES** ◯ **NO**

If not, what is your primary language? ______________________________

Please list any other barriers to communication, or special accommodations that you require:

____

Patient Information:

First Name: ______________ **Middle Name:** ________ **Last Name:** ______________

Soc. Sec. Number (Required) __________ **DOB**________ **Age**_____ **Gender:** ○ **Male** ○ **Female**

Marital Status: ◯ **Married** ◯ **Single** ◯ **Divorced** ◯ **Separated** ◯ **Partnered** ◯ **Widow(er)**

How many children do you have (please list ages)? ______________________________

Ethnicity: ◯ **African American** ◯ **Hispanic** ◯ **Native American/Alaska Native** ◯ **Asian** ◯ **Caucasian**

◯ **Native Hawaiian/ other Pacific Islander** ◯ **Other**__________________

◯ **Wish not to specify**

Religious affiliation: __________________ **Patient's level of Education:** ______________

Height? _____**ft.** _____**in.** **Weight?** _______**lbs.** _______ **kilo** **BMI:** _______

Ideal Body Weight? __________

Address Info:

Street Address: ______________________________

City: ______________ **State:** ________ **Zip Code:** __________________

Email: ______________________ **Phone (home):** __________________

Phone (work): ____________________ **Phone (cell):** ____________________

OK to leave message at: ◯ **Work** ◯ **Home** ◯ **Cell**

Employment Information:

◯ **Full Time** ◯ **Part Time** ◯ **Retired** ◯ **Disabled** ◯ **Student** ◯ **Unemployed** ◯ **Homemaker** ◯ **Leave of Absence**

Current Employer: ________________________**Years Employed:** __________________

Employer's Address: ______________________________

Present or Former Occupation: ______________________________

If disabled specify year and cause: ______________________________

Can you walk unassisted? ◯ **YES** ◯ **NO** **How far walking before needing rest?** __________________ **(approximate # feet)**

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If you need assistant walking, what device(s) do you use? ◯ Cane ◯ Walker ◯ Crutches ◯ Other: ________________

Are you wheelchair bound and unable to stand at all? ◯ YES ◯ No How long in wheelchair? _______________ (month/year)

Do you have a Medical Surrogate, Power of Attorney, or anyone who makes medical decisions? ◯ YES ◯ NO

If yes, who? ____

Relationship to you? ____

Spouse Information:

Spouse Name: ____ Spouse's DOB: ____________________

Spouse's Employment Status: ◯ Full Time ◯ Part Time ◯ Retired ◯ Disabled ◯ Student ◯ Unemployed ◯ Homemaker

Spouse's Soc. Sec.:_______________________ Spouse's Employer: ____

Spouse's Employer Address: ____Years employed: _____________

Spouse's Cell: ____________________________________ May we contact your spouse? ◯ YES ◯ NO

Insurance Information: (This MUST be completed in addition to sending in a copy of your insurance cards)

Payment Type: ◯ Insurance ◯ Self-Pay

Primary Insurance: ___________________________________ Policy Number: __________________________________

Group #: ____________________________ Subscriber's Name: ____

Subscriber's DOB: _______________________ Insurance Provider Phone Number: ________________________________

Secondary Insurance: _________________________________ Policy Number: __________________________________

Group #: __________________________________ Subscriber's Name: _______________________________________

Subscriber's DOB: ____________________________ Insurance Provider Phone Number: ___________________________

Emergency Contact:

First Name: ____ Last Name: ______________________________________

Relationship to you? ___________________________________ Phone: ____

** I hereby authorize BHMG-Bariatric Surgery to discuss my process, test results, and any appointments with the following named person(s):**

Name: ____ Relationship: ______________________________________

Name: ____ Relationship: ______________________________________

Patient's Signature: ____ Date: ________________________________

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Primary Care Physician:

Name: ____

Address: ____

City: __________________________ **State:** ____________ **Zip Code:** ____________________

Have you discussed Weight Loss Surgery with this doctor? ◯ YES ◯ NO **Is this doctor supportive?** ◯ YES ◯ NO

How did you hear about us? ____

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

General:

◯ Fevers ◯ Night Sweats ◯ Appetite Change ◯ Weight Gain ◯ Insomnia ◯ Tired/No Energy ◯ Hair Loss ◯ NONE

◯ Other: ____________________

Head and Neck:

◯ Wear Glasses/Contacts ◯Sinus Drainage ◯Dentures, Partial/Full ◯Regular Ear Infections ◯ Vision Problems ◯Nose bleeds

◯ Allergies ◯Blurred/Double Vison ◯Hearing Problems ◯ Hoarseness ◯ Glaucoma ◯ NONE ◯ Other: ______________

Cardiovascular:

◯ Heart Attack ◯ Congestive Heart Failure ◯ Varicose Veins ◯ Ankle/Leg Ulcers ◯ Clogged Arteries ◯Irregular Heart Beat

◯ Atrial Fibrillation ◯ Chest Pain w/ activity ◯ High Blood Pressure ◯ Dyspnea on Exertion ◯ Elevated Triglycerides

◯ MVP/Valve Damage/Rheumatic Fever ◯ Leg Cramps ◯Elevated Cholesterol ◯ Rhythm Changes ◯ Palpitations ◯ DVT

◯ Ankle Swelling ◯ Rapid Heart Beat ◯ Heart Murmur ◯ NONE ◯ Other: ____________________________

Respiratory:

◯ Asthma ◯ Pneumonia ◯ Use of CPAP/Bipap ◯ Pulmonary Embolism ◯ Emphysema/COPD ◯Chronic Cough ◯Use of Oxygen

◯ Sleep Apnea ◯ Bronchitis ◯ Shortness of Breath at Rest ◯ Snoring ◯ NONE ◯ Other: ______________________

Gastrointestinal:

◯ Heartburn ◯ Diarrhea ◯ Constipation ◯ Difficulty Swallowing ◯ Rectal Bleeding ◯ Abdominal Pain ◯ Gallbladder Issues

◯ Nausea/Vomiting ◯ Barrett's Esophagus ◯ Hiatal Hernia ◯ Blood in Stool ◯ IBS ◯ Hemorrhoids ◯ Black, Tarry Stools

◯ Enlarged Liver ◯ Jaundice ◯ GERD ◯ Ulcers ◯ History of Liver Enzymes ◯ Umbilical Hernia ◯ Fissure/Polyps

◯ Ventral Hernia ◯ Cirrhosis/Hepatitis ◯ Pancreatic Disease ◯ Incisional Hernia ◯ NONE ◯ Other: ________________

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Endocrine:

◯ Parathyroid ◯ Low Blood Sugar ◯ "Pre-Diabetes" ◯ Abnormal Facial Hair ◯ Hypothyroid ◯ Excessive Thirst ◯ Hypothyroid

◯ Diabetes ◯ Excessive Urination ◯ Goiter ◯ Endocrine Gland Tumor ◯ Gout ◯ NONE ◯ Other: ___________________________

Bladder/Kidney:

◯ Kidney Stones ◯ Kidney Failure/Renal Insufficiency ◯ Trouble starting urine ◯ Loss of bladder control ◯ Blood in urine

◯ Leaking urine w/ cough, laugh, sneeze ◯ Burning/Pain on urination ◯ Prostate Problems ◯ Men: PSA test in last year?

◯ Menstrual Pain ◯ NONE ◯ Other: ____

Gynecologic (For Women ONLY)

◯ Infertility/Problems Conceiving ◯ PCOS ◯ Excessively Heavy Periods ◯ Currently Pregnant ◯ Irregular Periods

◯ Post-Menopausal ◯ Menstrual Pain ◯ Uterine/Ovarian Cancer ◯ Plan to have more children ◯ NONE ◯ Other: _________

Breast:

◯ Pain ◯ Lumps/ Fibrocystic Disease ◯ Cancer ◯ NONE ◯ Other: ____

Musculoskeletal:

◯ Shoulder Pain ◯ Hip Pain ◯ Foot Pain ◯ Plantar Fasciitis ◯ Broken Bones ◯ Muscle Pain/Spasm ◯ Fibromyalgia

◯ Neck Pain ◯ Wrist Pain ◯ Knee Pain ◯ Heel Pain ◯ Carpal Tunnel ◯ Sciatica ◯ Elbow Pain ◯ Back Pain ◯ Lupus

◯ Ankle Pain ◯ Ball of Foot Pain ◯ Rheumatoid Arthritis ◯ NONE ◯ Other: ____

Neurologic:

◯ Balance Disturbance ◯ Stroke ◯ Knocked Unconscious ◯ Loss of vision from high pressure in brain ◯ Dizziness ◯ Seizures

◯ Convulsions ◯ Numbness/Tingling ◯ Restless Leg Syndrome ◯ Weakness ◯ Multiple Sclerosis ◯ NONE

◯ Other: ____

Psychiatric: ◯ NONE **Are you currently under the care of a mental health provider?** ◯ YES ◯ NO

◯ Depression ◯ Bipolar Disorder ◯ Alcoholism/Substance Abuse ◯ Been in chemical dependency program

◯ Currently taking medications for psychiatric problems/depression ◯ Attention Deficit Disorder ◯ Anxiety

◯ Seen a psychiatrist/or counselor ◯ Been hospitalized for psychiatric problems ◯ Attempted Suicide ◯ Victim of Abuse

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Blood/Lymphatic:

◯ Low Platelets ◯ Bruises Easily ◯ Bleeding/Clotting Disorder ◯ Prior Blood Transfusion ◯ Anemia ◯ Lymphoma ◯ HIV/Aids

◯ Swollen Lymph Nodes ◯ History of DVT/PE ◯ NONE ◯ Other: ____

Skin:

◯ Frequent Skin Infections ◯ Psoriasis ◯ Hair/Nail Changes ◯ Keloids (Raised Scars) ◯ Rash under breast/skin folds ◯ Rosacea

◯ Poor Wound Healing ◯ NONE ◯ Other: ____

Family Medical History: (Check All That Apply)								
	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Morbid Obesity								
Diabetes: Age Occurred/Diagnosed								
High Blood Pressure								
Stroke: Age Occurred								
Heart Attack: Age Occurred								
Cardiovascular Disease								
Sleep Apnea								
Cancer: Type & Age Occurred								
Death: Age & Cause								
If living, what age								

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Social History:

Do you smoke now? ◯ Yes ◯ No If yes, how many packs per day? ____________________

Have you smoked in the past? ◯ Yes ◯ No Date you quit smoking? ____________________

Do you use smokeless tobacco (dip/chew)? ◯ Yes ◯ No How frequently do you use? ____________________

Do you consume alcohol? ◯ Yes ◯ No How many times per week? ____________________

How many years do/did you drink alcohol? ____________________

Has anyone ever voiced concern over your alcohol use? ____________________

Have you ever used street drugs? ◯ Yes ◯ No If so what type? ____________________

How long since you last used street drugs? ____________________

How frequently do you use drugs? ____________________ When did you quit? ____________________

Has anyone ever voiced concern over your drug use? ____________________

Blood Consent: **YOU MUST BE WILLING TO ACCEPT BLOOD PRODUCTS DURING OR AFTER SURGERY IF YOUR CONDITION IS SUCH THAT THE PHYSICIAN DEEMS IT NECESSARY**

◯ Jehovah's Witness

Patient's Signature: ____________________ Date: ____________________

Allergies: ◯ Latex, Reaction ____________________

◯ Iodine, Reaction ____________________

◯ Tape/Adhesives, Reaction____________________

◯ IV Contrast Dye, Reaction____________________

◯ No Known Allergies/NONE ____________________

Medications (list any medication and your reaction) ____________________

Foods (list all and reaction) ____________________

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Please list all routine medications you take

Medication Name	Taken for what condition	Dose/How often

Surgical History

Gallbladder: ◯ Open ◯ Laparoscopic	Nissen Fundoplication ◯ Yes ◯ No
Appendectomy: ◯ Open ◯ Laparoscopic	Tonsillectomy Year
Hysterectomy: ◯ Total ◯ Partial	Mouth Surgery Year
Hernia: ◯ Hiatal ◯ Abdominal	Kidney Surgery ◯ Yes ◯ No
Tubal Ligation ◯ Yes ◯ No	Heart Surgery (type) Year
Cesarean Section ◯ Yes ◯ No	Other:
Colonoscopy ◯ Yes ◯ No	
Endoscopy ◯ Yes ◯ No	

Previous Weight Loss Surgery: ____

(We will need a copy of the Operation Report from your previous surgery)

List any complications of WLS: ____

Weight prior to surgery: _________________ **Lowest weight achieved**______________________

Anesthesia Problems:

◯ Nausea ◯ Vomiting ◯ Difficulty Waking Up ◯ Breathing Stopped ◯ Heart Stopped

◯ Difficulty Urinating ◯ Woke up during surgery ◯ NONE ◯ Other: ___________________________________

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Weight Loss History:

What is your maximum lifetime weight? _________________ **How long have you been overweight?** ___________________

How long have you been 35 pounds overweight? _________________ **At what age did you start dieting?** _______________

How long have you been 100 pounds or more overweight? ____

Have you ever had “stomach stapling” or gastric restriction procedure? ____

What is the most weight you have ever lost on a single diet? __________**How did you lose the weight?** __________________

How long did you sustain the weight loss? _________________ ◯ **No diet attempts of any kind**

Unsupervised Diet Attempts:

◯ Body for Life ◯ Gloria Marshall ◯ Richard Simmons ◯ Health Spa ◯ High Protein ◯ Stillman Diet ◯ Herbal Life

◯ Sugar Busters ◯ Low Carb ◯ Low Fat ◯ Mayo Clinic ◯ Calorie Counting ◯ Atkin’s Diet ◯ South Beach ◯ Fasting

◯ Cabbage Soup ◯ Scarsdale ◯ Slim Fast ◯ Other: ____

Supervised Diet Attempts:

◯ Nutri-System ◯ TOPS ◯ LA Weight Loss ◯ Overeaters Anonymous ◯ Optifast ◯ Diet Center ◯ Weight Watchers

◯ HMR ◯ Jenny Craig ◯DASH ◯ Other: ____

Weight Loss Medications:

◯ Acutrim ◯ Dexatrim ◯ Wellbutrin ◯ Amphetamines ◯ Adipex ◯ Didrex ◯ Phendiet ◯ Tenuate ◯Prozac

Other: ____

Thank you for taking the time to fill out our Patient Profile Packet.

Please mail completed packet and copy of insurance cards to the following address:

Baptist Health Bariatric Surgery-Dr. Jahan Miremami

100 Professional Drive, Suite 2

London, KY 47041

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Fax (606) 330-4178

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