Patient Information Packet

BAPTIST HEALTH® MEDICAL GROUP

Preferred procedure

- ❍ Laparoscopic sleeve gastrectomy
- ❍ Laparoscopic greater curvature plication (LGCP)
- ❍ Laparoscopic adjustable gastric banding
- ❍ Laparoscopic Roux-en-Y gastric bypass

Choose a surgeon

- ❍ G. Derek Weiss, MD
- ❍ Paige Quintero, MD
- ❍ Undecided

Previous revision/weight-loss surgery

Original surgery:_____

Date of surgery:_____

Surgeon: _____

Revision type

- ❍ Laparoscopic sleeve gastrectomy
- ❍ Stomach intestinal pylorus-sparing (SIPS) surgery

Are you able to read, write and communicate in the English language? ❍ Yes ❍ No

If not, what is your primary language?_____

List any other barriers to communication or special accommodations that you require: _____

Patient information

First name:_____ Middle name:_____ Last name:_____

Social Security number:_____ Date of birth:_____ Age:_____ Gender: ❍ Female ❍ Male

Marital status: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Partnered ❍ Widow(er)

How many children do you have (list ages)?_____

Ethnicity: ❍ African American ❍ Hispanic ❍ Native American or Alaska Native ❍ Choose not to specify

❍ Asian ❍ Caucasian ❍ Native Hawaiian / Other Pacific Islander ❍ Other:_____

Religious affiliation:_____ Patient's level of education:_____

What is your height?_____ feet _____ inches How much do you weigh?_____ pounds BMI:_____

Address information

Street address:_____

City:_____ State:_____ ZIP code:_____

E-mail:_____ Phone (home):_____

Phone (work):_____ Phone (cell):_____

OK to leave message at: ❍ Home ❍ Work ❍ Cell

Patient employment information

Employment status: ❍ Full time ❍ Retired ❍ Disabled ❍ Student

❍ Part time ❍ Unemployed ❍ Homemaker ❍ Leave of absence

Patient's current employer:_____ Years employed:_____

Employer's address:_____

Patient's present or former occupation:_____

Disabled? ❍ Yes ❍ No If yes, specify the year and cause: Year:_____ Cause:_____

Can you walk unassisted? ❍ Yes ❍ No How many feet can you walk before needing rest?_____

If you need assistance walking, what device(s) do you use? ❍ Cane ❍ Walker ❍ Crutches ❍ Other:_____

Are you wheelchair bound and unable to stand? ❍ Yes ❍ No How long in a wheelchair?_____ (Month/year)

Do you have a medical surrogate, power of attorney or anyone who makes your medical decisions?

❍ Yes ❍ No If yes, who?_____ Relationship to you?_____

Spouse information

Spouse's name:_____ Spouse's date of birth:_____

Spouse's employment status: ❍ Full time ❍ Retired ❍ Disabled ❍ Student
❍ Part time ❍ Unemployed ❍ Homemaker ❍ Leave of absence

Spouse's occupation:_____ Spouse's SSN:_____

Spouse's employer:_____ Years employed:_____

Employer's address:_____ Spouse's cell phone:_____

Insurance information (This section must be filled out in addition to sending in a copy of your insurance card.)

Payment type: ❍ Insurance ❍ Self-pay

Primary insurance

Insurance company:_____

Policy number:_____ Group number:_____

Subscriber name:_____ Subscriber date of birth:_____

Customer service phone:_____ Provider phone:_____

Secondary insurance

Insurance company:_____

Policy number:_____ Group number:_____

Subscriber name:_____ Subscriber date of birth:_____

Customer service phone:_____ Provider phone:_____

Emergency contact

First name:_____ Last name:_____

Relation to you:_____ Phone:_____

"I hereby authorize Baptist Health Medical Group Bariatric Surgery to discuss my process, diagnostic test results, and any scheduled appointments with the following named person(s):"

Name:_____ Relation to you:_____

Name:_____ Relation to you:_____

Patient signature:_____ Date:_____

Primary care physician

First name:_____ Last name:_____

Street address:_____

City:_____ State:_____ ZIP code:_____ Phone:_____

Have you discussed weight-loss surgery with your physician? ❍ Yes ❍ No Is your physician supportive? ❍ Yes ❍ No

How did you hear about us? ☐ Radio ☐ TV ☐ Newspaper ☐ Family/friend ☐ Internet ☐ Social media
☐ Other:_____

Medical history/review of symptoms (Check all that apply.)

General: ☐ **NONE**

☐ Fevers ☐ Weight gain ☐ Tired/no energy

☐ Night sweats ☐ Insomnia ☐ Hair loss

☐ Appetite change ☐ Other:_____

Head and neck: ☐ **NONE**

☐ Wear contacts/glasses ☐ Vision problems ☐ Hearing problems

☐ Sinus drainage ☐ Nosebleeds ☐ Hoarseness

☐ Dentures, partial/full ☐ Allergies ☐ Glaucoma

☐ Regular ear infections ☐ Blurred/double vision ☐ Other:_____

Cardiovascular: ☐ **NONE**

☐ Heart attack ☐ Chest pain w/activity ☐ Rhythm changes

☐ Congestive heart failure ☐ High blood pressure ☐ Palpitations

☐ Varicose veins ☐ Dyspnea on exertion ☐ Ankle swelling

☐ Ankle/leg ulcers ☐ Elevated triglycerides ☐ Phlebitis/deep vein thrombosis

☐ Clogged heart arteries ☐ Rheumatic fever/valve damage/MVP ☐ Rapid heartbeat

☐ Irregular heartbeat ☐ Cramping in legs when walking ☐ Heart murmur

☐ Atrial fibrillation ☐ Elevated cholesterol ☐ Other:_____

Respiratory: ☐ **NONE**

☐ Asthma ☐ Emphysema/COPD ☐ Bronchitis

☐ Pneumonia ☐ Chronic cough ☐ Shortness of breath at rest

☐ Use CPAP/BiPAP ☐ Use of oxygen ☐ Snoring

☐ Pulmonary embolism ☐ Sleep apnea ☐ Other:_____

Endocrine: ☐ **NONE**

☐ Parathyroid ☐ Hypothyroid ☐ Goiter

☐ Low blood sugar ☐ Excessive thirst ☐ Endocrine gland tumor

☐ Prediabetes ☐ Diabetes (diet or pills) ☐ Diabetes (insulin shots)

☐ Abnormal facial hair ☐ Excessive urination ☐ Gout

☐ Other:_____

Gastrointestinal: ☐ **NONE**

☐ Heartburn ☐ Hiatal hernia ☐ Ulcers

☐ Diarrhea ☐ Blood in stool ☐ History of liver enzymes

☐ Constipation ☐ IBS ☐ Umbilical hernia

☐ Difficulty swallowing ☐ Hemorrhoids ☐ Fissure/polyps

☐ Rectal bleeding ☐ Black, tarry stool ☐ Ventral hernia

☐ Abdominal pain ☐ Enlarged liver ☐ Cirrhosis/hepatitis

☐ Gallbladder problems ☐ Jaundice ☐ Pancreatic disease

☐ Nausea/vomiting ☐ GERD ☐ Incisional hernia

☐ Barrett's esophagus ☐ Other:_____

Bladder/kidney: ☐ **NONE**

☐ Kidney stones ☐ Blood in urine ☐ Prostate problems

☐ Kidney failure/renal insufficiency ☐ Leaking urine w/cough/laugh/sneeze ☐ Men: PSA test in last year?

☐ Trouble starting urine ☐ Burning/pain on urination ☐ Urinary urgency/frequency

☐ Overall loss of bladder control ☐ Other:_____

Gynecologic: (for women only) ☐ **NONE**

☐ Problems conceiving/infertility ☐ Currently pregnant ☐ Uterine/ovarian cancer

☐ PCOS ☐ Menstrual irregularity ☐ Menstrual pain

☐ Excessively heavy periods ☐ Plan to have more children ☐ Postmenopausal

Breast: ☐ **NONE** ☐ Cancer

☐ Pain ☐ Lumps/fibrocystic disease ☐ Other:_____

Musculoskeletal: ☐ **NONE**

☐ Shoulder pain ☐ Neck pain ☐ Elbow pain

☐ Hip pain ☐ Wrist pain ☐ Back pain

☐ Foot pain ☐ Knee pain ☐ Ankle pain

☐ Plantar fasciitis ☐ Heel pain ☐ Ball of foot pain

☐ Broken bones ☐ Carpal tunnel syndrome ☐ Lupus

☐ Muscle pain/spasm ☐ Sciatica ☐ Rheumatoid arthritis

☐ Fibromyalgia ☐ Other:_____

Neurologic: ☐ **NONE**

☐ Balance disturbance ☐ Dizziness ☐ Restless leg syndrome

☐ Stroke ☐ Seizures or convulsions ☐ Weakness

☐ Knocked unconscious ☐ Numbness/tingling ☐ Multiple sclerosis

☐ Pseudotumor cerebri (loss of vision from high pressure in the brain) ☐ Other:_____

Psychiatric: ☐ **NONE** **Are you currently under the care of a mental health provider?** ☐ **Yes** ☐ **No**

☐ Depression ☐ Anxiety

☐ Bipolar disorder ☐ Have seen a psychiatrist or counselor

☐ Alcoholism/substance use disorder ☐ Been hospitalized for psychiatric problems

☐ Been in a chemical dependency program ☐ Attempted suicide

☐ Currently taking medications for psychiatric problems or for depression ☐ Experienced mental/emotional/sexual/physical abuse

☐ Attention deficit disorder ☐ Other:_____

Blood/lymphatic: ☐ **NONE**

☐ Low platelets (thrombocytopenia) ☐ Anemia ☐ HIV/AIDS

☐ Bruise easily ☐ Lymphoma ☐ Swollen lymph nodes

☐ Bleeding/clotting disorder ☐ Blood thinning medication use ☐ History of DVT/PE

☐ Prior blood transfusion ☐ Other:_____

Skin: ☐ **NONE**

☐ Frequent skin infections ☐ Keloids (excessively raised scars) ☐ Poor wound healing

☐ Psoriasis ☐ Rashes under breasts/skin folds ☐ Rosacea

☐ Hair or nail changes ☐ Other:_____

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 occurred							
High blood pressure							
Stroke - age occurred							
Heart attack - age occurred							
Cardiovascular disease							
Sleep apnea							
Cancer: type & age occurred							
Death - age & cause							
If still living, current age							

Social history

Do you smoke now? ❍ Yes ❍ No If yes, how many packs per day?_____

Have you smoked in the past? ❍ Yes ❍ No If you have quit, how many years since?_____

For how many years did you use tobacco? _____ years

Do you use snuff or chew? ❍ Yes ❍ No If yes, how frequently do you use?_____

Do you consume alcohol now? ❍ Yes ❍ No

If yes, how many times per week? _____ If yes, how many drinks each time?_____

For how many years do/did you drink alcohol?_____ years

Is anyone concerned about the amount you drink? ❍ Yes ❍ No If you have quit, how many years since?_____

Do you use street drugs now? ❍ Yes ❍ No If yes, which drugs?_____

If yes, how frequently do you use these drugs?_____ If you have quit, how many years since?_____

Blood consent

*****You must be willing to accept blood or blood products during or after surgery if your condition is such that the physician deems it necessary. (❍ *check if you are a Jehovah's Witness)*

Patient signature:_____ Date:_____

Allergies: ☐ NONE

☐ Latex, reaction:_____ ☐ Tape (adhesives), reaction:_____

☐ Iodine, reaction:_____ ☐ IV contrast dye, reaction:_____

Medications (List any medications that you are allergic to and your reaction.):_____

_____

Foods (List foods and your reaction.):_____

List prescribed medications:	**Taken for what condition:**	**Dosage/how often:**
☐ **NONE**		

Surgical procedure(s)	☐ **NONE**		**Year**		**Year**
Gallbladder:	❍ Open	❍ Laparoscopic	_____	Tonsillectomy	_____
Appendectomy:	❍ Open	❍ Laparoscopic	_____	Mouth surgery	_____
Hysterectomy:	❍ Total	❍ Partial	_____	Heart: ❍ CABG ❍ Stent ❍ Valve	_____
Hernia:	❍ Hiatal	❍ Abdominal	_____	Pacemaker	_____
Tubal ligation			_____	Back:_____	_____
Cesarean section			_____	Knee: ❍ Right ❍ Left	_____
Colonoscopy			_____	Kidney surgery	_____
Endoscopy			_____	Other:_____	_____
Nissen fundoplication			_____	Other:_____	_____

Previous weight-loss surgery (WLS): _____

(We will need a copy of the surgical report from your previous weight-loss surgery.)

List any complications of WLS: _____

Original weight prior to surgery: _____ ❍ Estimated ❍ Actual Lowest weight achieved: _____ ❍ Estimated ❍ Actual

Anesthesia problems: Please tell us about any problems that you have had with anesthesia. ❍ **NONE**

❍ Nausea	❍ Heart stopped	❍ Woke up during procedure
❍ Vomiting	❍ Stopped breathing	❍ Other:_____
❍ Difficulty waking up	❍ Difficulty urinating	

Weight loss history:

What is your maximum lifetime weight? _____ How long have you been overweight?_____years

How long have you been 35 pounds overweight?_____years

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

What age did you start dieting?_____

Have you ever had a "stomach stapling" or other gastric restriction procedure? ❍ Yes ❍ No

(If yes, provide this information in your previous surgical history.)

What is the most weight you have ever lost on a single diet?_____ pounds How did you lose the weight?_____

How long did you sustain the weight loss?_____ ❍ No diet attempts of any kind.

Check all that apply.

Unsupervised diet attempts: ❍ NONE

❍ Body for Life/Bill Phillips	❍ High protein	❍ Low fat	❍ Cabbage soup
❍ Pritikin diet	❍ Stillman diet	❍ Mayo Clinic	❍ Fasting
❍ Gloria Marshall	❍ Herbalife	❍ Calorie counting	❍ Scarsdale diet
❍ Richard Simmons	❍ Sugar Busters	❍ Atkin's diet	❍ SlimFast
❍ Health spa	❍ Low carbohydrate	❍ South Beach Diet	❍ Other:_____

Supervised diet attempts: ❍ NONE

❍ Nutrisystem	❍ Overeaters Anonymous	❍ WeightWatchers®	❍ Jenny Craig
❍ TOPS	❍ Optifast®	❍ HMR	❍ DASH
❍ LA Weight Loss	❍ Diet Center	❍ Other:_____	

Over-the-counter or prescribed medications for weight loss: ❍ NONE

❍ Acutrim®	❍ Dexatrim	❍ Ionamin/Adipex	❍ Phendiet	❍ Prozac
❍ Wellbutrin	❍ Amphetamines	❍ Didrex	❍ Tenuate	❍ Phentrol

Thank you for taking the time to fill out our patient profile packet.

Mail the completed packet and a copy of your insurance card to the following address:

Baptist Health Medical Group Bariatric Surgery
2716 Old Rosebud Road, Suite 350
Lexington, KY 40509
Phone: 859.543.1577
Fax: 859.543.1637