BAPTIST HEALTH®

MEDICAL GROUP

# Patient Information Packet

**Preferred Procedure:**

- ❍ Laparoscopic Adjustable Gastric Banding
- ❍ Laparoscopic Roux-en-Y Gastric Bypass
- ❍ Revision-Previous Weight Loss Surgery
- ❍ Laparoscopic Sleeve Gastrectomy

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

If not, what is your primary language?_____

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

**Do you have a healthcare companion or caretaker? ❍ YES ❍ NO**

**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

How many children do you have (please 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?_____ft _____in How much do you weigh?_____lbs. BMI:_____**

**Address Information:**

Street Address:_____

City:_____ State:_____ Zip Code:_____

E-mail:_____ Phone (home):_____

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

**Patient Employment Information:**

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

Patient's Current Employer:_____ Years Employed:_____

Patient's 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 far before needing rest?_____ (Approximate # of feet)

If you need assistance 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 your medical decisions?**

❍ **YES** ❍ **NO** If yes, who?_____Relationship to you?_____

**Do you have a living will?** ❍ YES ❍ NO

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**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:_____

Spouse's Employer's address:_____ Spouse's Cell Phone:_____

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**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 #:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Customer Service Phone:_____ Provider Phone:_____

**Secondary Insurance**

Insurance Company:_____

Policy Number:_____ Group #:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Customer Service Phone:_____ Provider Phone:_____

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**Emergency Contact**

First Name:_____ Last Name:_____

Relation to you:_____Phone:_____

"I hereby authorize Baptist Health Medical Group to discuss my process, diagnostic test results and any scheduled appointments with the following named person(s), and further consent to the staff leaving messages for me on a voicemail/answering machine":

Name:_____ Relation to you:_____

Name:_____ Relation to you:_____

Patient Signature:_____ Date:_____

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**Primary/Referring 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 ☐ Other:_____

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**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. (❍ *If Jehovah's Witness please check)*

Patient Signature:_____Date:_____

**Weight Loss History**

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 When did you start dieting?_____Age

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

**(If yes, please provide this information when entering in your previous surgical history.)**

What is the most weight you have ever lost on a single diet?_____lbs. 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 | ❍ Stillman Diet | ❍ Mayo Clinic | ❍ Fasting |
| ❍ Gloria Marshall | ❍ Herbal Life | ❍ Calorie Counting | ❍ Scarsdale |
| ❍ Richard Simmons | ❍ Sugar Busters | ❍ Atkin's Diet | ❍ Slim Fast |
| ❍ Health Spa | ❍ Low Carbohydrate | ❍ South Beach | ❍ Other:_____ |

**Supervised Diet Attempts: ❍ NONE**

| | | | |
|---|---|---|---|
| ❍ Nutri-System | ❍ Overeaters Anonymous | ❍ Weight Watchers | ❍ 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 |
| ❍ Redux | ❍ Byetta | ❍ Plegine | ❍ Sanorex | ❍ Meridia |
| ❍ Xenical | ❍ Diuretics | ❍ Pondimin | ❍ Phenteramine | |
| ❍ Fen-Phen, | | | | |

# of months:_____ ❍ Other:_____

**Behavioral Treatments for Weight Loss: ❍ NONE**

| | |
|---|---|
| ❍ Hospitalization | ❍ Hypnosis |
| ❍ Physical Therapy | ❍ Psychological Therapy |
| ❍ Residential Programs | ❍ Other:_____ |

**Exercise: ❍ NONE**

| | |
|---|---|
| ❍ Walking or Running | ❍ Stationary cycle or treadmill |
| ❍ Swimming | ❍ Weight Training |
| ❍ Team Sports | ❍ Other:_____ |

**Eating Habits, Do you:**

Snack between meals? ❍ Yes ❍ No

Eat a lot of sweets? ❍ Yes ❍ No

Drink caffeine-containing drinks? ❍ Yes ❍ No

- If yes, how many cups per day?_____

Eat large meals? (gorge) ❍ Yes ❍ No

Drink carbonated beverages? ❍ Yes ❍ No

- If yes, how many cans/bottles per day?_____

Drink soda pop? ❍ Yes ❍ No ❍ Diet ❍ Regular

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

❍ Binging and Purging ❍ Binging followed by food restriction ❍ Vomiting

❍ Excessive Exercise ❍ Excessive Calorie Restriction/Fasting

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

Do you currently force yourself to vomit after eating? ❍ Yes ❍ No

Why do you feel you eat? ❍ Physical Hunger ❍ Loneliness ❍ Anxiousness ❍ Makes me happy ❍ Bored

What reasons do you feel contribute to your weight? ❍ Over Consumption ❍ Inactivity ❍ Emotional Wellbeing

What else contributes to your weight struggle, i.e. how do you account for why you have been unable to lose weight and/or maintain?

_____

_____

Please tell us how your weight is interfering with your health and life? _____

_____

**Why are you seeking weight loss surgery?** _____

_____

Please tell us why you feel you can be successful with weight loss surgery, despite the extreme lifestyle and dietary changes required?

_____

_____

If you use eating as an emotional outlet, what will you substitute when your eating is restricted?_____

_____

_____

**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 | ☐ Nose Bleeds | ☐ 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 | ☐ Shortness of Breath on Exertion | ☐ Ankle Swelling |
| ☐ Ankle / Leg Ulcers | ☐ Elevated Triglycerides | ☐ Phlebitis / DVT |
| ☐ Clogged Heart Arteries | ☐ Rheumatic Fever / Valve Damage / MVP | ☐ Rapid Heart Beat |
| ☐ Irregular Heart Beat | ☐ 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 of CPAP / BiPAP | ☐ Use of Oxygen | ☐ Snoring |
| ☐ Pulmonary Embolism | ☐ Sleep Apnea | ☐ Had a sleep study; when:_____ |
| ☐ Other:_____ | | |

| **Gastrointestinal** | ☐ **NONE** | |
|---|---|---|
| ☐ Heartburn | ☐ Hiatal Hernia | ☐ Ulcers |
| ☐ Diarrhea | ☐ Blood in Stool | ☐ History of elevated Liver Enzymes |
| ☐ Constipation | ☐ IBS (irritable bowel syndrome) | ☐ 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/sneezing | ☐ Men: PSA test in last year? |
| ☐ Overall Loss of Bladder Control | ☐ Urinary Urgency/Frequency/Pain/Burning | ☐ 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 ☐ Post-Menopausal

Current method of birth control: _____

How many pregnancies have you had:_____ Date of Last Pap Smear?_____

How many miscarriages or abortions have you had:_____ Date of last menstrual period?_____

**Breast** ☐ **NONE**

☐ Nipple Discharge ☐ Lumps / Fibrocystic Disease ☐ Other:_____

☐ Pain ☐ Cancer Date of last Mammogram: _____

**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

☐ Pseudo tumor Cerebri (loss of vision from high pressure in brain) ☐ Other:_____

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

☐ Depression/Anxiety ☐ Hospitalized for psychiatric problems When:_____

☐ Bipolar Disorder ("manic-depression") ☐ Attempted suicide When: _____

☐ Alcoholism / Substance Abuse ___ Past? ___ Present? ☐ Experience Suicidal Ideation When: _____

☐ Been in a chemical dependency program When: _____ ☐ Inflicted self-harm When: _____

☐ Schizoaffective disorder ☐ Victim of Mental/Emotional/Sexual/Physical Abuse

☐ Borderline Personality Disorder ☐ Other:_____

**Endocrine** ☐ **NONE**

☐ Parathyroid ☐ Hypothyroid ☐ Goiter

☐ Low Blood Sugar ☐ Excessive Thirst ☐ Endocrine Gland Tumor

☐ "Pre-Diabetes" ☐ Diabetes (Diet or Pills) ☐ Diabetes (Insulin Shots)

☐ Abnormal Facial Hair ☐ Excessive Urination ☐ Gout

☐ PCOS

☐ Other:_____

**Blood/Lymphatic** ☐ **NONE**

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

☐ Bruise Easily ☐ Lymphoma ☐ Swollen Lymph Nodes

☐ Bleeding/Clotting Disorder ☐ Blood thinning medicine 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:_____

| **List Prescribed Medications:** | **Taken for what condition:** | **Dosage/How Often:** |
|---|---|---|
| ☐ **NONE** | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| **Current Pharmacy:** | **Address:** | **Phone #** |
|---|---|---|
| | | |

**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** ☐ **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 the reaction):_____

| **Surgical Procedure(s):** | ☐ **NONE** | **Year** | | **Year** |
|---|---|---|---|---|
| Gallbladder | (Open) | _____ | Tonsillectomy | _____ |
| Gallbladder | (Laparoscopic) | _____ | D & C | _____ |
| Appendectomy | (Open) | _____ | Ear Surgery:_____ | _____ |
| Appendectomy | (Laparoscopic) | _____ | Mouth Surgery:_____ | _____ |
| Hysterectomy | (Vaginal) | _____ | Heart surgery: CABG/Stents | _____ |
| Hysterectomy | (Abdominal) | _____ | Valve Replacement | _____ |
| Ovary Surgery: | ❍ Ovaries Removed | _____ | Pacemaker | _____ |

Hernia: ❍ Hiatal ❍ Inguinal ❍ Incisional ❍ Umbilical

| | | | | |
|---|---|---|---|---|
| Tubal Ligation | _____ | Knee: ❍ Right | ❍ Left | _____ |
| Cesarean Section | _____ | Breast Biopsy: ❍ Right | ❍ Left | _____ |
| Colonoscopy | _____ | Anti-reflux procedure / Nissen Fundoplication | | _____ |
| Hemorrhoidectomy | _____ | Kidney Surgery | | |
| Colon Resection | _____ | Back:_____ | | _____ |
| Endoscopy/EGD | _____ | Other:_____ | | _____ |

Previous Weight Loss Surgery (WLS): _____

**(We will need a copy of the Operation 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

**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 | |

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

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

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

**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, what age | | | | | | | |

Name of person completing packet: _____

Relationship to patient: _____

Signature of person completing packet: _____

Signature of patient: _____

Thank you for taking the time to complete the Patient Information Packet.
Please return this packet, a copy of your insurance cards front and back, and all signed insurance forms to Baptist Health Medical Group.