

**Department of General Surgery- Surgical Weight Loss Center
Lahey Hospital & Medical Center**

Referring Physician (*Doctor who sent you to see us*): _____

Primary Care Physician (*Internist/Family doctor*): _____

Reason for visit: _____

Medication Allergies:

<u>Drug</u>	<u>Reaction</u> (<i>rash, hives, throat closing</i>)

Medical History: (*Circle those that apply, both current and past*)

Abdominal pain	Diarrhea	Palpitations
Abnormal ECG	Diverticulitis	Pancreatic cancer
Alcoholism	Fatigue	Pancreatitis
Anemia	Fatty liver	Peptic ulcer disease
Ankle pain	Fibrocystic disease	Polycystic ovary syndrome
Anorexia nervosa	Foot pain	Prediabetes
Anxiety	GERD	PTSD
Asthma	Gastrointestinal bleeding	Pulmonary arterial hypertension
Bipolar disorder	H. pylori infection	Pulmonary embolism (blood clot lungs)
Breast cancer	Headaches	Rectal bleeding
Breast mass	Heartburn	Seizures
Bulimia nervosa	Hepatitis	Sickle cell anemia
Burn injury	Hip pain	Sleep apnea
Cancer	HIV/AIDS	Small intestine cancer
Chest pain	Hyperlipidemia	Stroke
CHF	Hypertension	Substance abuse
Cholelithiasis (gallstones)	Iron deficiency	Thyroid disease
Cirrhosis	Irritable bowel syndrome	Thyroid nodule
Clotting disorder	Kidney disease	TIA (mini stroke)
Colon cancer	Knee pain	Tinea corporis (rash under belly)
Colon polyps	Liver cancer	Ulcers (GI) (stomach or intestines)
Constipation	Liver disease	Urinary incontinence
COPD	Low back pain	Vitamin B1 deficiency
Coronary artery disease	Lower extremity edema	Vitamin B12 deficiency
Deep vein thrombosis (blood clot legs)	Vomiting	Vitamin D deficiency
Depression	Myocardial infarction (heart attack)	Wound dehiscence (opening)
Diabetes mellitus	Nausea	Wound infection
Other:	Osteoarthritis	

Surgical History: (*circle those that apply*)

Abdomen surgery	Cholecystectomy (open)	Lap Band
Adenoidectomy	Colon surgery	Roux-en-Y (gastric bypass)
Appendectomy	Colonoscopy	Sleeve gastrectomy
Back surgery	Cosmetic surgery	Small intestine surgery
Biliopancreatic diversion (BPD)	Dilate and curettage	Spine surgery
Biliopancreatic diversion with duodenal switch	Eye surgery	Thyroid surgery
Breast surgery	Fracture surgery	Tonsillectomy
C-section	Hernia repair	Tubal ligation
CABG (heart surgery)	Hip replacement	Tonsillectomy
Cardiac catheterization	Hysterectomy	Umbilical hernia
Carpal tunnel release	Joint replacement	Upper GI endoscopy
Cesarean section low transverse	Knee arthroscopy	Valve replacement
Cholecystectomy (lap)	Knee surgery	
	Other: _____	

Anesthesia History: (circle those that apply)

Anesthesia awareness Malignant hyperthermia Prolonged awakening
Difficult intubation PONV Pseudocholinesterase deficiency

Social History:

Are you currently employed? Yes No Current or Former Occupation _____

Are you on disability? Yes No How long have you been on disability? _____

Are you married? Yes No

Who do you live with? _____

What is your highest level of education? _____

Are you on any food assistance programs (Food stamps, Meals-on-Wheels, WIC, etc)? Yes No

Tobacco use: Current smoker Former smoker Never a smoker

Type of tobacco: Cigarettes Pipe Cigars

Packs/day: _____ Years: _____

Quit date: _____

Drug use: Yes No

Type: _____

Use/week: _____

Alcohol Use: Yes No

Drinks/Week

_____ Glasses of wine

_____ Cans of beer

_____ Shots of liquor

_____ Drinks containing 0.5 oz of alcohol

Family History:

Problem Relationship (father, sister, etc,) Age at diagnosis

Obesity _____

Heart disease _____

Hypertension _____

Diabetes _____

Cancer (type) _____

Alcohol/Drug abuse _____

Other _____

If you have anxiety, depression, bipolar disorder, PTSD, an eating disorder or other psychiatric diagnosis, please fill out the following:

Do you see a psychiatrist? Yes No If yes, who do you see? _____

Do you see a psychologist/social worker/therapist? Yes No If yes, who do you see? _____

Have you ever been hospitalized for any of these conditions? Yes No

If yes, when was your last hospitalization? _____

For Staff use Only:

Height: _____ Weight: _____ BMI: _____ BP: _____ Pain: _____

Which Procedure Are You Interested In (please circle)?

Gastric Bypass

Sleeve Gastrectomy

LAP Band

Undecided

Weight History

LIFE EVENT	AGE	WEIGHT
High School Graduation		
Lowest weight in last 5 years		
Highest weight in last 5 years		

Dietary History

List **all** diets and diet programs that you have tried:

PROGRAM	WHEN?	HOW LONG?	WAS IT M.D. SUPERVISED?	WEIGHT LOST?
Supervised by Primary Care Physician				
Supervised by Endocrinologist				
Supervised by Registered Dietitian				
<u>Circle all that apply:</u> Fen Phen, Redux, Xenical, Meridia, Phentermine				
Weight Watchers				
Jenny Craig				
Nutri-System				
Atkins				
South Beach Diet				
LA Weight Loss				
Liquid Diet				
Diet Workshop				
Overeaters Anonymous				

How old were you when you first seriously started dieting? _____

Are you exercising right now? NO/ YES

Type (walking/biking/swimming,etc) _____

How long (30 minutes, 45 minutes, etc) _____

days/week _____

Do you have any exercise equipment at home? _____

Do you have a gym membership? NO/ YES

(Please answer the following questions if you are not already on CPAP therapy for sleep apnea)

OSA Screening Questionnaire (circle all that apply)

- | | | |
|--|------------------------|----------------------------|
| 1. Do you snore >3 nights per week? | Yes (2) | No (0) |
| 2. Is snoring loud (hear through the walls)? | Yes (2) | No (0) |
| 3. Have you been told you stop breathing? | Frequently (5) | Occasionally (3) Never (0) |
| 4. Collar size? | Males: >17 (5) <17 (0) | Females: >16 (5) <16 (0) |
| 5. Treatment for hypertension? | Yes (2) | No (0) |
| 6. Do you doze during the day when not active? | Yes (2) | No (0) |
| 7. Do you doze while driving or at a stop light? | Yes (2) | No (0) |

OSA RISK (total points): High >9, Moderate 6-8, Low <5

Total Score: _____

Epworth Sleepiness Scale

Write the number of the most appropriate statement in the spaces provided below:

- 0 = would never doze**
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

- _____ Watching TV
_____ Sitting talking with someone
_____ Sitting quietly after lunch without alcohol
_____ Sitting, inactive in a public place (i.e. theatre or meeting)
_____ Sitting and reading
_____ As a passenger in a car for an hour without a break
_____ In a car, while stopped for a few minutes in traffic
_____ Lying down to rest in the afternoon when circumstances permit

Total Score: _____

How long have you had the symptoms/occurrences as reported above? _____