



We are delighted you have chosen the Obesity Solutions Bariatric Program for your weight loss surgery. Our skilled and experienced surgeons, combined with our dedicated Bariatric Team, have designed a comprehensive program with proven success.

Enclosed in this packet are the materials you need to get started with the screening process for our program. This information is vital to maximize your opportunity for success.

Please complete the medical history form, answering all of the questions fully and honestly. We also recommend that you keep a photocopy of the completed form for your personal records. You may return this form via postal delivery, fax or simply stop by our office to drop it off.

Patient Information Form Directions

1. Please print with blue or black ink.
2. Include an enlarged front & back copy of your insurance card(s). Please provide copies of ALL health insurance cards, even if that insurance does not cover weight loss surgery.
3. Include a copy of your driver's license/identification card.
4. Complete every page of the application.
5. Every item on the application should be answered with a "yes", "no", or "n/a" for not applicable, do not leave anything blank.
6. Explain all "yes" answers.
7. Provide your primary care physician's first & last name, address, phone number and fax number.

Please allow sufficient time for postal delivery and initial processing of the patient information form once it has been received by our staff.

If you have any questions regarding how to complete your form, please contact our office at 770-534-0110 or our Bariatric Coordinator at 678-207-4016.

We know you are looking forward to your new life and we are proud to be part of this endeavor.

Thank you,

Robert L. Richard, MD, FACS
Miguel del Mazo, MD, MS, FACS
And the staff of Obesity Solutions

Name: _____

Bariatric Program Patient Information

PART I. PATIENT DEMOGRAPHIC AND INSURANCE INFORMATION

Patient's Name _____ Preferred name to be called _____

Social Security # _____ Date of Birth _____

Mailing Address _____

(Street) (Apt #) (City) (State) (Zip Code)

Home Phone _____ Cell Phone _____ Work Phone _____

May we call you at work? _____ What is the best way to reach you during the day? _____

Female Male Race/Ethnicity _____ Marital Status: Single Married Divorced Widowed

Email _____

Employer's Name & Address _____

Occupation _____

Please list the name, address, phone and fax numbers of the **physician who referred** you to our program.

If a physician did not refer you to our program, then how did you **first** hear about us? Circle one:

Friend	Family Member	Doctor's Office	Google/web	Obesity Solutions Website
Newspaper	Longstreet Website	Radio	TV	Billboard
Northeast Ga. Medical Center Website				

TYPE OF SURGERY

Obesity Solutions is honored to be able to offer their patients choices. Our surgeons want you to be comfortable in the decision you have made to have weight loss surgery. Obesity Solutions feels that pre operative education is a key component to your weight loss success no matter which procedure you choose to have. In order to complete that education, we provide online education for Gastric Bypass, Sleeve Gastrectomy and Laparoscopic Adjustable Gastric Banding Surgery.

Please indicate which type(s) of surgery you would like to be considered for?
(Check all that apply.)

_____ Roux-en Y Gastric Bypass

_____ Laparoscopic Adjustable Gastric Band (LAGB) (Lap-Band® or Realize Band®)

_____ Sleeve Gastrectomy

_____ Revision of a previous gastric surgery

_____ Undecided

Name: _____

PERSONAL MEDICAL HISTORY

- Have you had or do you have any of the following illnesses or symptoms?
- Please mark **EVERY** blank with "YES" or "NO."
- For every "YES" answer, please indicate the treatment(s) you have tried including prescriptions and over-the-counter medications, medical or non-medical treatment and surgeries. Please provide as much detail as possible including severity of the illness/symptoms, dates of treatment and whether or not the treatment provided relief.

BONES/JOINTS

Arthritis/Osteoarthritis _____ Low Back Pain/Sciatica _____ Pain in Ankles _____ Pain in Feet _____ Pain in Knee _____
Pain in Hips _____ Other _____

CANCER

Cancer _____ Type _____ Treatment _____

ENDOCRINE

Diabetes _____ Insulin Dependent _____ Non-Insulin Dependent _____ Gestational/Pregnancy _____ Neuropathy (Numbness of
Hands and/or Feet) _____ Thyroid Disease (Hyper) _____ (Hypo) _____ Other _____

GI

Belching Acid _____ Heartburn _____ Reflux _____ Peptic Ulcer _____ Colitis _____ Gallbladder disease _____
Hiatal Hernia _____ Hepatitis (Type) _____ Bowel problems _____ IBS _____ Constipation _____ Diarrhea _____

HEART

Abnormal EKG _____ Angina (Chest Pain) _____ Cardiac Arrest (Heart Attack) _____ Cardiac Bypass _____ Congestive Heart Failure _____ Heart
Disease _____ Heart Murmur _____ High Blood Pressure/HTN _____ High Cholesterol _____ High Triglycerides _____ Other _____

KIDNEY/RENAL

Kidney/Renal Disease _____ Kidney Stones _____ Other _____

MENTAL HEALTH

Alcohol Abuse _____ Anxiety Disorder _____ Depression _____ Illegal Drug Abuse _____ Past Suicide Attempts _____
Other _____ Previous Mental Health Counseling _____

OB/GYN

Infertility _____ Hysterectomy _____ Menstrual Irregularity _____ # of Pregnancies _____ Type of Delivery _____
Is it possible you are currently pregnant? _____ Other _____

RESPIRATORY

Asthma _____ Bronchitis _____ COPD _____ Emphysema _____ Shortness of Breath _____ TB/Tuberculosis _____
Have you ever been diagnosed with Obesity-Hypoventilation Syndrome _____ Other _____

SKIN

Infections/Rashes/Ulcers _____ Other _____

SLEEP

Coughing/Choking at Night _____ Excessive Snoring _____ Narcolepsy _____ Nighttime Reflux _____ Sleep Apnea _____
Have you had a sleep study? _____ Do you use CPAP/BiPAP? _____ Other _____

UROLOGY

Frequent Urinary Tract Infections _____ Leakage of Urine _____ Other _____

VASCULAR/BLEEDING

Abnormal Bleeding _____ Blood Clots/DVT _____ Venous Stasis Disease _____ Other _____

Name: _____

OTHER MEDICAL INFORMATION Please list any other medical information not listed above, including illnesses, conditions, surgeries and hospitalizations. _____

Have you ever had a blood transfusion? (If yes, give date and reason.) _____

Do you have religious objection to the use of blood products? _____

Do you have any person or family history of abnormal bleeding? (If yes, please explain, include details and dates.) _____

FAMILY HISTORY.

Medical/Psychiatric Conditions should include any suicide attempts, mental illnesses, and any alcohol drug or other types abuse.

	Age	Ht	Wt	<u>Medical/Psychiatric Condition</u>	<u>Family Member is Deceased?</u>
Mother	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____
Siblings	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Children	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
<i>Your Mother's Side of the Family</i>					
Grandmother	_____	_____	_____	_____	_____
Grandfather	_____	_____	_____	_____	_____
Aunt	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Uncle	_____	_____	_____	_____	_____
<i>Your Father's Side of the Family</i>					
Grandmother	_____	_____	_____	_____	_____
Grandfather	_____	_____	_____	_____	_____
Aunt	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Uncle	_____	_____	_____	_____	_____

Epworth Sleep Scale

Sleep problems are a serious threat to your health, safety and well-being. The Epworth Scale is a quick and simple test designed to detect if you may have a sleep disorder. Please answer the following questions and total your score to see if you may have a sleep problem.

How likely are you to doze or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would NEVER doze 1 = SLIGHT chance of dozing 2 = MODERATE chance of dozing 3 = HIGH chance of dozing

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

Name: _____

Bariatric Food and Nutrition History

Age ____ Height: _____ Current weight: _____ Goal Wt _____
 Estimate # of calories you are consuming daily: _____ In the past 6 months, have you had any *unintentional* weight loss or gain? Yes / No ____lbs.

Please be as specific as possible when completing this history as this information may be requested, and forwarded to your insurance company for the approval process.

Wt in high school: ____ 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. At what age did you start dieting? _____
 Have you ever had counseling with a registered dietitian or nutritionist? Yes No Who? _____

What was your single greatest weight loss? _____ lbs. How long did it take to regain the weight? _____
 How was this weight loss obtained? (Be specific, i.e. Weight Watchers, Diet Pills, etc.) _____
 How long did you sustain that weight loss? _____ How many times have you lost over 25 pounds? _____

Are you currently under a physician's care for weight loss? Yes No

Physician Name/Address/Phone: _____

Do you have any food allergies, intolerances or avoidances? Yes No _____
 Do you take vitamins/minerals/ herbal supplements Yes No If yes, what kind? _____

Please submit documentation where applicable that supports diet attempts. Please check and provide specific information for all diets that apply.

Medical Supervised/Non-Medical Diet Programs	Number of Attempts	When (dates)	Length of Time	Weight Loss	Weight Regained
Medi-fast /Opti-fast					
Fen/Phen or Redux					
Meridia					
Xenical					
Behavior Mod/Psy Therapy					
Center for Medical Wt loss					
Prozac? Synthroid?					
Diabetic Diet					
Weight Watchers					
Nutri-Systems					
Jenny Craig					
Over Eaters Anonymous					
Sugar Busters					
Liquid Diets					
Slim Fast					
Metracal					
Liquid Protein					
Low Calorie					
Low Fat					
High Protein					
Self Imposed Fasts					
Dr. Atkins					
Richard Simmons					
Herbal Life					
Metabolite					
Mayo Clinic Diet					
Zone Diet					
Cabbage Soup					
Accutrim/Dexatrim					
Other					

Name: _____

NUTRITION RELATED BEHAVIORS

Who does the cooking at home? _____ Who does the shopping? _____

How often do you eat out (away from home) ? ___ 1-2 times per week ___ 3-4 times per week ___ over 4 times per week

Do you snack between meals?	Yes	No	Do you eat convenience/package foods?	Yes	No
Do you eat large meals?	Yes	No	How often do you eat each day?	_____	times.
Do you eat a lot of sweets?	Yes	No	Do you eat at night?	Yes	No
Do you drink a lot of soda?	Yes	No	Sodas (Diet or Regular)?	_____	How many per day? _____
Do you drink alcohol?	Yes	No	Which kind? beer/wine/liquor	How often?	_____
Do you like fruits/vegetables?	Yes	No	Do you drink milk?	_____	How often? ___ Skim/2%/ Whole
How often do you eat meat?	_____		Do you use fat?	_____	What kind? _____

Are you an emotional eater? What causes you to eat? _____

Have you ever forced yourself to vomit after eating? (binge and purge) Yes No

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

Have you always been overweight? Yes No

Usually I eat with someone? Yes No I eat when I am not hungry? Yes No

What would you consider your pace of eating? slow normal fast

Explain why you feel you can be successful with weight loss after this surgery, despite the extreme lifestyle and dietary changes needed: _____

List one eating behavior you would like to change right now? _____

ACTIVITY / EXERCISE:

In regards to daily activity, would you consider yourself: very active somewhat active not very active
Number of hours/day watching TV: _____ Number of hours/day on computer: _____

To what extent do you enjoy activity/exercise? (circle one) Not at all Slightly Moderately Greatly
Where do you exercise: Health Club YMCA Home Outdoors Pool Walking Jogging

Are you active in any organized activities: ___No Yes: _____
Aerobic Training (group class, walking, swimming etc): Yes No Resistance Training (Weight lifting) : Yes No
How many days per week? _____ How long do you exercise each day? _____

Have you participated in Activity/Exercise in the past: ___No Yes___ What Kind _____
What kinds of exercise do you like? _____

Is there a physician who can document your diet/weight loss attempts for at least 6 months? Yes No
Physician name and contact information: _____

Please list other questions or concerns you have regarding nutrition and exercise:
