LONGSTREET CLINIC
Center for Weight Management

We are delighted you have chosen the center for Weight Management at Longstreet Clinic 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. Make sure to fill out your demographic and insurance information.
3. Be sure to bring your Insurance card and driver's license/identification card with you to your appointment.
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

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	Billboard
Newspaper	Longstreet Website	Radio	TV	Northeast Ga. Medical Center Website

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TYPE OF SURGERY

The Center for Medical Weight Loss 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. The Center for Medical Weight Loss 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, Duodenal Switch 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)
_____ Sleeve Gastrectomy
_____ Duodenal Switch/Biliopancreatic Diversion
_____ Revision of a previous gastric surgery
_____ Undecided

Name:_____

PART II. MEDICAL HISTORY

Age_____ Current Height_____ Current Weight_____ BMI_____

Smoking History:

____ Current Smoker Packs per day ____ _____ Former Smoker Year Quit _____

____ Never Smoked _____ Smokeless Tobacco Products

Do you drink alcohol? ___ How often _____ **Do you exercise**? _____ How often & what type? _____

Do you have a strong support system? _____

Who is your support person(s)? _____

Have you had any prior gastric bypass/weight loss surgery? (If yes, please give the type of procedure, date of surgery, name, address and phone number of the surgeon and the facility where the surgery was performed.)

_____

_____

Have you ever taken Phen/Fen?_____ Have you ever taken Redux?_____

TREATING PHYSICIANS (*Please list all doctors you are currently seeing.)*

Name Address/Phone Number Reason

_____

_____

_____

MEDICATIONS *(List all current **prescription, vitamins & over-the-counter** medications you use.)*

Medication Name Amount/Dosage How Often? Reason/Prescribing M.D.

_____

_____

_____

_____

_____

ALLERGIES *(Please list any allergies you have, including **foods**, **medications**, **metals** or **other substances**.)*

Type of Allergy Reaction

_____

_____

_____

SURGICAL HISTORY *Please list any previous surgeries you have had.*

Surgery Reason Dates Complications

_____

_____

_____

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	***Medical/Psychiatric Condition***	***Family Member is Deceased?***
Mother	____	____	____	_____	____
Father	____	____	____	_____	____
Siblings	____	____	____	_____	____
	____	____	____	_____	____
	____	____	____	_____	____
Children	____	____	____	_____	____
	____	____	____	_____	____
Your Mother's Side of the Family					
Grandmother	____	____	____	_____	____
Grandfather	____	____	____	_____	____
Aunt	____	____	____	_____	____
	____	____	____	_____	____
Uncle	____	____	____	_____	____
Your Father's Side of the Family					
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 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 _____ **TOTAL** _____
Sitting and talking with someone _____
Sitting quietly after lunch without alcohol _____
In a car, while stopping for a few minutes in traffic _____

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/packaged 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:
_____