

SUNCOAST SURGICAL ASSOCIATES
Bariatric Surgery – Patient Information Profile

**LEE MEMORIAL
HEALTH SYSTEM**

DATE COMPLETED:

Complete all sections using ball point pen in black/blue ink. If you have any questions, please call our office at 239-343-9966 between the hours of 8:30 am – 4:30 pm Monday through Friday.

PERSONAL DETAILS

Surname: _____ Given Names: _____

Address: _____

City, State: _____ Zip Code: _____

Telephone No: (Home) _____ (Work) _____

Cell No: _____

Date of Birth: _____ Age: _____

Social Security Number: _____

Occupation: _____

Health Insurance: _____

Member Name if other than Self: _____

Membership No.: _____ Group No: _____

CONTACT PERSONS:

This information is often vital to us if we need to contact you urgently. Occasionally people move or change phone numbers and do not let us know.

1. Next of Kin:

Name: _____ Relationship: _____

Address: _____

City, State: _____ Zip Code: _____

Telephone No: (Home) _____ (Work) _____

2. Additional Contact:

Name: _____ Relationship: _____

Address: _____

City, State: _____ Zip Code: _____

Telephone No: (Home) _____ (Work) _____

3. Additional Contact:

Name: _____ Relationship: _____

Address: _____

City, State: _____ Zip Code: _____

Telephone No: (Home) _____ (Work) _____

Patient Name: _____ DOB: _____

REFERRAL INFORMATION

Where did you hear about our weight loss surgery program? _____

Referring Doctor: _____ Date of Referral: _____

Address: _____

City, State: _____ Zip Code: _____

Telephone Contact: _____

Local Doctor: _____

Address: _____

City, State: _____ Zip Code: _____

Telephone Contact: _____

Specialist Physician/Surgeon: _____

SOCIAL PROFILE

FAMILY STRUCTURE:

Who will be your caretaker after the surgery: _____

(Please have this person accompany you to your first surgeon’s consultation)

- Married Single
 Divorced Partner/Relationship

Children/Ages: _____

Support persons/friends: _____

Hobbies/Interests: _____

WEIGHT HISTORY

Please indicate your weight at the following times. Please indicate whether you consider your weight was below average, average, above average or very heavy in the relevant boxes.

	Below Average	Average Weight	Above Average	Very Heavy
Birth Weight				
Weight at starting school (5-6 years)				
Weight at the beginning of high school (10-12 years)				
Weight at the end of high school (15-18 years)				
Weight at time of commencing work (21 years)				
Weight at time of marriage (if applicable)				

Patient Name: _____ DOB: _____

WEIGHT LOSS HISTORY

PAST ATTEMPTS: (Please include amount of weight lost and regained if applicable)

Weight Watchers: _____ Duration: _____

Jenny Craig/Nutrisystem/LA Weight Loss etc: _____
 _____ Duration: _____

Hypnotherapy: _____ Duration: _____

Fad Diets: _____ Duration: _____

Appetite Suppressants: _____ Duration: _____

Any other drug treatment for obesity: _____ Duration: _____

Were you ever placed on Phen-Phen: _____ Duration: _____

Cardiologists: _____

Details of any other weight loss measures (including surgical):

Was there are particular event that led to significant weight gain:

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following and if so, please indicate:

	PARENT	SIBLING/ CHILD	OTHER RELATIVES (cousins, aunts, grandparents etc)	NO FAMILY HISTORY	DON'T KNOW
Diabetes					
Heart Disease					
Hypertension					
Gout					
Gallstones					
Obesity					
Snoring/Sleep Apnea					
Asthma					
Allergies					
Hayfever					
Dermatitis/Eczema					
High Cholesterol					
Osteoporosis					
Hip Fractures					

Patient Name: _____ DOB: _____

FAMILY MEDICAL HISTORY (continued)

Place on Blood Thinners? (Coumadin/Warfarin): _____

Deep Venous Thrombosis of the lower extremities (blood clots)? _____

Pulmonary Embolus (blood clots to the lungs)? _____

ALLERGIES (including foods, medications, dressings): Yes No

If yes, please give details: _____

ALCOHOL:

Do you drink alcohol? Never Rarely Regularly

How many standard glasses do you drink per day? _____

How many days do you drink per week? _____

From the list below, please check the alcoholic beverage you drink (check the one you most frequently drink):

- Beer Light Beer Red wine White Wine Sparkling Wine
 Fortified wine Spirits (specify): _____

When do you usually drink? Please check all that apply but circle your main one.

- Social Occasions Parties With Meals Before/After Meals Weekends

If you do not drink alcohol, is there any reason for this? _____

SMOKING:

Do you smoke? Yes No Never – If yes, how many per day? _____

Have you smoked in the past? Yes No – If so, how many per day? _____

For how many years? _____ When did you stop smoking? _____

VITAMINS/SUPPLEMENTS:

Do you take multivitamin tablets or other dietary supplements? Yes No

If yes, how often do you take them? Rarely Monthly Weekly Most Days Everyday

Please list the multivitamins or other dietary supplements you usually take: _____

Do you take folic acid tablets? Yes No

If yes, how often do you take them? Rarely Monthly Weekly Most Days Everyday

What is the dose? 200 mg 400 mg

Patient Name: _____ DOB: _____

FAMILY MEDICAL HISTORY (continued)

FEMALES:

Do you have regular periods (26-33 days)? Yes No

If not, please describe _____

Do you have problems with excessively heavy periods? Yes No

If yes, please describe _____

Have you had difficulty in conceiving in the past? Yes No

Do you currently have problems with infertility? Yes No

Have you suffered from excess body hair or acne? Yes No

Have you ever been told by a doctor that you have polycystic ovaries? Yes No

Have you had problems with pregnancy and/or childbirth? Yes No

If so, in what way? _____

Have you had a caesarean section? Yes No

If so, why? _____

SURGICAL HISTORY

Please give details of any past operations? _____

History of placement of an Inferior Vena Cava Filter? _____

Previous weight loss surgery? Yes No

If so, which type, when, name of surgeon:

Patient Name: _____ DOB: _____

PERSONAL MEDICAL HISTORY

Have you ever suffered with any of the following health problems?

- Diabetes Yes No Details: _____
- Diabetes while pregnant Yes No Details: _____
- Asthma Yes No Details: _____
- Respiratory/Breathing Problems Yes No Details: _____
- Arthritis or Joint Pain Yes No Details: _____
- Back Pain Yes No Details: _____
- Kidney or Urinary Disorder Yes No Details: _____
- Neurological Yes No Details: _____
- Psychological/Nervous Disorder Yes No Details: _____
- Gallstones Yes No Details: _____
- Reflux or Heartburn Yes No Details: _____
- Gastric or Duodenal Ulcer Yes No Details: _____
- Hepatitis or Liver Disease Yes No Details: _____
- High Blood Pressure Yes No Details: _____
- Heart Disease Yes No Details: _____
- High Cholesterol Yes No Details: _____
- Anemia or Bleeding Disorder Yes No Details: _____
- Thrombosis or Clotting Disorder Yes No Details: _____
- Varicose Veins or Leg Swelling Yes No Details: _____
- Eczema or Skin Condition Yes No Details: _____
- Hayfever or Rhinitis Yes No Details: _____

Please give details of any major illnesses/problems: _____

Patient Name: _____ DOB: _____

SLEEP HISTORY

How many hours sleep do you get a night? _____

Is there anything else that keeps you awake at night? Yes No

Details? _____

Would you consider the quality of your sleep is. Good Fair Poor

If your sleep is a major problem to you or your partner, would you be prepared to have a sleep study performed now and after you lose weight? Yes No

SCREENING FOR SLEEP APNEA:

The following questions should guide clinical suspicion:

1. Snoring:

a) Do you snore on most nights (more than 3 times/week)? Yes (2)
 No (0)

b) Is your snoring loud (can it be heard through a door or wall)? Yes (2)
 No (0)

2. Has it ever been reported to you that you stop breathing or gasp during sleep? Never (0)
 Occasionally (3)
 Frequently (5)

3. What is your collar size?

Male: Less than 17 inches (0)
 17 inches or greater (5)

Female: Less than 16 inches (0)
 16 inches or greater (5)

4. Have you had, or are you currently being treated for, high blood pressure? Yes (2)
 No (0)

5. Do you occasionally doze, or fall asleep during the day when:

a) You are not busy or active? Yes (2)
 No (0)

b) You are driving or stopped at a light? Yes (2)
 No (0)

SCORE: _____

OBSTRUCTIVE SLEEP APNEA:

Sleep apnea is a common disorder characterized by repetitive collapse of the pharyngeal airway during sleep.

CONSEQUENCES INCLUDE:

Sleep disruption, waking sleepiness, poor job performance, decreased quality of life, and/or increased motor vehicle accidents. In addition, sleep apnea may contribute to systemic hypertension, mild pulmonary hypertension, arrhythmias and, possibly, myocardial infarction & stroke.

DIAGNOSIS:

In a patient with a reasonable probability of sleep apnea, sleep study is indicated.

Patient Name: _____ DOB: _____

SLEEP HISTORY (continued)

How likely are you to **doze off 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 haven't done some of these things recently, try to work out how they would have affected you.

Use the following table to choose the **most appropriate option** for each situation by placing a tick in the boxes below:

Situation	[0] 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 (e.g. a theatre or a meeting)				
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 to someone				
Sitting quietly after a lunch without alcohol				
In a car, while stopped for a few minutes in the traffic				

EMPLOYMENT:

Current Employment:

Are you currently employed? Yes No

Are you full-time, part-time or casual? _____

If you are unemployed, what is the reason? _____

Are you actively looking for work? _____

Has your weight made it difficult to find employment? _____

If employed, please state what level of activity your job involves:

Little (sedentary job) Moderately Active Very Active (laboring, etc.)

MEDICATIONS:

Please indicate whether you are now or have previously taken any of the following medications. If yes, please state the name of the medication and how long you have been or were taking it.

Medication for psychiatric disorder Yes No Details: _____

Migraine medication Yes No Details: _____

Medications to assist weight loss Yes No Details: _____

Drugs for epilepsy Yes No Details: _____

Drugs for asthma or breathing Yes No Details: _____

Hormones, e.g. The Pill. Yes No Details: _____

 HRT Yes No Details: _____

 Cortisone Yes No Details: _____

List the names of all medications you take. Include dosage and how frequently you take:

Patient Name: _____ DOB: _____

BREATHING HISTORY

Does being at work ever make your chest tight or wheezy? Yes No

Details: _____

Have you ever had to change your job because it affected your breathing? Yes No

Details: _____

Have you ever worked in a job, which exposed you to vapors, gas dust or fumes? Yes No

Details: _____

ASTHMA:

Have you ever had asthma? (check one of the following)

- Never Current In the Past Don't Know

Have you ever had to spend a night in the hospital because of asthma or breathing problems? Yes No

If yes, was it in the last 12 months? Yes No

In the last 12 months, have you visited a hospital casualty department or seen a doctor urgently because you had asthma or breathing problems? Yes No

Details: _____

In the last 12 months, have you taken a course or prednisolone because of asthma or breathing problems? Yes No

Details: _____

In the last 12 months, have you missed work or school because of asthma or breathing problems? Yes No

Details: _____

COUGH AND SHORTNESS OF BREATH:

Do you usually have a cough? Yes No

Do you usually bring up phlegm from your chest when you cough? Yes No

Do you get short of breath on exertion? Yes No

Do you get short of breath walking on the flat? Yes No

Do you get short of breath walking uphill or doing housework? Yes No

In the last 12 months, have you had an attack of shortness of breath that came on when you were not exercising and without obvious cause Yes No

WHEEZE: A whistling noise that comes from the chest and may cause breathlessness or difficulty in breathing

In the last 12 months, have you had wheezing in your chest? Yes No

In the last 12 months, have you had an attack of wheezing that came on after you stopped exercising? Yes No

In the last 12 months, have you had a feeling of tightness in your chest on waking in the morning? Yes No

ACTIVITY LEVEL: What exercise do you do on a regular basis?

How many sessions of exercise (walking, sports, etc.) do you do per week for more than 30 minutes at a time? _____

What sort of activities? _____

Do you require assistance in walking? _____

How far (measured in feet) can you walk without feeling labored or feel the need to stop? _____

How do you feel when exercising? Please mark level on scale:



Patient Name: _____ DOB: _____

GASTRO ESOPHAGEAL REFLUX / INDIGESTION

Do you have a history of heartburn or indigestion? Yes No

Details: _____

If yes, how often do you have reflux during the day?

Many times/day Daily Most days Most weeks Occasionally

Do you suffer heart burn/indigestion during the night? Yes No

If so, how often? Many times/day Daily Most days Most weeks Occasionally

What aggravates or causes your reflux?

Details: _____

Do you have difficulty swallowing? Yes No Details: _____

Does food ever get stuck? Yes No Details: _____

Does food or fluid reflux into the mouth? . . . Yes No Details: _____

Do you vomit with reflux? Yes No Details: _____

Do you suffer from recurrent sore throats? . . Yes No Details: _____

Do you suffer from a hoarse voice? Yes No Details: _____

Do you suffer from a regular cough at night? . Yes No Details: _____

Please list any treatments you may use for reflux/heartburn or indigestion:

PERSON COMPLETING FORM (PRINT NAME): _____

PHYSICIAN SIGNATURE: _____ **DATE/TIME:** _____

Patient Name: _____ DOB: _____