

BRISTOL HOSPITAL BARIATRIC PROGRAM

PATIENT INFORMATION SHEET

DATE: _____ FAMILY PHYSICIAN: _____

PATIENT NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: HOME _____ CELL: _____ WK: _____

EMAIL: _____ DOB: _____ AGE: _____

SS#: _____ MARITAL STATUS: M S D W SEX: M F

PLACE OF EMPLOYMENT: _____

HOW DID YOU HEAR ABOUT US: _____
CONTACT INFORMATION IS VERY IMPORTANT. PLEASE UPDATE INFORMATION IF YOU MOVE. FOLLOW UP OF OUR PATIENTS IS VERY IMPORTANT TO US AND DOES CONCERN YOUR WELFARE. PLEASE PROVIDE US WITH AT LEAST TWO CONTACTS THAT WILL BE ABLE TO CONTACT YOU IF YOU SHOULD MOVE, ETC..

NEXT OF KIN: _____ **RELATION:** _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

CONTACT # 2: _____ **RELATION:** _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

ADDRESS: _____ CITY: _____ STATE: _____

ZIP: _____ PHONE: _____ GROUP #: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S SS#: _____

SUBSCRIBER'S DOB: _____ SUBSCRIBER'S SEX: M F

SECONDARY INSURANCE COMPANY: _____

ADDRESS: _____ CITY: _____ STATE: _____

ZIP: _____ PHONE: _____ GROUP #: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S SS#: _____

SUBSCRIBER'S DOB: _____ SUBSCRIBER'S SEX: M F

INSURANCE IS NOT GUARANTEED PAYMENT. BALANCE IS DUE WITHIN 90 DAYS OF THE INSURANCE CLAIM UNLESS ARRANGEMENTS HAVE BEEN MADE THROUGH OUR OFFICE.

FINANCIAL AGREEMENT

“THE INFORMATION STATED ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE. I, THE PERSON RESPONSIBLE FOR PAYMENT OF MEDICAL CARE FOR THE ABOVE PATIENT, AGREE TO PAY FOR THE OFFICE VISIT AND SERVICES THE DAY THE CARE IS PROVIDED. I AGREE TO PAY ANY BALANCE DUE ON OTHER CHARGES WITHIN 90 DAYS FROM THE DATE THAT SERVICE IS PROVIDED”.

SIGNATURE: _____ DATE: _____

BARIATRIC MEDICAL QUESTIONNAIRE

DATE TODAY: _____

LAST NAME: _____ **FIRST NAME:** _____ **MI:** _____ **AGE:** _____ **BIRTHDATE:** _____

MARITAL STATUS: **M** **S** **W** **D**

OCCUPATION: _____

The information you provide will help us with your treatment

PRIMARY HEALTH CARE PROVIDER (PLEASE LIST LAST 5 YEARS) **OK FOR US TO NOTIFY THIS PHYSICIAN?**

1. **PHYSICIAN NAME:** _____
ADDRESS: _____ **YES** **NO**
PHONE NUMBER: _____
DATES OF TREATMENT: _____

2. **PHYSICIAN NAME:** _____
ADDRESS: _____ **YES** **NO**
PHONE NUMBER: _____
DATES OF TREATMENT: _____

3. **PHYSICIAN NAME:** _____
ADDRESS: _____ **YES** **NO**
PHONE NUMBER: _____
DATES OF TREATMENT: _____

4. **PHYSICIAN NAME:** _____
ADDRESS: _____ **YES** **NO**
PHONE NUMBER: _____
DATES OF TREATMENT: _____

5. **PHYSICIAN NAME:** _____
ADDRESS: _____ **YES** **NO**
PHONE NUMBER: _____
DATES OF TREATMENT: _____

6. **PHYSICIAN NAME:** _____
ADDRESS: _____ **YES** **NO**
PHONE NUMBER: _____
DATES OF TREATMENT: _____

WEIGHT LOSS ATTEMPTS

| # | Program | Program Dates | Weight Loss | Weight Regained | How Long to Regain | Physician Supervised? Y/N | Dietitian Supervised? Y/N |
|----|---|---------------|-------------|-----------------|--------------------|---------------------------|---------------------------|
| 1 | Weight Watchers | | | | | | |
| 2 | Jenny Craig | | | | | | |
| 3 | Diet Center | | | | | | |
| 4 | High Protein/Low Carb (Atkins, Southbeach) | | | | | | |
| 5 | Nutri-System | | | | | | |
| 6 | Sugar Buster | | | | | | |
| 7 | Tops | | | | | | |
| 8 | Over-the-Counter Diet Pills | | | | | | |
| 9 | SlimFast or similar | | | | | | |
| 10 | Phentermine (Adipex, Fastin, Etx) | | | | | | |
| 11 | Fenfluramine/Phentermine (Fen/Phen) | | | | | | |
| 12 | Meridia or Xenical | | | | | | |
| 13 | Hypnosis, Jaw wiring, Acupuncture | | | | | | |
| 14 | Others | | | | | | |

Refer to numbers from above

| # | Doctor / Address / Phone |
|---|--------------------------|
| | |
| | |
| | |

Refer to numbers from above

| # | Dietitian / Address / Phone |
|---|-----------------------------|
| | |
| | |
| | |

The above information is correct to the best of my knowledge

Signature

Date

WEIGHT HISTORY:

Estimated Height: _____

Estimated Current Weight: _____

WEIGHT AT THESE AGES:

High School Graduation: _____

Age 21: _____

Age 25: _____

Age 35: _____

Age 40: _____

Age 45: _____

Age 50: _____

**HIGHEST
ADULT**

WEIGHT: _____

AT AGE: _____

LOWEST ADULT

WEIGHT: _____

AT AGE: _____

1. Describe exercise programs attempted:

2. How many meals per day do you eat? _____

3. List your favorite foods:

4. Do you snack? Yes No Describe food types and how often you snack:

5. Why do you think your diet attempts were unsuccessful?

6. Describe your work related physical activities:

7. Describe your off work hobby/physical activities:

I HAVE/HAVE NOT had previous WEIGHT LOSS SURGERY. If yes, complete below:

Date of previous weight loss surgery: _____

Surgeon/address: _____

Type of procedure: Gastric Bypass
Vertical Banded Gastroplasty (stomach stapling)
Non-Adjustable Band
Other: _____

HEALTH HISTORY
Have you had any of the following?
(Circle those that apply)

CARDIOPULMONARY

Heart attack
 Heart cath
 Heart Surgery
 Heart valve prolapse
 High blood pressure
 Chest pain
 Angina
 Pain in arm
 Abnormal heart beat
 Swelling hands/feet
 Leg cramps
 Walking at night
 Asthma
 Emphysema
 Abnormal chest x-ray
 Tuberculosis
 Frequent cough
 Cough up blood
 Lung surgery
 Collapsed lung
 Swelling of joints
 Night sweats
 Wake up with shortness of breath
 Shortness of breath when:
 Walking several blocks
 One flight of stairs
 On laying down

GASTROINTESTINAL

Reflux/hernia
 Stomach ulcers
 Gallbladder disease
 Hepatitis/ Jaundice
 Crohn's
 Ulcerative Colitis
 Hemorrhoids
 Liver Disease
 Food avoidance

HEENT

Frequen Headaches
 Fainting spells
 Dizziness
 Unconscious spells
 Blurred Vision
 Spots Before Eyes
 Change in Vision
 Earaches
 Wear glasses/ Contacts
 Recurrent sores in mouth
 Recurrent sore throat
 Enlarged veins in legs
 Persistent hoarseness
 Gum soreness or bleeding
 Recurrent Nose Bleeds

MUSCULO-SKELETAL-NEURO

Recurrent back pain
 Neuritis/neuralgia
 Joint Pain
 Sleep apnea
 Redness or heat of joints
 Tingling in hands or feet
 Muscle spasms
 Trembling of extremity
 Broken bones
 Ruptured disc
 Neck injury
 Arthritis/rheumatism
 Paralysis
 Stroke
 Bipolar
 Under care of psychiatrist now or past?
 Depression
 Fits of anger
 Mood swings
 Outpatient/Inpatient counseling or
 treatment for "mental disorder"?
 Treatment for substance abuse

ENDOCRINE

Diabetes (insulin dependent)
 Diabetes (non Insulin dependent)
 Thyroid disease
 Adrenal Disease
 Growth in neck/throat
 Hot flashes
 Tiredness with no reason
 Slow wound healing
 Brittle nails
 Inability to stand heat/cold
 Skin rash

GENITOURINARY

Pain or burning w/ urination
 Difficulty starting urination
 Urinate at night?
 # of times?
 Blood in urine
 Full bladder feeling but
 urinate small amount?
 Lose urine w/ cough?
 Discharge from penis?
 Kidney stones
 Prostate problems
 # times urinate daily?

NUTRITIONAL

Poor growth
 Anemia
 Brittle nails
 Dyspigmentation of skin
 Easily bruise
 Dark concentrated urine
 Poor wound healing
 Sores in mouth (recurrent)
 Changes in taste
 Glossy red tongue
 Dental caries
 Red swollen gums
 Dry cracked lips
 Dry scaly skin
 Swelling in extremities
 Dry brittle hair
 Thin sparse hair
 White spots on nails
 Dry eyes
 Sudden unexplained weight
 gain or loss

7. PERSONAL HISTORY

Have you had or do you have? Circle if yes:

- Measles
- German measles
- Mumps
- Chicken pox
- Whooping cough
- Scarlet fever
- Scarletina
- Diphtheria
- Small pox
- Polio
- Gonorrhea
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Tuberculosis
- HIV positive

- Bleeding chest
- Anesthesia reaction
- Blood transfusion reaction
- Do you smoke cigarettes? Y N
Packs per day? _____
of years? _____
- Use alcoholic beverages
- Use "recreational or street drugs
- Chew tobacco? Y N
of years? _____

X-RAYS: Have you had and date

- Chest _____
- Stomach or colon _____
- Gallbladder _____
- Extremities _____
- Back _____
- Teeth _____
- Other _____
- Electrocardiogram _____
- Cardiac catheter _____
- Echocardiogram _____
- MRI _____
- CT scan _____

GYNECOLOGICAL HISTORY:

- Age at onset on menses: _____
- Number of pregnancies: _____
- Number of children: _____
- Vaginal deliveries: _____
- C-sections: _____

BREAST MEDICAL HISTORY

- Breast surgery of any type: Y N
- Breast lump not operated: Y N
- Breast cancer: Y N
- Last mammogram: _____

DRUG ALLERGIES (LIST)

FOOD ALLERGIES (LIST)

CURRENT MEDICATIONS

MEDICATION **PURPOSE**

HOSPITALIZATIONS (non surgical)

DIAGNOSIS **WHEN**

SURGICAL HISTORY (CIRCLE AND LIST DATE OF SURGERY IF KNOWN)

- | | | |
|--------------------------------|--------------------------|---------------------------|
| _____ Appendectomy | _____ Heart | _____ Ovaries |
| _____ Back | _____ Hernia (hiatal) | _____ Prostate |
| _____ Breast cancer | _____ Hernia (umbilical) | _____ Thyroid |
| _____ Cancer (any type) | _____ Hernia (inguinal) | _____ Tonsillectomy |
| _____ Colon/intestinal surgery | _____ Hernia (ventral) | _____ Tubal ligation |
| _____ Gallbladder | _____ Knee | _____ Ulcers, stomach |
| _____ Hemorrhoids | _____ Lung | _____ Uterus hysterectomy |
| | | _____ Other |
| | | _____ |

Are You Being Treated For: (Circle if yes and complete)

| <u>Condition:</u> | <u>Doctor / Address / Phone #</u> | <u>Medication</u> |
|---|--|--------------------------|
| Asthma | | |
| Diabetes | | |
| Heartburn (GERD) | | |
| Hypertension | | |
| Heart Disease <div style="text-align: right; padding-right: 20px;"> Heart Attack Heart Surgery Stents </div> | | |
| Sleep Apnea | | |
| Other | | |



**IT HAS BEEN PROVEN THAT 1 IN EVERY 3
AMERICANS SUFFER FROM A SLEEP DISORDER**

DO YOUR SLEEP HABITS CONCERN YOU?

If your answer is YES, complete the following quiz and score yourself on the right.

- 1. I have been told that I snore
- 2. I have been told that I stop breathing while I sleep
- 3. I have gained weight
- 4. I suffer from high blood pressure
- 5. I feel fatigued during the day
- 6. I suffer from morning headaches
- 7. I have lost interest in sex
- 8. I sweat excessively during the night
- 9. I suddenly wake up unable to breathe
- 10. My family and friends say that they have noticed a change in my personality

- 11. I have been told that I kick in my sleep
- 12. I experience a "creepy, crawly" sensation in my legs
- 13. I have excessive daytime drowsiness
- 14. I have been told that I am a restless sleeper
- 15. I awaken with sore or achy muscles
- 16. I often have trouble staying asleep throughout the night

- 17. I have fallen asleep while driving
- 18. I experience vivid nightmares soon after falling asleep
- 19. No matter how hard I try to stay awake, I fall asleep
- 20. I fall asleep throughout the day
- 21. I feel paralyzed when I am waking up or falling asleep
- 22. I feel like I am hallucinating when I fall asleep

- 23. I feel afraid to go to sleep
- 24. I have trouble falling asleep
- 25. Thoughts run through my mind, preventing me from going to sleep
- 26. It often takes me an hour or more before I fall asleep
- 27. I wake up in the middle of the night unable to return to sleep

SCORES

Place the number checked from each of the following sections in the space provided below.

Questions 1-10

If you marked three or more of these questions, you show symptoms that are associated with Sleep Apnea.

Sleep Apnea is a life threatening sleep disorder which frequently causes you to stop breathing. It can happen hundreds of times per night while you sleep and you may not even be aware it is happening.

Questions 11-16

If you marked three or more of these questions, you show symptoms that are associated with Myoclonus or Restless Leg Syndrome.

Myoclonus or Restless Leg Syndrome is an unpleasant feeling that occurs in the legs when a person is sitting or lying still, especially at bedtime.

Questions 17-22

If you marked three or more of these questions, you show symptoms that are associated with Narcolepsy.

Narcolepsy is a lifelong disorder that is characterized by uncontrollable sleep attacks during the day.

Questions 23-27

If you marked three or more of these questions, you show symptoms that are associated with insomnia.