Surgical Specialists Of Wyoming Valley

PATIENTS NAME:_____ DATE:_____

DATE OF BIRTH: _____ AGE:_____

REASON FOR APPOINTMENT:_____

_____

PHARMACY PREFERENCE & LOCATION:_____

_____

REFERRING PHYSICIAN: _____

FAMILY PHYSICIAN: _____

CARDIOLOGIST: _____

GYNECOLOGIST: _____

GASTRO PHYSICIAN: _____

ONOCOLOGY PHYSICIAN: _____

ADDITIONAL PHYSICIAN(S) IF APPLICABLE:

_____

_____

_____

_____

TO BE FILLED OUT BY PATIENT

MEDICAL INFORMATION/HISTORY:

Height_____ Current Weight_____ BMI_____
Weight 1 year ago_____ Weight 5 years ago_____
How long have you been trying to lose weight?_____
Have you seen a Nutritionist/Dietitian?_____
If yes, who?_____ and when?_____
How long have you been overweight?_____
How long have you been at least 100 pounds overweight?_____
Are you depressed? **Y/N**
Have you ever seen a psychiatrist/psychologist? **Y/N**
If yes, who?_____when?_____
Have you ever been hospitalized for emotional reasons?_____
Do you drink alcohol? **Y/N**
If yes, what do you drink and how much?_____
Have you ever used recreational drugs? **Y/N**
If yes, which ones?_____

Have you ever been on a physician-supervised diet? **Y/N**
If yes, what physician?_____when?_____
What were the results?_____
Your most recent diet_____
Results_____

Which of the following supervised weight loss programs have you tried in the past?

Diet	Year	Duration	Weight Loss	Weight Regained
Atkins Diet				
Deal-A-Meal				
Eaters Anonymous				
Fasting				
Jenny Craig				
LA Weight Loss				
Lo-cal lo-fat diets				
Medifast Optifast				
Nutri-system/Formula 3				
Physician Weight loss				
Richard Simmons				
Slim Fast				
Susan Powter				
TOPS				
Weight Loss Clinic				
Weight Watchers				
Other:				

WEIGHT AND EATING PATTERNS

What is the most weight you have lost on a diet?_____

Maximum weight loss_____ What method was most effective?_____

What caused regain?_____

Family history of obesity_____

Over the past month, what do you typically eat during the day and night?

6am-10am_____

10am-12pm_____

12pm-2pm_____

3pm-6pm_____

6pm-8pm_____

8pm-10pm_____

After 10pm_____

Do you binge? **Y/N**

Have you ever made yourself vomit after eating? **Y/N**

If yes, how frequently did/does it occur?_____

How do you feel before and after vomiting?_____

Have you ever used laxatives or diuretics for the purpose of weight loss? **Y/N**

If yes, what?_____How often?_____

Do you exercise? **Y/N**

If yes, current exercise plan_____

ATTITUDE TOWARD SURGERY

Why do you want to lose weight? _____

How much do you expect to lose? _____

Do you imagine the surgery will affect your life? _____

_____

What is your understanding of the risks/side effects? _____

_____

Are you aware of the changes you must make in your diet/activity level? **Y/N**

What changes, if any, have you already made? _____

How does your spouse/significant other/family feel about your surgery?

_____

What arrangements have you made for your recovery? _____

_____

PATIENT HISTORY FORM

Name				**Date**			
Phone				DOB		Age	
Sex		Referred by	☐ Self ☐ PCP ☐ Other:				

Vitals				
BP: _____ /_____	P: _____ R: _____	TEMP: _____	HEIGHT: _____	WEIGHT: _____

Patient Medical History:		
☐ Cancer _____	☐ Hypertension	☐ Stroke
☐ Cardiac Disease	☐ High Cholesterol	☐ Seizure Disorder
☐ COPD	☐ Thyroid Disease	☐ Osteoporosis
☐ Diabetes	☐ Liver Disease	☐ Diverticulitis
☐ Asthma	☐ Kidney Disease	☐ Sleep Apnea
☐ Arthritis	☐ GERD	

Past Surgical History:		
☐ Cardiac By Pass	☐ Colostomy	☐ Splenectomy
☐ Hernia Repair _____	☐ Ileostomy	☐ Tonsillectomy
☐ Knee Surgery	☐ Hysterectomy (partial total)	☐ Abdominal Aortic Aneurysm
☐ Hemorrhoidectomy	☐ Appendectomy	☐ Gallbladder Surgery
☐ Breast Biopsy	☐ Thyroidectomy	☐ Mastectomy
☐ Vascular Surgery		

Have You Had Any of the Following Symptoms Recently?			
☐ Nausea	☐ Change in Bowel Habits	☐ Yellow Skin	☐ Vomiting Blood
☐ Vomiting	☐ Abdominal Pain	☐ Bloating	☐ Constipation
☐ Diarrhea	☐ Blood in Stool	☐ Heart Burn	☐ Dizziness
☐ Weakness	☐ Numbness	☐ Back Pain	☐ Joint Pain
☐ Joint Swelling	☐ Bipolar	☐ Depression	☐ Anxiety
☐ Rash	☐ Breast Tenderness	☐ Dryness	☐ Suspicious Lesions
☐ Itching	☐ Nipple Discharge	☐ Abnormal Bruising	☐ Bleeding
☐ Enlarged Lymph Nodes			

Social History
Occupation:
Smoker?: ☐ Yes ☐ No ☐ Never ☐ Former (when did you quit) _____ _____ /day for _____ years.
Alcohol?: ☐ Yes ☐ No _____ /day for _____ years.

Family History	
Medical Problems	Family Member
☐ Cancer	
☐ Heart Disease	
☐ High Blood Pressure	
☐ High Cholesterol	
☐ Diabetes	
☐ Lung Disease	
☐ Seizure Disorder	
☐ Rheumatic Fever	
☐ Tuberculosis	

Medications (PATIENT MUST PROVIDE A MEDICATION LIST WITH DOSAGES UPON EACH APPOINTMENT)			
Medication	**Dosage/ Times Taken**	**Medication**	**Dosage/ Times Taken**

Allergies & Reactions			
Meds		**Foods**	**Other**

Recent Colonoscopy	Recent EGD	Recent Mammogram

Testing Within the Last 3 Months			
☐ Arteriogram	☐ Ultrasound	☐ Cat Scan	☐ Blood Work
☐ MRI/MRA	☐ CT Angio	☐ Upper GI	

BARIATRIC SCREENING QUESTIONNAIRE PLEASE PRINT

PATIENTS NAME _____Date of Birth_____/____/_____Age_____

TO BE FILLED OUT BY NURSING STAFF

HEIGHT| WEIGHT | IBW | EBW | BMI | BP | T | R | 02SAT

_____|_____|_____|_____|_____|_____|_____|_____|_____|

CO- MORBID MEDICAL PROBLEMS

_____ Diabetes

_____ Sleep apnea

_____ HTN

_____CAD

_____Back /Joint problems

_____Gastric Reflux

_____Depression

_____ Infertility

_____ Asthma/lung problems

_____High Cholesterol

_____ Blood Clots

_____ DVT

_____PE

_____Other

SURGICAL SPECIALISTS OF WYOMING VALLEY
200 SOUTH RIVER STREET
PLAINS, PA 18705

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003 the Federal HIPAA Privacy Rule requires out practice to comply with certain legal requirements designed to protect your personal health information. HIPAA gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). Individuals are also provided the right to request confidential communications of PHI be made by alternative means; such as sending correspondence to the individuals work place instead of home. We may need your written authorization to release PHI even if you are the one requesting the release.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND REVIEWED THE PRIVACY PRACTICES OF SURGICAL SPECIALISTS OF WYOMING VALLEY

SIGNATURE OF PATIENT OR LEGAL GUARDIAN **DATE**

PRINT NAME

HIPAA QUESTIONNAIRE

I wish to be contacted in the following manner: (Check all that apply)

_____ Home Telephone number_____
_____Ok to leave a detailed message on machine/ or with person
_____Leave a message with a call back number only
_____Work Telephone Number
_____Ok to leave a detailed message with office employee
_____Ok to fax to my work place
_____Ok to mail information to my workplace

Ok to communicate information about me to: (Check all that apply)
_____Spouse
_____Family Member (s)Please list their names below:

_____

Caregivers: Please list their names below:

_____

Others: Please list their names below:

_____

I am fully aware that a cell phone is not a secure & private line.

Name: _____ DOB: _____

Bariatric Patient Surgery Test

This test is given to all preoperative Weight Loss Surgery patients to gauge their understanding of the procedure, the lifestyle commitment, benefits and risks involved.
Please bring this along with you to your next office visit and we will review your answers with you.

1. I will need to have pre-operative tests and a psychological evaluation prior to being approved for surgery.
   a) yes
   b) no
   c) the surgeon will decide on a patient by patient basis

2. Pick the possible complications that could happen to you during surgery:
   a) injuries to organs
   b) heart attack
   c) blood clots
   d) all of the above

3. Pick the possible complications that could occur after your surgery:
   a) malnutrition/vitamin deficiency
   b) infection
   c) dumping syndrome with bypasses
   d) intestinal leaks
   e) all of the above

4. After surgery if I repeatedly eat too much food, I can damage the pouch or esophagus.
   True False

5. I should drink with my meals in order to help push the food through.
   True False

6. If I have the gastric bypass procedure, I will have to take vitamins for the rest of my life after surgery.
   True False

7. Pick the foods that may cause "Dumping Syndrome".
   a) Chicken, fish, cheeses
   b) Cookies, candy, soda, milkshakes
   c) Fruits and vegetables
   d) Yogurt and cottage cheese

9. I can start a walking program _____ after surgery.
   a) 1 week
   b) 4-6 weeks
   c) never
   d) immediately

10. My new stomach (pouch) will hold approximately
   a) ½ - ¾ cup
   b) 2 cups
   c) 3 cups
   d) none of the above

11. I may be able to regain weight after this surgery.
   True False

12. Of the descriptions below, pick the best one that describes the surgery that you will be having done.
   a) Part of the stomach is removed, making a small pouch so that I cannot eat a lot.
   b) A band is placed around the stomach, so that I cannot eat a lot.
   c) The stomach is divided to make a small pouch, not allowing me to eat a lot, then a "Y" segment of small bowel is attached to the new pouch.

13. I need to drink at least _____ of fluids daily (avoiding fruit juices, soda and sports drinks)
   a) 1 cup (8 oz.)
   b) 2 cups (16 oz.)
   c) 6-8 cups (48-64 oz.)
   d) I should not drink fluids

14. After surgery, I am at higher risk for ulcers if I:
   a) smoke
   b) take aspirin/ibuprofen
   c) drink alcohol on a regular basis
   d) all of the above

15. Alternatives to surgery include:
   a) a physician's supervised diet
   b) weight watchers
   c) a low calorie diet
   d) exercise
   e) all of the above

16. Benefits of bariatric surgery include:
   a) improvement or resolution of diabetes, hypertension, and sleep apnea
   b) weight loss
   c) both a & b

17. Before surgery I will need to:
    a) focus on healthy eating
    b) begin an exercise program
    c) practice not drinking with meals
    d) all of the above

18. Lifestyle changes I need to consider after the surgery include:
    a) avoid foods high in fat and sugar
    b) drink at least 64 oz. of sugar free fluids every day
    c) include a protein food with every meal
    d) all of the above

19. Psychological changes that may be experienced after surgery can include:
    a) depression
    b) relationship changes
    c) inability to cope with the change in diet
    d) all of the above

20. My surgeon is available to follow me through my recovery for:
    a) 3 months
    b) 6 months
    c) 1 year
    d) forever

I fully understand the lifestyle changes, benefits and risks involved with the procedure.

_____

(Signature)

_____

(Date)