Center for Surgical Weight Loss
Patient Assessment

*The information requested on this form is very important
and must be filled out thoroughly in order to obtain your insurance approval

Name:_____ Date:_____

List Your Doctors

SPECIALTY	NAME	LOCATION	PHONE #
Primary Care Physician			
Endocrinologist			
Cardiologist			
Gynecologist			
Other			
Other			

Referral Source

How did you learn about Lahey Clinic's Center for Surgical Weight Loss?

- Primary Care Physician
- Friend or Family
- Internet
- Television
- Newspaper
- Other _____

Have you attended a support group? If yes, where & when_____

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For office use only:

Sex:_____ Age:_____ Height:_____

Weight:_____ BMI:_____ BP:_____

Place ID sticker here

Which Procedure Are You Interested In?

☐ Gastric Bypass ☐ LAP Band ☐ Undecided

Weight History

LIFE EVENT	AGE	WEIGHT
High School Graduation		
Lowest weight in last 5 years		
Highest weight in last 5 years		

Dietary History

List **all** diets and diet programs that you have tried:

PROGRAM	WHEN?	HOW LONG?	WAS IT M.D. SUPERVISED?	WEIGHT LOST?
Supervised by Primary Care Physician			Yes	
Supervised by Endocrinologist			Yes	
Supervised by Registered Dietitian				
Circle all that apply: Fen Phen, Redux, Xenical, Meridia, Phentermine				
Weight Watchers				
Jenny Craig				
Nutri-Systems				
Atkins				
South Beach Diet				
LA Weight Loss				
Liquid Diet				
Diet Workshop				
Overeaters Anonymous				
Other				
Other				

How old were you when you first seriously started dieting?_____

Past Medical History

Please circle "yes" or "no" to all that apply:

Cardiovascular:		
Angina/Chest Pain	NO / YES	
MI (Heart Attack)	NO / YES	If yes, when?
Heart Murmur	NO / YES	
Bleeding Disorders	NO / YES	If yes, explain:
Ever had a blood transfusion	NO / YES	If yes, explain:
High Cholesterol	NO / YES	
High Blood Pressure	NO / YES	Year diagnosed?
Atrial Fibrillation	NO / YES	
Abnormal EKG	NO / YES	If yes, when?
Abnormal Stress Test	NO / YES	If yes, when?
CABG	NO / YES	If yes, when?
Angioplasty	NO / YES	If yes, when?
Vascular/Circulation:		
Venous Stasis Disease	NO / YES	
Varicose Veins	NO / YES	
Leg swelling	NO / YES	
Pulmonary:		
Asthma	NO / YES	
Shortness of Breath	NO / YES	How many flights of stairs can you climb?
Sleep Apnea Syndrome	NO / YES	If yes, when was it diagnosed?
Abnormal Sleep Study	NO / YES	Are you using CPAP? NO / YES
Hypoventilation Syndrome	NO / YES	
Emphysema	NO / YES	
History of Pulmonary Embolus	NO / YES	
Gastrointestinal:		
GERD (reflux)	NO / YES	
Heartburn	NO / YES	
Hiatal Hernia	NO / YES	
Belching acid/sour fluid	NO / YES	
Have you had an endoscopy	NO / YES	If yes, when?
Gallbladder Disease	NO / YES	Have you had your gallbladder removed?
		If yes, Open or Laparoscopic?
Liver Cirrhosis	NO / YES	
Hepatitis	NO / YES	
Kidney Disease	NO / YES	
Colitis	NO / YES	
Family history of colon cancer	NO / YES	

Past Medical History (continued)

Genito-urinary		
Leakage of urine with laugh, cough or sneeze		Always / Frequently
Wears a pad		Always / Frequently
Endocrine		
Thyroid Disease	NO / YES	
Diabetes	NO / YES	If yes, is it diet or medication controlled?
		Average blood sugar reading?
		How often do you check your sugars?
Muscular/Skeletal		
Low Back Pain	NO / YES	
Sciatica	NO / YES	
Hip Pain	NO / YES	
Knee Pain	NO / YES	
Ankle/Foot Pain	NO / YES	
Weight Related Injury	NO / YES	If yes, explain:
Have you seen an orthopedic surgeon for any of these conditions?		NO / YES
General		
AIDS/HIV exposure	NO / YES	
Do you wear dentures	NO / YES	
Psychiatric		
Depression	NO / YES	
Anorexia or bulimia	NO / YES	
PTSD	NO / YES	
Bipolar disorder	NO / YES	
Have you been hospitalized for any of these conditions?	NO / YES	If yes, when?
Other		
Please explain below:		

OSA Screening Questionaire (circle all that apply)

1. Do you snore >3 nights per week?	Yes (2)	No (0)		
2. Is snoring loud (hear through the walls)?	Yes (2)	No (0)		
3. Have you been told you stop breathing?	Frequently (5)	Occasionally (3)	Never (0)	
4. Collar size?	Males:	>17 (5),	<17 (0)	
	Females:	>16 (5),	<16 (0)	
5. Treatment for hypertension?	Yes (2)	No (0)		
6. Do you doze during the day when not active?	Yes (2)	No (0)		
7. Do you doze while driving or at a stop light?	Yes (2)	No (0)		

OSA RISK (total points): High >9, Moderate 6-8, Low <5

Total Score:_____

Epworth Sleepiness Scale

Write the number of the most appropriate statement in the spaces provided below:

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 talking with someone
_____ Sitting quietly after lunch without alcohol
_____ Sitting, inactive in a public place (i.e. theatre or meeting)
_____ As a passenger in a car for an hour without a break
_____ In a car, while stopped for a few minutes in traffic
_____ Lying down to rest in the afternoon when circumstances permit

Total Score: _____

Past Surgical History

List the operation or injury:	Date:

Medications

List all medications, vitamins, and minerals below:	Dose:	Frequency:

Allergies

Please list all medication allergies	Reaction

Women: Obstetric and Menstrual History

Age at first period:_____ Date of last period:_____ Number of pregnancies:_____

Number of live births:_____ Miscarriages/abortions:_____

Obstetric complications:_____

Do you use: Birth Control Pills: NO / YES Estrogens: NO / YES

Estimate weight gained with pregnancy

#1: Start_____ Delivery_____ #2: Start_____ Delivery_____ #3: Start_____ Delivery_____ #4: Start_____ Delivery_____

Family History

Mother: Alive / Deceased Age_____
List medical conditions_____

Father: Alive / Deceased Age_____
List medical conditions_____

Sibling 1: Alive / Deceased Age_____
List medical conditions_____

Sibling 2: Alive / Deceased Age_____
List medical conditions_____

Sibling 3: Alive / Deceased Age_____
List medical conditions_____

Sibling 4: Alive / Deceased Age_____
List medical conditions_____

Sibling 5: Alive / Deceased Age_____
List medical conditions_____

Sibling 6: Alive / Deceased Age_____
List medical conditions_____

Social History

Single Married Divorced Widowed

What is your occupation?_____

How many children do you have?_____

Tobacco Use: NO / YES # Cigs/day_____ Last used_____

Alcohol Use: NO / YES # Drinks/day_____ Last used_____

Recreational Drugs: NO / YES Type_____ Last used_____
Amount_____

Exercise: NO / YES Type_____
How long_____
days/week_____

NOTES (for staff use only):

ROS

GENERAL:	fever, chills, night sweats, weight change, fatigue, weakness
SKIN:	skin changes, hair changes, nail changes, itching, rashes, soars, lumps
HEAD:	trauma, headache location, frequency, nausea, vomiting, vision changes
EYES:	glasses, contact lenses, blurriness, tearing, itching, acute visual loss
EARS:	hearing loss, tinnitus, vertigo, discharge, earache
NOSE/SINUSES:	rhinorrhea, stuffiness, sneezing, itching, allergy, epistaxis
MOUTH/THROAT:	bleeding gums, hoarseness, sore throat, lesions, swollen neck
BREASTS:	skin changes, masses / lumps, pain, discharge, self exam, last mammogram
RESPIRATORY:	SOB, wheeze, cough, sputum, hemoptysis, pneumonia, asthma, bronchitis, emphysema, tuberculosis, last chest X-ray
CV:	CAD, HTN, increased lipids, arrhythmia, palpitations, syncope, murmurs, dyspnea on exertion, orthopnea, PND, edema, last EKG
GI:	appetite, nausea, vomiting, indigestion, dysphagia, reflux, IBS, bowel movement frequency / change, stool color, diarrhea, constipation, bleeding (hematemesis, hemorrhoids, melena or hematechezia), abdominal pain, jaundice, hepatitis
URINARY:	frequency, hesitancy, urgency, polyuria, dysuria, hematuria, nocturia, incontinence, stones, infection
GENITAL:	**General**: STD history and treatment, sex interest, function, problems, contraception methods **Male**: penile discharge of sores, testicular pain or masses, hernias, BPH **Females**: menarche, period regularity, frequency, duration, dysmenorrheal, last period, itching, discharge, sores, pregnancies and complications, miscarriages/abortions, birth control, menopause, hot flashes/sweats
VASCULAR	leg edema, claudication, varicose veins, thromboses/emboli
MS:	muscle weakness, back pain, arthritis, joint stiffness or pain, range of motion, instability, redness, swelling, gout
NEUROLOGIC:	loss of sensation, numbness, tingling, tremors, weakness or paralysis, fainting or blackouts, seizures, HA
HEMATOLOGIC:	anemia, easy bruising or bleeding, petechiae, purpura, transfusions
ENDOCRINE:	heat or cold intolerances, excessive sweating, polyuria, polydipsia, polyphagia, diabetes, thyroid problems
PSYCHIATRIC:	mood, anxiety, depression, tension, memory

PHYSICAL EXAM NOTES

PLAN

Number of pounds patient needs to lose prior to surgery?
Endocrine Consult?
HMR?
Cardiac Consult?
Exercise Stress Test?
Dobutamine Stress Echo?
EKG?
GI Consult?
Upper Endoscopy?
Upper GI series?
Pulmonary Consult?
Sleep Study?
Nicotine Screen?
TSH?
Psychological F/U?
Notes to be faxed from outside provider?
Other?