Department of General Surgery - Surgical Weight Loss Center
Lahey Hospital & Medical Center

Referring Physician (Doctor who sent you to see us):

Primary Care Physician (Internist/Family doctor):

Reason for visit: ____________________________________________________________

Medication Allergies:

<table>
<thead>
<tr>
<th>Drug</th>
<th>Reaction (rash, hives, throat closing)</th>
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Medical History: (Circle those that apply, both current and past)

**Abdominal pain**

**Diarrhea**

**Palpitations**

**Fatigue**

**Pancreatitis**

**Anemia**

**Fatty liver**

**Peptic ulcer disease**

**Ankle pain**

**Fibrocystic disease**

**Polycystic ovary syndrome**

**Anorexia nervosa**

**Foot pain**

**Prediabetes**

**Anxiety**

**GERD**

**PTSD**

**Asthma**

**Gastrointestinal bleeding**

**Pulmonary arterial hypertension**

**Bipolar disorder**

**H. pylori infection**

**Pulmonary embolism (blood clot lungs)**

**Breast cancer**

**Headaches**

**Rectal bleeding**

**Breast mass**

**Heartburn**

**Seizures**

**Bulimia nervosa**

**Hepatitis**

**Sickle cell anemia**

**Burn injury**

**Hip pain**

**Sleep apnea**

**Cancer**

**HIV/AIDS**

**Small intestine cancer**

**Cholesterol**

**Hyperlipidemia**

**Stroke**

**CHF**

**Hypertension**

**Substance abuse**

**Cholelithiasis (gallstones)**

**Iron deficiency**

**Thyroid disease**

**Cirrhosis**

**Irritable bowel syndrome**

**Thyroid nodule**

**Clotting disorder**

**Kidney disease**

**TIA (mini stroke)**

**Colon cancer**

**Knee pain**

**Tinea corporis (rash under belly)**

**Colon polyps**

**Liver cancer**

**Ulcers (GI) (stomach or intestines)**

**Constipation**

**Liver disease**

**Urinary incontinence**

**COPD**

**Low back pain**

**Vitamin B1 deficiency**

**Coronary artery disease**

**Lower extremity edema**

**Vitamin B12 deficiency**

**Deep vein thrombosis (blood clot legs)**

**Vomiting**

**Vitamin D deficiency**

**Depression**

**Myocardial infarction (heart attack)**

**Nausea**

**Wound dehiscence (opening)**

**Diabetes mellitus**

**Osteoporosis**

**Wound infection**

**Other:** __________________________________________

Surgical History: (circle those that apply)

**Abdomen surgery**

**Cholecystectomy (open)**

**Lap Band**

**Adenoidectomy**

**Colon surgery**

**Roux-en-Y (gastric bypass)**

**Appendectomy**

**Colonoscopy**

**Sleeve gastrectomy**

**Back surgery**

**Cosmetic surgery**

**Small intestine surgery**

**Biliopancreatic diversion (BPD)**

**Dilate and curettage**

**Spine surgery**

**Biliopancreatic diversion with duodenal switch**

**Eye surgery**

**Tonsillectomy**

**Breast surgery**

**Hernia repair**

**Tubal ligation**

**C-section**

**Hip replacement**

**Tonsillectomy**

**CABG (heart surgery)**

**Hysterectomy**

**Umbilical hernia**

**Cardiac catheterization**

**Joint replacement**

**Upper GI endoscopy**

**Carpal tunnel release**

**Knee arthroscopy**

**Valve replacement**

**Cesarean section low transverse**

**Knee surgery**

**Cholecystectomy (lap)**

**Other:** __________________________________________
Anesthesia History: (circle those that apply)
Anesthesia awareness  Malignant hyperthermia  Prolonged awakening
Difficult intubation    PONV      Pseudocholinesterase deficiency

Social History:
Are you currently employed? Yes  No  Current or Former Occupation ____________________________
Are you on disability? Yes  No  How long have you been on disability? _______________________
Are you married? Yes  No
Who do you live with? _________________________________________________________________
What is your highest level of education? ___________________________________________________
Are you on any food assistance programs (Food stamps, Meals-on-Wheels, WIC, etc)? Yes  No

Tobacco use:  Current smoker  Former smoker  Never a smoker
Type of tobacco:  Cigarettes  Pipe  Cigars
Packs/day: ___________  Years: ____________
Quit date: ____________

Drug use: Yes  No  Alcohol Use: Yes  No
Type: ____________  Drinks/Week
Use/week: _________  _______ Glasses of wine
_________  Cans of beer
_________  Shots of liquor
_________  Drinks containing 0.5 oz of alcohol

Family History:
Problem  Relationship (father, sister, etc.)  Age at diagnosis
Obesity _______________________________________________________________________________
Heart disease __________________________________________________________________________
Hypertension __________________________________________________________________________
Diabetes _______________________________________________________________________________
Cancer (type) __________________________________________________________________________
Alcohol/Drug abuse _______________________________________________________________________
Other __________________________________________________________________________________

If you have anxiety, depression, bipolar disorder, PTSD, an eating disorder or other psychiatric diagnosis, please fill out the following:
Do you see a psychiatrist? Yes  No  If yes, who do you see? _____________________________
Do you see a psychologist/social worker/therapist? Yes  No  If yes, who do you see? ______________
Have you ever been hospitalized for any of these conditions? Yes  No
If yes, when was your last hospitalization? ________________________________

For Staff use Only:
Height: ___________  Weight: ___________  BMI: ___________  BP: ___________  Pain: ___________
### Which Procedure Are You Interested In (please circle)?

- Gastric Bypass
- Sleeve Gastrectomy
- LAP Band
- Undecided

### Weight History

<table>
<thead>
<tr>
<th>LIFE EVENT</th>
<th>AGE</th>
<th>WEIGHT</th>
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<tbody>
<tr>
<td>High School Graduation</td>
<td></td>
<td></td>
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<tr>
<td>Lowest weight in last 5 years</td>
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<tr>
<td>Highest weight in last 5 years</td>
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</table>

### Dietary History

List all diets and diet programs that you have tried:

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>WHEN?</th>
<th>HOW LONG?</th>
<th>WAS IT M.D. SUPERVISED?</th>
<th>WEIGHT LOST?</th>
</tr>
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<tbody>
<tr>
<td>Supervised by Primary Care Physician</td>
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<td>Supervised by Endocrinologist</td>
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<tr>
<td>Supervised by Registered Dietitian</td>
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<tr>
<td>Circle all that apply: Fen Phen, Redux, Xenical, Meridia, Phentermine</td>
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<tr>
<td>Weight Watchers</td>
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<tr>
<td>Jenny Craig</td>
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<tr>
<td>Nutri-System</td>
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<td>Atkins</td>
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<tr>
<td>South Beach Diet</td>
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<tr>
<td>LA Weight Loss</td>
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<tr>
<td>Liquid Diet</td>
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<td>Diet Workshop</td>
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<tr>
<td>Overeaters Anonymous</td>
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</table>

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

Are you exercising right now? □NO/ □YES
- Type (walking/biking/swimming, etc) ____________________________
- How long (30 minutes, 45 minutes, etc) ____________________________
- # days/week ____________________________

Do you have any exercise equipment at home? ____________________________
Do you have a gym membership? □NO/ □YES
(Please answer the following questions if you are not already on CPAP therapy for sleep apnea)

**OSA Screening Questionnaire** (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

- _____ Watching TV
- _____ Sitting talking with someone
- _____ Sitting quietly after lunch without alcohol
- _____ Sitting, inactive in a public place (i.e. theatre or meeting)
- _____ Sitting and reading
- _____ 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:**

How long have you had the symptoms/occurrences as reported above? _____