**Department of General Surgery- Surgical Weight Loss Center**

**Lahey Hospital & Medical Center Burlington / Lahey Outpatient Center Danvers**

Referring Physician (*Doctor who suggested you to see us*):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician (*Internist/Family doctor*):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication Allergies:**

Drug Reaction *(rash, hives, throat closing)*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Medical History:** (*Circle those that apply, both current and past*)

Abdominal pain Diarrhea Palpitations

Abnormal ECG Diverticulitis Pancreatic cancer

Alcoholism 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

Chest pain 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 Osteoarthritis 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

Duodenal Switch Eye surgery Thyroid surgery

Breast surgery Fracture surgery Tonsillectomy

C-section Hernia repair Tubal ligation

CABG (heart surgery) Hip replacement Umbilical hernia

Cardiac catheterization Hysterectomy Upper GI endoscopy

Carpal tunnel release Joint replacement Valve replacement

Knee arthroscopy Cholecystectomy (lap) Knee surgery 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any barriers to learning (Seeing, Hearing, Understanding, Communication language barrier, Learning disability,

Developmental disability, Unable to read, Unable to write)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you learn best (reading, seeing, doing, listening)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything that would prevent you from learning right now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you on any food assistance programs (Food stamps, Meals-on-Wheels, WIC, etc)? Yes No

Can you afford $25 per month for Vitamins after surgery (minimum cost)? Yes No

**Tobacco use**: Current smoker Former smoker Never a smoker

Type of tobacco: Cigarettes Pipe Cigars Electronic Cigarette Chewing Tobacco

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does anyone in your family have a history of a blood clotting or bleeding disorder? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Staff use Only:**

Height: \_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_ BMI: \_\_\_\_\_\_\_\_\_\_\_\_\_ BP: \_\_\_\_\_\_\_\_\_\_\_ Pain: \_\_\_\_\_\_\_\_\_\_

**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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you see a psychologist/social worker/therapist? Yes No

If yes, who do you see? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized for any of these conditions? Yes No

If yes, when was your last hospitalization? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been diagnosed with an eating disorder? Yes No

What type of eating disorder? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you receive treatment? Yes No

Do you engage in stress or emotional eating? Yes No

How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Which Procedure Are You Interested In (please circle)?**

Gastric Bypass Sleeve Gastrectomy Duodenal Switch Undecided

Lap Band Removal Revisional Surgery

**Weight History**

|  |  |  |
| --- | --- | --- |
| LIFE EVENT | AGE | WEIGHT |
| Weight at 18 years old |  |  |
| Lowest weight in last 5 years |  |  |
| Highest adult weight |  |  |

How old were you when you began to struggle with your weight? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dietary History**

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Type of Program | What year? | For how long? | Supervised by medical Provider? | How much did you lose? |
| Supervised by  Primary Care Physician |  |  |  |  |
| Supervised by  Endocrinologist |  |  |  |  |
| Supervised by  Registered Dietitian |  |  |  |  |
| Lahey Medical Weight Loss |  |  |  |  |
| Weight Loss Medication |  |  |  |  |
| Weight Watchers |  |  |  |  |
| Jenny Craig |  |  |  |  |
| Nutri-System |  |  |  |  |
| Atkins |  |  |  |  |
| South Beach Diet |  |  |  |  |
| LA Weight Loss |  |  |  |  |
| Liquid Diet |  |  |  |  |
| Diet Workshop |  |  |  |  |
| Overeaters Anonymous |  |  |  |  |

What is the most weight you have ever lost when trying to lose weight? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you exercising right now? ☐NO/ ☐YES

Type (walking/biking/swimming,etc) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long (30 minutes, 45 minutes, etc) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# days/week: 0 1 2 3 4 5 6 7

Do you have any exercise equipment at home?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a gym membership? ☐NO/ ☐YES; Do you use it? ☐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:  Females: | >17 (5)  >16 (5) | <17 (0)  <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: \_**

Do you wake up with headaches in the morning? ☐NO/ ☐YES

Do you wake up choking/gasping for breath? ☐NO/ ☐YES

Do you have restless sleep/wake up frequently through the night? ☐NO/ ☐YES

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

**Your Current Medications**

*(Please enter below or attach current list from home)*

|  |  |  |
| --- | --- | --- |
| **Name of Medication/ Vitamin** | **Frequency** | **Dose** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Reminder: Please make sure that you have contacted your insurance plan’s customer service department (call the # on the back of your card) to ensure that your policy will cover weight loss surgery at Lahey.**