MEDICAL/SURGICAL HISTORY FORM

Name: ______________________________ **DOB:** ____ /____ /_______ **Date:** ____ /____ /_______

If you are interested in a surgical procedure, please check which procedure:

- ☐ Gastric Bypass
- ☐ Sleeve Gastrectomy
- ☐ Lap Band
- ☐ Undecided
- ☐ Revision of Previous Surgery

Physician use only

HT __________

WT __________

BMI __________

Medical History (please circle yes or no to the following questions)

Has a Doctor or Health Professional ever told you that you have or treated you for any of the following?

Nervous System:

Stroke, mini stroke, or one-sided weakness?	NO	YES
Chronic headaches/migraines?	NO	YES
Seizures?	NO	YES
Numbness or tingling in neck, arms, or hands?	NO	YES

Heart and Circulation:

High blood pressure?	NO	YES
High cholesterol?	NO	YES
Congestive heart failure?	NO	YES
Heart attack?	NO	YES
Heart valve abnormalities?	NO	YES
Abnormal heart rhythms?	NO	YES
Do you ever experience chest pain or palpitations?	NO	YES
Symptoms with exercise?	NO	YES

If yes, explain: ____

Heart stress test?	NO	YES
Cardiac catheterization or angioplasty?	NO	YES
Pacemaker or implantable defibrillator?	NO	YES

Patient Information or Sticker

Name:

DOB:

Medical Record #:

Name: ______________________ DOB: ____ /____ /________ Date: ____ /____ /________

Lungs and Breathing:

Sleep apnea?	NO	YES
CPAP or BIPAP machine?	NO	YES
Have you ever had a sleep study?	NO	YES
Asthma?	NO	YES
Emphysema or COPD?	NO	YES
Pulmonary embolus?	NO	YES

How many blocks can you walk without becoming short of breath?
(please circle one of the choices listed below)

Less than 1/2 block   1/2 block   1 block   1-2 blocks   more than 2 blocks

Liver, Gallbladder, Stomach, Intestine

GERD/Acid Reflux?	NO	YES
Heartburn?	NO	YES
If yes, how many times per week?	____ times/week	
Difficulty swallowing food or liquid?	NO	YES
Gallstones?	NO	YES
Pancreatitis?	NO	YES
Cirrhosis?	NO	YES
Stomach/duodenal ulcers?	NO	YES
Hiatal hernia?	NO	YES
Hepatitis (A, B or C)?	NO	YES
Crohns/Ulcerative Colitis?	NO	YES
Irritable Bowel Syndrome?	NO	YES
Chronic constipation?	NO	YES
History of GI cancer?	NO	YES
Have you ever had a colonoscopy, barium enema, or upper endoscopy?	NO	YES

If yes, include the date and reason why:

____

____

____

____

Physician use only

Patient Information or Sticker

Name:

DOB:

Medical Record #:

Name: ______________________________ DOB: ____ /____ /________ Date: ____ /____ /________

Blood and Clotting:

Are you willing to accept a blood transfusion?	NO	YES
Anemia?	NO	YES
Sickle cell disease?	NO	YES
Clotting or platelet disorder?	NO	YES
Deep Venous Thrombosis (DVT - Blood clot in your arm, leg, chest, etc.)?	NO	YES
Have you ever been on Coumadin?	NO	YES

Are you on any of the following?:

Aspirin   Plavix   NSAIDS (Ibuprofen, Advil, Motrin, Naprosyn)

Endocrine:

Diabetes?	NO	YES
Thyroid disease?	NO	YES
Polycystic ovarian syndrome?	NO	YES
Cushings Disease?	NO	YES
Excessive thirst, urination, or hunger?	NO	YES
Visual changes (wavy lines, spots)?	NO	YES
Changes in body temperature (very cold or hot)?	NO	YES

Miscellaneous:

Depression?	NO	YES
Schizophrenia?	NO	YES
Other psychiatric disorder?	NO	YES
Joint pain (hip, knee, ankle, lower back)?	NO	YES

If yes, circle the areas that are affected

Lower back   hip   knee   ankle

Urinary stress incontinence? NO YES

If yes, how many pads do you use per day? _____ pads/day

Kidney stones and/or other kidney disease? NO YES

Physician use only

* Will patient accept blood products?
☐ Yes ☐ No

*Procedures discussed?
☐ Yes ☐ No

Patient Information or Sticker

Name:

DOB:

Medical Record #:

Name: ______________________________ DOB: ____ /____ /______ Date: ____ /____ /______

Physician use only

Miscellaneous continued:

HIV? NO YES

Autoimmune disease (rheumatoid arthritis, lupus, etc)? NO YES

If yes, please explain:

____

____

____

____

Pregnancy History:

How many times have you been pregnant? ______

How many times have you delivered? ______

Have you ever had a c-section? NO YES

(If yes, how many)? ______

Complications following delivery or c-section? NO YES

Problems during pregnancy (increased BP or blood sugar)? NO YES

Have you ever had a tubal ligation? NO YES

Have you ever had problems becoming pregnant? NO YES

If yes, please explain:

____

____

____

Surgical History:

Have you ever had prior surgery? NO YES

Have you ever had weight loss surgery? NO YES

If yes, list all surgeries that you have had and the year in which they occurred:

____

____

____

____

____

Patient Information or Sticker

Name:

DOB:

Medical Record #:

Name: ____________________ DOB: ____/____/______ Date: ____/____/______

Surgical History continued:

Have you ever experienced any of the following after surgery?

Blood clot(s)? NO YES

Abnormal bleeding? NO YES

Problems with anesthesia? NO YES

If yes please explain:

____

____

Difficulty healing? NO YES

If yes please explain:

____

____

Drug Allergies? NO YES

If yes, describe the reaction you had:

____

____

Social History:

Current smoker? NO YES

If yes, how much do you smoke (pack(s)/day): _____ pack(s)/day

How many years have you smoked: _____ years

Past smoker? NO YES

If yes, indicate the number of months since you quit: _____ months

Drink alcoholic beverages? NO YES

If yes, indicate the number of drinks/week: ____ drinks/week

Current IV drug use? NO YES

Past IV drug use? NO YES

Do you live alone? NO YES

Do you use a wheelchair or walker? NO YES

Occupation: ______________________________

Physician use only

Patient Information or Sticker

Name:

DOB:

Medical Record #:

Name: ______________________ DOB: ____/____/______ Date: ____/____/______

Family History: (parents and siblings):

Check here if your family history is unknown ☐

Obesity	NO	YES
High Cholesterol	NO	YES
Bleeding	NO	YES
Diabetes	NO	YES
High blood pressure	NO	YES
Heart disease	NO	YES
Heart Attack	NO	YES
DVT (blood clots in arm, leg, chest, etc.)	NO	YES
Cancer	NO	YES
Anesthesia difficulty	NO	YES
Sleep apnea	NO	YES
Asthma	NO	YES

Current medications:

Please include all prescriptions and over the counter medications, herbs and vitamins. (You may bring a separate list)

Medication	Dose	Frequency

Physician use only

Patient Information or Sticker

Name:

DOB:

Medical Record #:

Name: ______________________ DOB: ____ /____ /______ Date: ____ /____ /______

Please check all previous weight loss program or medications you have tried:

Program	Date	Weight (lost or gained)	Length of participation
Weight Watchers			
Overeaters Anonymous			
Liquid diets (optifast)			
Diet pills (phen-fen, redux)			
Diet pills (meridia, xenical)			
Diet pills (phentermine, Topamax)			
Nutrisystem			
Jenny Craig			
OTC diet pills			
Nutritionist/dietitian			
Surgery			
Other			

Physician use only

Patient Information or Sticker

Name:

DOB:

Medical Record #:

Name: ______________________ DOB: ____/____/______ Date: ____/____/______

Surgical Candidates Only:

PERSONAL STATEMENT

PLEASE TELL US IN YOUR OWN WORDS WHY YOU ARE PURSUING WEIGHT LOSS SURGERY – GIVE THREE DIFFERENT REASONS FOR ENTERING THE PROGRAM AND INCLUDE ANY PERSONAL GOALS. PLEASE USE ADDITIONAL PAPER IF NECESSARY.

Patient Information or Sticker

Name:

DOB:

Medical Record #:

Weight loss surgery insurance coverage

Please read this carefully prior to seeing your surgeon

Although morbid obesity is considered to be a chronic medical disease by the medical community, it does not carry the same consideration by the health insurance industry. Thus, unlike other medical conditions where surgeons determine the need for surgery, in respect to weight loss surgery, your insurance will often determine this need. Thus, not all insurance will cover weight loss surgery. For example, if you have the health insurance through Perdue Farms or Wicomico Board of education, you will not have the coverage for weight loss surgery. Furthermore, even if your insurance does provide the coverage for weight loss surgery, you must meet particular conditions set by your insurance prior to obtaining the approval of your surgery. For example, CareFirst insurance originating from state of Maryland will require 7 months duration of medical follow up prior to their review of an approval of weight loss surgery where as Medicare and Conifer insurance do not.

Our role as your surgeon is to evaluate you to see if you have the medical necessity for the weight loss surgery. *Your responsibility is to see if your insurance has the weight loss surgery coverage.* If you have the medical necessity and coverage, we will work together to meet the conditions set by your insurance so that the approval can be obtained. Since these conditions vary from different insurance products and appear to change haphazardly, it may be possible that your initial surgery approval may be denied and may require resubmission for the final approval.

Remember, medical necessity does not mean that you will automatically receive the approval for the weight loss surgery from your insurance.

Name: ____ Date:____________________

STOP-Bang questionnaire

Yes	No	Question
☐ Yes	☐ No	**Snoring?** Do you **snore loudly** (loud enough to be heard through closed doors, or your bed partner elbows you for snoring at night)?
☐ Yes	☐ No	**Tired?** Do you often feel **tired, fatigued, or sleepy** during the daytime (such as falling asleep during driving)?
☐ Yes	☐ No	**Observed?** Has anyone **observed** you **stop breathing** or **choking/gasping** during your sleep?
☐ Yes	☐ No	**Pressure?** Do you have or are being treated for **high blood pressure?**
☐ Yes	☐ No	**Body mass index more than 35 kg/m^2?**
☐ Yes	☐ No	**Age older than 50 years old?**
☐ Yes	☐ No	**Neck size large? (measured around Adam's apple)** For male, is your shirt collar 17 inches or larger? For female, is your shirt collar 16 inches or larger?
☐ Yes	☐ No	**Gender = Male?**
Scoring criteria*:		
For general population		
Low risk of OSA: Yes to 0 to 2 questions		
Intermediate risk of OSA: Yes to 3 to 4 questions		
High risk of OSA: Yes to 5 to 8 questions		

OSA: obstructive sleep apnea

* For validated scoring criteria in obese patients, please refer to UpToDate topic on surgical risk and the preoperative evaluation and management of adults with obstructive sleep apnea.

References:

1. *Chung F, Yegneswaran B, Liao P, et al. STOP questionnaire: a tool to screen patients for obstructive sleep apnea. Anesthesiology 2008; 108:812.*
2. *Chung F, Subramanyam R, Liao P, et al. High STOP-Bang score indicates a high probability of obstructive sleep apnoea. Br J Anaesth 2012; 108:768.*

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