Beth Israel Lahey Health

Patients Name: ______________________________

DOB (Date of Birth): __________________________

Best telephone number: _______________________

Email:______________________________________

Permanent Address: ____

Insurance Carrier and Insurance ID:____

Name of Primary Care Provider (PCP): ______________________________________

PCP Telephone number: ____

How did you hear about our program? ______________________________________

Height (inches):_____________________________

Weight (pounds):____________________________

BMI (Body Mass Index, if known):_______________

Have you previously been screened at another weight loss surgery program? o Yes o No

If yes, where and date: ____

o Please check here if you give permission for your records to be faxed to our clinic.

I am interested in the (check all that apply):

o Gastric Sleeve o Gastric Bypass o Undecided o Other____________________

Have you already had previous Weight Loss Surgery? o Yes o No

If yes, which surgery did you have? (date and location):_____________________________

If you had weight loss surgery, your reason for contacting our clinic (please check all that apply):

o Medical issues (reflux, vomiting, difficulty swallowing, etc) Add comments here:____________

____

o Weight gain/ regain

o Bariatric follow up care only

o My insurance changed

o Moved

o Referral from my PCP

Past Medical History: Please check all that apply:

- Type 2 Diabetes
- Type 1 Diabetes
- Obstructive Sleep Apnea (OSA)
- Hypertension (HTN)
- Hyperlipidemia (high cholesterol / triglycerides)
- PCOS
- Fatty Liver Disease
- Osteoarthritis
- Pseudotumor Cerebri
- Asthma
- Stroke
- Renal/ Kidney disease
- Infertility
- History of blood clots
- Other blood disorders
- Thyroid disorders (Hypothyroidism / Hyperthyroidism)
- Cancer (kind) ____________________ In remission? (dates) ____________________
- Coronary Artery Disease
- Other cardiac disease or events _________
- Bipolar disorder
- Schizoaffective disorder
- Borderline personality disorder
- Binge eating disorder
- Anorexia / Bulimia
- Obsessive Compulsive Disorder
- ADHD
- Learning disabilities
- Other: _______________________________

FAMILY Past Medical History: Please check all that apply to immediate family members:

- Type 2 Diabetes
- Type 1 Diabetes
- Obstructive Sleep Apnea (OSA)
- Hypertension (HTN)
- Hyperlipidemia (high cholesterol / triglycerides)
- PCOS
- Fatty Liver Disease
- Osteoarthritis
- Pseudotumor Cerebri
- Asthma
- Stroke
- Renal/ Kidney disease
- Infertility
- History of blood clots
- Other blood disorders
- Thyroid disorders (Hypothyroidism / Hyperthyroidism)
- Cancer (kind) ____________________ In remission? (dates) ____________________
- Coronary Artery Disease
- Other cardiac disease or events _________
- Bipolar disorder
- Schizoaffective disorder
- Borderline personality disorder
- Binge eating disorder
- Anorexia / Bulimia
- Obsessive Compulsive Disorder
- ADHD
- Learning disabilities
- Other: _______________________________

Medications: Do you take any medication? ○ Yes ○ No

If yes, please list all current medication: ____

____

____

Do you take any **vitamins, minerals and/or herbal supplements**: ○ Yes ○ No

If yes, please list all: ____

____

Past Surgical History: Please fill in

Surgery #1 (and date): ____

Surgery #2 (and date): ____

Surgery #3 (and date): ____

Allergies:

Medication allergies:____

Food allergies:____

Other allergies: ____

What do you consider your **functional health status**?

○ Independent- no assistance needed to complete activities of daily living

○ Partially Dependent- I require some assistance from another person to complete activities of daily living

○ Fully Dependent - I require full assistance from another person to complete activities of daily living

Are you currently on disability? ○ Yes ○ No

Diet History

Previous Weight Loss Attempt(s) (check all that apply and length of time):

- Low carb / Atkins / Keto: Year /Length of time_______________________________________
- Low fat / reduced calories (calorie counting): Year /Length of time______________________
- Intermittent Fasting: Year /Length of time____
- Prepared meals / Liquid diet (meal replacements): Year /Length of time__________________
- Weight Watchers, HMR, Optifast, Noom, other programs: Year /Length of time____________
- Working/worked with MD, Endocrinologist, Dietitian, etc: Year /Length of time______________________________
- Laxatives: Year /Length of time____
- Anti Obesity Medication: Year /Length of time_______________________________________
- Other weight loss Medication and supplements (please list): Year /Length of time______________________________
- Other: Year /Length of time____
- None

Weight History

What is the most amount of weight loss you have lost (How much and when)?_______________

____

What and when was your highest weight? ____

What is your lowest weight (and year)____

What do you feel has been your biggest barrier to losing weight? __________________________

____

In your opinion, what are some factors that contribute to your obesity? (check all that apply)

- Portion size
- Genetics / hormones
- Grazing
- Insufficient physical activity
- Excessive sugar & sweetened beverages (soda, juice, coffee drinks, etc)
- Compulsive eating
- Eating too many fats/carbs
- Binge eating
- Emotional eating
- Skipping meals/ meal inconsistency
- Convenience meals / dining out
- Pregnancy
- Menopause
- Injury / medical event: ____

Have you been **hospitalized** in the past year for either a medical or psychiatric issue?

○ Yes ○ No Please comment here: ____

Who is your **designed support person/ people** for after surgery?

Please put their name and relationship: ____

Do you have a **therapist or mental health provider**? ○ Yes ○ No

If yes, name and contact information: ____

○ Please check here if you give permission for our clinic to be in contact with your mental health provider.

Food/Financial Security:

Do you have any financial challenges at this time that affect your ability to buy food, medicine or pay your bills? ○ Yes ○ No

Do you receive any financial assistance for food: (SNAP, Meals on Wheels, food pantries, etc)? ○ Yes ○ No

Do you have stable housing? ○ Yes ○ No

Substance Use: Do you use the following substances (check all that apply and enter in frequency of use per day/week/month/year). If no longer using, date of last use.

○ Alcohol: ___________________________ ○ Cigarettes:_____________________________

○ Vaping: ___________________________ ○ Hookah:_______________________________

○ Marijuana:_________________________ ○ Nicotine:_______________________________

○ Chewing tobacco ___________________ Other substances:________________________

○ None of the above

Why do you want to have weight loss surgery now? __________________________________

____

Do you feel that you have the time to commit to a weight loss surgery program now? _______

____

STOP BANG Sleep Apnea Questionnaire

Name____ Age ____________________

Height (inches):_____________ Weight (pounds): _____________ BMI: _____________

Collar size of shirt: S M L XL (or ________inches)

Neck circumference (measured by staff) ___________cm

Snoring: Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?

□ Yes □ No

Tired: Do you often feel tired, fatigued, or sleepy during the day?

□ Yes □ No

Observed: Has anyone observed that you stop breathing during your sleep?

□ Yes □ No

Blood pressure: Do you have or are you being treated for high blood pressure?

□ Yes □ No

BMI more than 35 kg/m2?

□ Yes □ No

Age over 50 years?

□ Yes □ No

Neck circumference greater than 40 cm?

□ Yes □ No

Gender, male?

□ Yes □ No