CHRISTUS® GOOD SHEPHERD Health System

New Patient Bariatric Questionnaire

Date & Method you viewed Dr. McDermott's Seminar:

DATE: _____ ❑Monthly Meeting ❑DVD ❑Online

PERSONAL INFORMATION

Name: _____ Date of Birth: _____ Age: _____ Gender: _____

Address: _____ Home Phone: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____ Social Security #: _____

Patient Email: _____ Spouse/Partner Name: _____

Ethnicity (optional): ❑White ❑Hispanic ❑Black ❑ Asian ❑Native American ❑Other: _____

Patient Occupation: _____Employer: _____ ❑Full Time ❑ Part Time

Patient Work Phone (Optional): _____ Patient Work Email (Optional): _____

Pharmacy: _____ Location: _____

PRIMARY Insurance Company: _____

Subscriber Name: _____Sub DOB: _____

Subscriber/ID #: _____ Plan: _____

Group #: _____ Ins Phone: _____

SECONDARY Insurance Company: _____

Subscriber Name: _____ Sub DOB: _____

Subscriber/ID #: _____ Plan: _____

Group #: _____ Ins Phone: _____

HEALTH CARE PROVIDER

Primary Care Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

I give Good Shepherd Surgical Associates permission to discuss my medical care with the following person(s):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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Please review the co-morbidities and indicate any that you have been previously diagnosed with, when you were diagnosed and all medications that you are currently taking for the selected item. This information will be reviewed, monitored and tracked at each post-operative appointment.

❑ **Diabetes Type 1**:
Date diagnosed: _____
Current Medication: _____

❑ **Diabetes Type 2**:
Date diagnosed: _____
Current Medication: _____

❑ **High Cholesterol:**
Date diagnosed: _____
Current Medication: _____

❑ **Hypertension:**
Date diagnosed: _____
Current Medication: _____

❑ **Osteoarthritis:**
Date diagnosed: _____
Current Medication: _____

❑ **Gastro Esophageal Reflux Disease:**
Date diagnosed: _____
Current Medication: _____

❑ **Sleep Apnea:**
Date diagnosed: _____
Do you use a CPAP? _____

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OBESITY HISTORY

Obesity has been a problem for _____ years, since:

❑Childhood ❑Teenage Years ❑Adult Years ❑Pregnancy

PHYSICIAN SUPERVISED DIET: Insurance companies' definition of Physician Supervised Diet means that you have gone monthly to your physician or other health care provider, specifically for weight loss. If you have participated in this type of diet, please check how long you did the program.

❑3 month's ❑6 month's ❑12 month's ❑More than a year

Did you participate in this Physician Supervised Program within the last two years from today's date?

❑No ❑Yes Dates: _____

If yes: Physician Name: _____ Phone number: _____

►**Activity Level**: (Please check the one level that most accurately describes your activity.)

❑Sedentary (very little exercise)
❑Mild exercise (stairs, walk over three blocks without becoming short of breath, golf)
❑Occasional vigorous exercise (work or recreation – less than 30 minutes/4x a week)
❑Regular vigorous exercise (work or recreation – more than 30 minutes/4x a week)

Do you mow your lawn?	❑Yes	❑No	Do you climb stairs daily?	❑Yes	❑No
Is your house on two levels?	❑Yes	❑No	Do you take daily walks?	❑Yes	❑No

►**Exercise Habits:**

❑Walking	❑Yoga/Pilates	❑Swimming
❑Aerobics	❑Curves	❑Gym/Club membership
❑Water aerobics	❑Physical Therapy	❑DVD/Video Tapes
❑Personal Trainer	❑Other: _____	

❑PT is unable to exercise due to: _____

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►**Weight Loss Drugs:**

Please indicate all weight loss drugs you have used in the past including herbal/homeopathic and over-the –counter:

Fen-Phen	❑Yes ❑No	Xenecal®	❑Yes ❑No
Phentermine (Fastin®)	❑Yes ❑No	Pondimin®	❑Yes ❑No
Meridia®	❑Yes ❑No	Others (include all): _____	

►**Food Habits**:

I am satisfied when I finish eating a meal.	❑Yes ❑No	I snack between meals.	❑Yes ❑No
I use food as a source of comfort.	❑Yes ❑No	I eat some sweets every day.	❑Yes ❑No
I am concerned about how much I eat.	❑Yes ❑No	I binge eat.	❑Yes ❑No
I am concerned about the types of food I eat.	❑Yes ❑No	I snack all day long.	❑Yes ❑No
I think a lot about food during the day.	❑Yes ❑No	I go without then gorge myself.	❑Yes ❑No
How many times per day do you eat?	_____	I eat normal size meals 3x daily.	❑Yes ❑No

►**Please indicate which diet programs you have tried by answering YES or NO to each of the diet programs listed:**

Book Diet	❑Yes ❑No	Self-Imposed Fasts	❑Yes ❑No	Herbal Life	❑Yes ❑No
Hypnosis	❑Yes ❑No	Over-the-Counter	❑Yes ❑No	High Protein	❑Yes ❑No
Metabolic Research	❑Yes ❑No	Liquid Protein	❑Yes ❑No	Jenny Craig	❑Yes ❑No
Dr. Atkins	❑Yes ❑No	Low Carbohydrate	❑Yes ❑No	Overeaters Anon.	❑Yes ❑No
Low Calorie	❑Yes ❑No	Weight Watchers	❑Yes ❑No	Nutri-System	❑Yes ❑No

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CURRENT MEDICATIONS:

Please complete for **each** drug and herbal and/or homeopathic medications taken including herbal dietary and weight loss supplements and over the counter medications (such as aspirin). Check medical containers for the correct dosage information.

Name of Medication	Strength	Frequency	Purpose	Start Date	Prescribing Physician

►Have you taken oral steroid pills (ex Prednisone®) in the last year? ❑Yes ❑No
►Are you taking COUMADIN ®? ❑Yes ❑No
►Are you taking PLAVIX®, EFFIENT®, PRADAXA®, XARELTO®, BRILINTA®? ❑Yes ❑No
►Do you take immunosuppressant's? ❑Yes ❑No

►ALLERGIES

Are you allergic to any of the following?

Latex: ❑Yes ❑No **Surgical Tape**: ❑Yes ❑No **X-Ray Dye**: ❑Yes ❑No **Iodine**: ❑Yes ❑No

►Please list ALL medications, including over-the-counter (OTC) medications that you are ALLERGIC to:

Medications **Symptoms/Reaction:**

1. _____ ❑Difficulty Breathing ❑Rash ❑Nausea ❑Itching ❑Other: _____
2. _____ ❑Difficulty Breathing ❑Rash ❑Nausea ❑ Itching ❑Other: _____
3. _____ ❑Difficulty Breathing ❑Rash ❑Nausea ❑Itching ❑Other: _____
4. _____ ❑Difficulty Breathing ❑Rash ❑Nausea ❑itching ❑Other: _____

►Please list ALL foods/herbs you are ALLERGIC to:

1. Shellfish ❑Yes ❑No ❑Difficulty Breathing ❑Rash ❑Nausea ❑itching ❑Other: _____
2. _____ ❑Difficulty Breathing ❑Rash ❑Nausea ❑ Itching ❑Other: _____
3. _____ ❑Difficulty Breathing ❑Rash ❑Nausea ❑Itching ❑Other: _____
4. _____ ❑Difficulty Breathing ❑Rash ❑Nausea ❑itching ❑Other: _____

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HISTORY OF PRESENT ILLNESS

Please check (✓) if you currently have or you have had problems with any of the following conditions.

- ❑ Alcoholism
- ❑ Allergies/Hay fever
- ❑ Anemia
- ❑ Anxiety
- ❑ Asthma
- ❑ Atrial Fibrillation
- ❑ Blood Transfusions
- ❑ CAD
- ❑ Cancer
- ❑ Cardiac Pacer
- ❑ Cardiovascular Disease
- ❑ Congestive Heart Failure
- ❑ Chicken Pox
- ❑ Cirrhosis
- ❑ Colitis
- ❑ COPD
- ❑ Chronic Renal Failure
- ❑ Crohn's Disease
- ❑ CVT (Stoke)
- ❑ Deep Vein Thrombosis (DVT)
- ❑ Pulmonary Embolus
- ❑ Depression
- ❑ Diabetes Type 1
- ❑ Diabetes Type 2
- ❑ Epilepsy
- ❑ Fracture
- ❑ Gastric Ulcer
- ❑ Gastrointestinal Disease
- ❑ Gestational Diabetes
- ❑ Glaucoma
- ❑ Heartburn
- ❑ Heart Murmur
- ❑ Hepatitis
- ❑ High Cholesterol
- ❑ Hyperlipidemia
- ❑ Hypertension
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Insulin Pump
- ❑ Joint Pain
- ❑ Kidney Disease
- ❑ PCI/PTCA/Stent Venous Stasis
- ❑ Kidney Infection
- ❑ Kidney Stone
- ❑ Migraines
- ❑ Multiple Sclerosis
- ❑ Myocardial Infarction
- ❑ Obesity
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Progressive Neurological Disorder
- ❑ Pulmonary Disease
- ❑ Rheumatic Fever
- ❑ Rheumatoid Arthritis
- ❑ Shingles
- ❑ STD
- ❑ Terminal Illness
- ❑ Thyroid Disease
- ❑ Transient Ischemic Attack
- ❑ Tuberculosis
- ❑ Valvular Problems

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SOCIAL HISTORY:

►**Marital Status**: ❑Single ❑Married ❑Separated ❑Divorced ❑Widowed ❑Significant other

►**Living Circumstance**:

Do you live: ❑Alone ❑With parents ❑With spouse ❑With significant other
❑With children ❑Other: _____

►**Tobacco**: Have you used tobacco products in the past? ❑Yes ❑No Year quit: _____
Tobacco used now? ❑Yes ❑No

❑Cigarettes:	Packs per day	_____	Number of years	_____
❑Cigars:	Number per day	_____	Number of years	_____
❑Pipe:	Times per day	_____	Number of years	_____
❑Chew:	Times per day	_____	Number of years	_____

►**Alcohol**: Do you drink alcohol daily? ❑Yes ❑No how much: _____
Drink more than one time daily? ❑Yes ❑No

►**Caffeine:** Do you use caffeine, including:

Coffee	❑Yes ❑No	How many cups daily?	_____
Soda with caffeine	❑Yes ❑No	How many daily?	_____
Other: _____		How often?	_____

►**Drugs**:

Do you currently use recreations/ street drugs? ❑Yes ❑No
If no, have you ever in the past? ❑Yes ❑No
Have you ever been enrolled in a drug treatment program? ❑Yes ❑No If yes, when? _____

►**SURGICAL HISTORY**

►It Is important that you complete this for any surgeries you may have had in the past.

Surgery	Date	Procedure (Open)	Procedure (Laparoscopic)	Surgeon	Reason for Surgery
Sinus					
Thyroid					
Tonsillectomy/ Adenoidectomy					
Breast					
Cancer (location)					
Eye: Cataract					
Eye: Corneal Transplant					

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►**SURGICAL HISTORY CONTINUED**

Eye: Glaucoma					
Neck: Carotid Endarterectomy					
Neck: Fusion					
Lung Biopsy					
Lung Removal					
Chest: Aneurysm					
Heart: Coronary Bypass					
Heart: Valve					
Heart: Pacemaker					
Back: Laminectomy					
Back: Vertebral/Cervical Disc (location)					
Joint replacement (location)					
Varicose veins (Sclerotherapy)					
ABDOMINAL SURGERIES	**Date**	**Procedure (Open)**	**Procedure (Laparoscopic)**	**Surgeon**	**Reason for Surgery**
Colon: Colostomy					
Colon: Removal					
Hysterectomy: Complete (ovaries gone)					
Hernia					
Ovary removal Both Right Left					
Tubal ligation					
C-Sections How many _____					
Appendectomy					
Bladder Suspension					
Intestine Removal					
Other Abdominal Surgeries					

►**ANESTHESIA SCREEN:**

Have you ever had anesthesia? ❑Yes ❑No

If yes, did you have any of the following: Nausea and Vomiting ❑Yes ❑No Cardiac Arrhythmias:

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Airway Difficulty	❑Yes ❑No	During Surgery	❑Yes ❑No
Narrow Airway	❑Yes ❑No	After Surgery	❑Yes ❑No
Difficult Intubation	❑Yes ❑No	Need for prolonged ventilation:	
Fever during surgery	❑Yes ❑No	Breathing machine	❑Yes ❑No
Difficulty waking up	❑Yes ❑No		

Have you ever had an unexplained complication during surgery or anesthesia? ❑Yes ❑No
Has a member of your family ever had an unexplainable complication? ❑Yes ❑No

►PAST MEDICAL STUDIES

Have you ever had any of the following tests?

	Normal	Abnormal	Date of last test	Reason for test
*EGD	❑	❑	_____	_____
*Cardiac Stress Test	❑	❑	_____	_____
*Cardiac Nuclear Medicine Scan	❑	❑	_____	_____
*Cardiac Catheterization	❑	❑	_____	_____

►FAMILY HISTORY

Using the letters in parenthesis from the Family Member Chart, please indicate on the line next to the conditions written below which family members have had:

❑Adopted
❑Unknown History

Alcoholism:_____
Anemia:_____
Anxiety:_____
Asthma:_____
CAD: _____
Cardiovascular Disease: _____
Congestive Heart Failure: _____

Congenital Anomaly: _____

COPD: _____

Crohn's Disease: _____

Depression: _____
Diabetes: _____

Epilepsy: _____
GERD: _____
High Cholesterol: _____
Hyperlipidemia: _____
Hypertension: _____

Hypothyroidism: _____
Kidney Disease:_____
Liver Disease:_____
Osteoarthritis:_____
Birth Defects: _____
Osteoporosis: _____
Pulmonary Disease: _____

Stroke: _____

Obesity:_____

Breast Cancer:_____

Ovarian Cancer:_____
Colon Cancer: _____

Medullary Thyroid Cancer: _____
Adrenal Tumor:_____
Pituitary Tumor: _____
DVT or PE (blood clots): _____
Heart Attack: _____

Family Member Chart
Mother (**M**)
Father (**F**)
Maternal Grandmother (**MGM**)
Maternal Grandfather (**MGF**)
Paternal Grandmother (**PGM**)
Paternal Grandfather (**PGF**)
Brother (**B**)
Sister (**S**)

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REVIEW OF SYSTEMS

(Please answer every question by checking (✓) each box

General

Change in Activity	❑Yes ❑No
Change in Appetite	❑Yes ❑No
Chills	❑Yes ❑No
Night Sweats	❑Yes ❑No
Fatigue	❑Yes ❑No
Fever	❑Yes ❑No
Sudden weight loss	❑Yes ❑No

HEENT

Post Nasal Drip	❑Yes ❑No
Trouble Swallowing	❑Yes ❑No
Voice Changes	❑Yes ❑No

Eyes

Sensitivity to light	❑Yes ❑No
Vision Changes	❑Yes ❑No

Respiratory

Breathing pauses during Sleep	❑Yes ❑No
Chest Tightness	❑Yes ❑No
Cough	❑Yes ❑No
Shortness of Breath	❑Yes ❑No
Wheezing	❑Yes ❑No

Cardiovascular

Chest Pain	❑Yes ❑No
Irregular Heartbeat	❑Yes ❑No

Gastrointestinal

Abdominal Distention	❑Yes ❑No
Abdominal Pain	❑Yes ❑No
Blood in Stool	❑Yes ❑No
Constipation	❑Yes ❑No
Diarrhea	❑Yes ❑No
Nausea	❑Yes ❑No
Vomiting	❑Yes ❑No

Endocrine

Cold Intolerance	❑Yes ❑No
Heat Intolerance	❑Yes ❑No
Frequent Thirst	❑Yes ❑No
Frequent Hunger	❑Yes ❑No
Frequent Urination	❑Yes ❑No

Genitourinary

Difficulty Urinating	❑Yes ❑No
Painful Urination	❑Yes ❑No
Urine Leakage	❑Yes ❑No
Blood in Urine	❑Yes ❑No

Musculoskeletal

Joint Pain	❑Yes ❑No
Back Pain	❑Yes ❑No

Skin

Rash	❑Yes ❑No
Open Wounds	❑Yes ❑No

Allergy/Immune

Environmental Allergies	❑Yes ❑No
Food Allergies	❑Yes ❑No
Immunocompromised	❑Yes ❑No

Neurologic

Dizziness	❑Yes ❑No
Light-Headedness	❑Yes ❑No
Numbness	❑Yes ❑No
Passes Out	❑Yes ❑No

Hematologic

Easy Bleeding	❑Yes ❑No
Easy Bruising	❑Yes ❑No

Psychiatric

Eating Disorder	❑Yes ❑No
Depressed Mood	❑Yes ❑No
Hallucinations	❑Yes ❑No
Nervous/Anxiety	❑Yes ❑No
Self Injury	❑Yes ❑No
Suicidal	❑Yes ❑No

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Weight Loss Surgery Patient Compliance Agreement

The purpose of this agreement is to ensure your understanding and commitment required to produce a successful outcome with regard to your bariatric surgical procedure.

Instructions: Please read each paragraph, and once you agree to the contents of that paragraph, please write your initials on the line next to each paragraph. If you have any questions please ask.

_____ I understand that I play an essential role in the treatment of my obesity and that my continuous active participation in my treatment is essential.

_____ I verify that I have completed a medical history questionnaire and that to the best of my knowledge it is true and correct.

_____ I will inform Good Shepherd Surgical Associates of any changes in my address, telephone number and health insurance.

_____ I agree to comply with the pre- and post-surgery protocols, which includes attending bariatric support group programs, following the diet(s) provided to me, and behavior modifications.

_____ I agree to take vitamins, and calcium and other supplements for life as directed by my surgeon and/or primary care physician.

_____ I understand that a medical condition that exists or may develop, not in direct relationship to my obesity surgery, must be treated by my primary care physician. I understand my surgeon may not be able to treat me or fill prescriptions for other medical conditions.

_____ I understand the importance of returning for all required scheduled visits (including clinical appointments and dietitian visits) and that I need to call in advance if I need to reschedule an appointment.

- 2 week, 6 week, 6 month, 1 year, then annually for 2 years.

_____ I understand that this surgery requires long-term follow up for optimal health and success with weight loss.

_____ I understand that if I do not follow through with all of the terms of this Agreement that my surgeon may refuse to perform the bariatric surgical procedure or may discharge me from the practice at any time.

_____ _____

Patient Signature Date Witness Signature Date

_____ _____

Patient Name DOB

CHRISTUS® GOOD SHEPHERD
Institute for Healthy Living

Dear Patient,

As part of your process for surgery you will be meeting with a Registered Dietitian Nutritionist (RDN) located at the Institute for Healthy Living (IHL) on Hawkins. Your follow-ups with the dietitian will generally take place at Dr. McDermott's office, but could be scheduled at the IHL in the event that the dietitian cannot attend clinic on the day you see Dr. McDermott.

The cost of your visits with the dietitian are not included in your cost for the surgery nor rolled into your 90-day follow-up plan with Dr. McDermott. There will be a charge incurred for each visit with the dietitian regardless of the location of your visits. The outpatient insurance verification department will contact your insurance company prior to your Initial Visit and inform you of these costs at that time.

If you have any questions regarding this process, please contact their office at 903-323-6560.

Thank you,
Good Shepherd Medical Center-IHL
Outpatient Nutrition and Diabetes Education Department

_____ _____
Patient Signature Date