CENTER FOR WEIGHT LOSS SURGERY
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Office Visit Form

Name: ____ Date of Birth: __________________ Today's Date: __________________

Current Insurance: ___________________________ Current Address: ____

REASON FOR YOUR VISIT TODAY:

Here for evaluation after:
- ❑ Sleeve Gastrectomy
- ❑ Duodenal Switch
- ❑ Gastric Bypass
- ❑ Abdominoplasty
- ❑ AGB (Lap-Band)
- ❑ Herniorrhaphy
- ❑ Cholecystectomy
- ❑ Emergency Room
- ❑ Single-Anastomosis Duodenal Switch
- ❑ Revision
- ❑ Other: _______________

❑ **Here for a specific problem:** *If there are multiple problems, please state them in the order of severity.*
Include the following information: 1.) When the problem began; 2.) Location; 3.) Recent changes in symptoms;
4.) Severity; 5.) Timing; 6.) When it most often occurs *(If abdominal pain, please indicate where on the graph to the right.)*

____

____

DATE OF LAST: Laboratory studies: ____________; X-ray: ____________; Ultrasound: ____________; EGD: ____________

CURRENT MEDICATIONS:

Please complete for each drug and herbal and/or homeopathic medications taken including herbal dietary and weight loss supplements.

Medication	Dose	Amount/Day	Date Started	By Whom	Reason

PAST MEDICAL HISTORY: Please check conditions you had prior to weight loss surgery and indicate whether they have changed. If it is a new condition, check NEW.

	Improved		Resolved		NEW	
Condition	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Shortness of breath	❑	❑	❑	❑	❑	❑
Sleep apnea	❑	❑	❑	❑	❑	❑
Hypertension	❑	❑	❑	❑	❑	❑
Leg swelling	❑	❑	❑	❑	❑	❑
Varicose veins	❑	❑	❑	❑	❑	❑
Heartburn	❑	❑	❑	❑	❑	❑
Back pain	❑	❑	❑	❑	❑	❑
Joint pain	❑	❑	❑	❑	❑	❑
Depression	❑	❑	❑	❑	❑	❑
Diabetes Mellitus	❑	❑	❑	❑	❑	❑
Elevated cholesterol	❑	❑	❑	❑	❑	❑
Elevated triglycerides	❑	❑	❑	❑	❑	❑
Anemia	❑	❑	❑	❑	❑	❑
Swallowing difficulties	❑	❑	❑	❑	❑	❑

Other: ____

PAST SURGICAL HISTORY:

Pre-operative weight: __________________________

Date of surgery: ______________________________

Type of bariatric surgery (please check):
- ❑ Gastric Bypass; Dimensions: ________________
- ❑ Adjustable Gastric Band
  - Total fluid: __________ cc
  - Date last adjusted: __________________________

Please check other surgeries you may have had:
- ❑ Tummy Tuck (Abdominoplasty)
- ❑ Herniorrhaphy ❑ Cholecystectomy
- ❑ Hysterectomy __ Uterus only __ Uterus & Ovaries
- ❑ Appendectomy
- ❑ Other: __________________________________

LAST HOSPITALIZATION (Include ER Visit):

Date: ____________ Place: ____________________

Reason: ______________________________________

WEIGHT LOSS SURGERY PATIENTS: Complete the following diet information.

Current Diet: ❑ Fasting ❑ Clear liquids ❑ Puree ❑ Soft ❑ Regular

Please describe your typical diet over a 24-hour period, writing down everything you are able to remember about the type and quantity/amount of food consumed, including snacks.

Time	Type	Quantity (oz.)	Calories	Protein (g)
		TOTALS ➲		

USUAL SUPPLEMENTS:

Protein
- Total grams/day ______________
- Type (whey, soy, rice) _________
- # of servings per day _________

Vitamins *# per day*
- ❑ Daily Multi-Vitamin ________
  - Brand: ____________________
- ❑ Calcium _________
- ❑ Iron _________
- ❑ Other: ______________________

USUAL FLUIDS:

Oz./quarts, daily _________

Name: ________________________________ Date of Birth: ______________ Today's Date: ______________

REVIEW OF SYSTEMS: Please answer each of the following as if the question begins with, "Are you…"

Constitutional:

1. Feeling weak/tired all the time? ❑ No ❑ Yes
2. Having trouble sleeping? ❑ No ❑ Yes
3. How many hours do you sleep per night? __________
4. Gaining / losing weight (if yes, circle one) ❑ No ❑ Yes
   Lbs. per month? _______ Since when? (month, year) _________
5. Having fever/chills? ❑ No ❑ Yes
6. Do you exercise at least 30 min/day? ❑ No ❑ Yes

Eye, Ear, Nose, Throat:

1. Having mouth sores? ❑ No ❑ Yes
2. Having visual problems? (e.g. at night) ❑ No ❑ Yes

Cardiovascular:

1. Experiencing swelling of arms / legs / ankles (circle) ❑ No ❑ Yes
2. Having palpitations/racing heart beats? ❑ No ❑ Yes
3. Having chest pains? ❑ No ❑ Yes
4. Having fainting spells? ❑ No ❑ Yes
5. Having shortness of breath climbing stairs? ❑ No ❑ Yes
   If yes, how many stairs? __________
6. Having problems with blood pressure? ❑ No ❑ Yes
7. Having calf pain? ❑ No ❑ Yes

Respiratory:

1. Having wheezing? ❑ No ❑ Yes
2. Experiencing shortness of breath? ❑ No ❑ Yes
3. Having problems with sleep apnea? ❑ No ❑ Yes
   Using a CPAP/Bi-PAP machine? ❑ No ❑ Yes

Gastrointestinal/Abdominal:

1. Having problems with nausea? ❑ No ❑ Yes
2. Vomiting? ❑ No ❑ Yes
3. Regurgitating (feedback)? ❑ No ❑ Yes
4. Vomiting blood? ❑ No ❑ Yes
5. Having heartburn? ❑ No ❑ Yes
6. Having indigestion? ❑ No ❑ Yes
7. Having abdominal pain? ❑ No ❑ Yes
   Where? ____________________ How long? ____________
8. Having "bulging" at the incision? ❑ No ❑ Yes
9. Having diarrhea? ❑ No ❑ Yes
   If yes: times/day ________ times/week ________
10. Constipated? ❑ No ❑ Yes
11. Having blood in your stools? ❑ No ❑ Yes

Musculoskeletal:

1. Having pain in any of the following areas?

Back	❑ No	❑ Yes	Knee	❑ No	❑ Yes
Hip	❑ No	❑ Yes	Ankle	❑ No	❑ Yes
Neck	❑ No	❑ Yes	Shoulder	❑ No	❑ Yes
Wrist	❑ No	❑ Yes	Arm	❑ No	❑ Yes

2. Experiencing fibromyalgia? ❑ No ❑ Yes
3. Experiencing carpal tunnel syndrome? ❑ No ❑ Yes
4. Losing excessive amounts of hair? ❑ No ❑ Yes
5. Having rashes under breasts? ❑ No ❑ Yes
   In abdominal fold? ❑ No ❑ Yes
   Have you seen a dermatologist? ❑ No ❑ Yes
6. Having problems with the wound/scar? ❑ No ❑ Yes
   ❑ Fluid/pus ❑ Redness ❑ Excessive tenderness
7. Having wound drain problems? ❑ No ❑ Yes
   ❑ Pulled out too much ❑ Painful ❑ Site is red
8. Having breast lumps or nipple discharge? ❑ No ❑ Yes

SOCIAL HISTORY:

Marital status: ________________________________
Current occupation: ________________________________
Past or current use of:
Tobacco products ❑ No ❑ Yes
Alcohol ❑ No ❑ Yes
Recreational Drugs ❑ No ❑ Yes
Do you attend Support Group meetings? ❑ No ❑ Yes
Date last attended? __________ Where? ________________

Neurological:

1. Having trouble with balance? ❑ No ❑ Yes
   Have you been to the ER because of falls? ❑ No ❑ Yes
2. Having recurrent headaches? ❑ No ❑ Yes
3. Having seizures? ❑ No ❑ Yes
4. Having episodic weakness? ❑ No ❑ Yes
5. Having numbness/tingling? ❑ No ❑ Yes
6. Having pain down the leg / thigh / arm (circle) ❑ No ❑ Yes
7. Having memory loss? ❑ No ❑ Yes

Psychiatric:

1. Depressed? ❑ No ❑ Yes | Suicidal? ❑ No ❑ Yes
2. Stressed? ❑ No ❑ Yes
   Due to: ❑ Spouse ❑ Significant other ❑ Family ❑ Friends
   ❑ Finances ❑ Job ❑ Other: ________________

Endocrine:

1. Having problems with sugar control (diabetes)? ❑ No ❑ Yes
   Are you on insulin? ❑ No ❑ Yes
2. Having problems with your thyroid gland? ❑ No ❑ Yes
   Are you on medication? ❑ No ❑ Yes
3. Having problems with cholesterol/triglycerides? ❑ No ❑ Yes
   Are you on medication? ❑ No ❑ Yes
4. Having numbness/tingling? Where: _________ ❑ No ❑ Yes
5. Having spasms? Where: ______________ ❑ No ❑ Yes

Hematologic/Lymphatic:

1. Do you have a history of anemia? ❑ No ❑ Yes

Genitourinary:

1. Having urinary leaks when coughing/sneezing? ❑ No ❑ Yes
2. Having difficulty voiding? ❑ No ❑ Yes

Gynecological:

1. Birth control: ______________ Date of last period: __________
2. Date of last pap exam: ____________ ❑ Normal ❑ Abnormal
   If abnormal, is there a history of abnormal? ❑ No ❑ Yes
3. How many pregnancies? ________ How many births? ________
   Vaginal delivery? ________ C-Sections? ________
4. Having problems with menstruation? ❑ No ❑ Yes

Allergies:

1. Having allergy symptoms? ❑ No ❑ Yes
2. Allergic to (please circle): Medications / Supplements / Food / LATEX
   Contrast dye / Iodine / List others: ______________________

FOR PATIENTS WITH ADJUSTABLE GASTRIC BAND:

1. Describe the largest amount you can eat in 30 min:
   (e.g. Big Mac or 6" sub) ____________________________
2. Check first box if you CAN eat, second box if you have NOT TRIED:
   Red meat ❑ ❑; Pasta ❑ ❑; White bread ❑ ❑; Sticky rice ❑ ❑
3. Do you feel your band is restricted? ❑ No ❑ Yes
4. Any recent change in the amount you can eat? ❑ No ❑ Yes
5. Do you still feel very hungry? ❑ No ❑ Yes
6. Are you consuming sugar? ❑ No ❑ Yes
7. Are you consuming milk? ❑ No ❑ Yes
8. Are you taking in liquids & food simultaneously? ❑ No ❑ Yes
9. Are you on appetite suppressants? ❑ No ❑ Yes
   Phentermine (Fastin), Dose _______, Duration: __________
10. Do you have port site tenderness? ❑ No ❑ Yes
11. Has anyone else adjusted your band? ❑ No ❑ Yes
    If yes, who? ______________________________
12. Has your heartburn recurred? ❑ No ❑ Yes

The information I have given on this form is both correct and complete to the best of my ability. I understand that I am financially responsible for all the charges for this visit.

Patient Signature: ______________________________

Date: ______________________________