



Weight Loss Surgery Center
330 Brookline Ave, Shapiro 3
Boston, MA 02215
Phone: (617) 667-2845 Fax: (617) 667-2866
www.bidmc.org/wls

Date: \_\_\_\_\_ \$500 Program fee is due at first medical visit (not covered by insurance)
Name: \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
Address: \_\_\_\_\_
Street City State Zip
Phone # s: ( ) ( ) ( )
Home Cell Work
Fax #: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_
Sex: M F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Number of children: \_\_\_\_\_
How did you hear about our program? \_\_\_\_\_ Marital Status: \_\_\_\_\_
Reason for referral: \_\_\_\_\_
Your Occupation: \_\_\_\_\_
Place of Employment: \_\_\_\_\_

If medically necessary would you accept a transfusion of blood or blood products? Yes No

Current Weight or best estimate: \_\_\_\_\_ Current Height or best estimate: \_\_\_\_\_

I am interested in: ( ) RNY Gastric Bypass ( ) LapBand ( ) Gastric Sleeve ( ) Not sure

People currently living in your household

Table with 3 columns: Name, Age, Relationship. Multiple rows for household members.

Designated Support Person for after surgery

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Medical Health Care Providers

Primary Care Physician: \_\_\_\_\_
Address: \_\_\_\_\_
Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Mental Health Providers

Therapist or Mental Health Counselor: \_\_\_\_\_
Address: \_\_\_\_\_
Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Psychopharmacologist: \_\_\_\_\_
Address: \_\_\_\_\_
Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

## Other Providers

Please list all other medical specialist and healthcare providers. If you need more space, list additional providers' names, specialties, addresses, telephone and fax numbers on the back of this page.

**Provider Name:** \_\_\_\_\_ **Specialty:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone:** ( ) \_\_\_\_\_ **Fax:** ( ) \_\_\_\_\_

**Provider Name:** \_\_\_\_\_ **Specialty:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone:** ( ) \_\_\_\_\_ **Fax:** ( ) \_\_\_\_\_

**Pharmacy Name:** \_\_\_\_\_

**Pharmacy Address:** \_\_\_\_\_

**Telephone:** ( ) \_\_\_\_\_ **Fax:** ( ) \_\_\_\_\_

## Insurance Information

**Insurance Company Name:** \_\_\_\_\_ **Policy/ID Number:** \_\_\_\_\_

**Insurance Company Address:** \_\_\_\_\_

**Named Insured:** \_\_\_\_\_ **Soc. Sec. #** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other

\*Please be sure to call/contact your insurance company to ensure weight loss surgery is covered under your insurance plan. You may want to request a copy of your coverage plan regarding weight loss surgery. In some cases your Human Resource department may be able to assist you with this inquiry. Official authorization is submitted after completion of the screening process.

## Substance Use History

List all of the below that you currently use with including the amounts that you use. List additional items on the back of this page.

Type of Substance	Amount Used	How often do you use this substance?	
Alcohol: _____	_____	_____ (per day)	_____ (per week)
Tobacco: _____	_____	_____ (per day)	_____ (per week)
Recreational Drugs: _____	_____	_____ (per day)	_____ (per week)
_____	_____	_____ (per day)	_____ (per week)
Carbonated Beverages: _____	_____	_____ (per day)	_____ (per week)
Caffeine: _____	_____	_____ (per day)	_____ (per week)

List product you have used in the past, how often, how long and the approximate date of last use.

Type of Substance	How often did you use this substance?	How long did you use this substance?	When did you stop using this substance?
Alcohol: _____	_____	_____	_____
Tobacco: _____	_____	_____	_____
Recreational Drugs: _____	_____	_____	_____
_____	_____	_____	_____

## Supplements and Prescription Medications

Please list all your current medications, supplements and remedies. If you need additional space, please continue on the back of this page.

### Prescription Drugs (including psychiatric medications and birth control)

Name and Dose	Reason for Taking	Date Started
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

### Over the Counter Medications

_____	_____	_____
_____	_____	_____
_____	_____	_____

### Vitamins, Minerals, and Herbal Supplements

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

### Food and Drug Allergies

Medications	Food
_____	_____
_____	_____
_____	_____
_____	_____

### Family History

Please indicate if your parents, siblings, and/or your children have had any of the following conditions.

	Which family member?	Living or Deceased?	Age
heart disease	_____	_____	_____
high cholesterol/lipids	_____	_____	_____
diabetes	_____	_____	_____
stroke	_____	_____	_____
obesity	_____	_____	_____
arthritis	_____	_____	_____
TB (tuberculosis)	_____	_____	_____
thyroid disease	_____	_____	_____
asthma	_____	_____	_____
cancer	_____	_____	_____

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Medical History

Please check each of the following conditions that you are experiencing now, or have experienced in the past.

### Heart and Circulation

### Comments

<input type="checkbox"/> High Blood Pressure	<hr/>
<input type="checkbox"/> Chest pain/angina	<hr/>
<input type="checkbox"/> Coronary Artery Disease (Clogged Arteries)	<hr/>
<input type="checkbox"/> Congestive heart failure	<hr/>
<input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Triglycerides	<hr/>
<input type="checkbox"/> Irregular or rapid heart beat (arrhythmias)	<hr/>
<input type="checkbox"/> Peripheral vascular disease (venous stasis)	<hr/>
<input type="checkbox"/> Leg swelling (edema)	<hr/>
<input type="checkbox"/> Heart murmur	<hr/>
<input type="checkbox"/> Stroke	<hr/>
<input type="checkbox"/> Blood Clots <input type="checkbox"/> Deep Vein Thrombosis	<hr/>

### Urinary and Renal

<input type="checkbox"/> Urinary tract infection	<hr/>
<input type="checkbox"/> Kidney disease	<hr/>
<input type="checkbox"/> Kidney stones	<hr/>
<input type="checkbox"/> Prostate issues	<hr/>
<input type="checkbox"/> Urinary Stress Incontinence	<hr/>

### Endocrine

<input type="checkbox"/> Diabetes <input type="checkbox"/> Last A1C level	<hr/>
<input type="checkbox"/> Hypoglycemia (low blood sugar)	<hr/>
<input type="checkbox"/> Recent increase in thirst or urination	<hr/>
<input type="checkbox"/> Abnormal hair growth	<hr/>
<input type="checkbox"/> Thyroid <input type="checkbox"/> Hypothyroidism (under active)	<hr/>
<input type="checkbox"/> <input type="checkbox"/> Hyperthyroidism (over active)	<hr/>
<input type="checkbox"/> Excessive hot or cold feeling	<hr/>
<input type="checkbox"/> Polycystic Ovary Syndrome	<hr/>
<input type="checkbox"/> Infertility	<hr/>
<input type="checkbox"/> Menstrual irregularities <input type="checkbox"/> Current Birth Control:	<hr/>

### Neurological

<input type="checkbox"/> Hearing changes	<hr/>
<input type="checkbox"/> Change in voice	<hr/>
<input type="checkbox"/> Migraine	<hr/>
<input type="checkbox"/> Numbness or tingling in hands or feet	<hr/>
<input type="checkbox"/> Seizures	<hr/>

### Blood

<input type="checkbox"/> Anemia	<hr/>
<input type="checkbox"/> Iron deficiency	<hr/>

### Musculoskeletal

<input type="checkbox"/> Pain Location(s) _____	Limits activity: Yes or No _____
<input type="checkbox"/> Arthritis Type _____	Location(s) _____
<input type="checkbox"/> Gout	<hr/>
<input type="checkbox"/> Impaired mobility... requiring: <input type="checkbox"/> walker <input type="checkbox"/> cane <input type="checkbox"/> wheelchair <input type="checkbox"/> other	<hr/>

## Medical History Continued

### Gastrointestinal/Digestive System

### Comments

<input type="checkbox"/> Gastroesophageal Reflux (GERD)	<hr/>
<input type="checkbox"/> Heartburn	<hr/>
<input type="checkbox"/> Ulcers	<hr/>
<input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Ulcerative Colitis	<hr/>
<input type="checkbox"/> Frequent diarrhea <input type="checkbox"/> Celiac Disease	<hr/>
<input type="checkbox"/> Frequent constipation	<hr/>
<input type="checkbox"/> Gallbladder <input type="checkbox"/> Gallstones <input type="checkbox"/> Removed	<hr/>
<input type="checkbox"/> Fatty liver	<hr/>
<input type="checkbox"/> Colon <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Polyps	<hr/>
<input type="checkbox"/> Liver <input type="checkbox"/> Hepatitis <input type="checkbox"/> Cirrhosis	<hr/>

### Skin

list any conditions: 

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### Psychiatric

Hospitalization for psychiatric illness    If yes, specify when: 

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Depression 

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Panic attacks      If yes, specify when: 

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Past Suicide Attempts (s)      If yes, specify when: 

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Bipolar disorder 

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Eating disorder     Anorexia     Vomiting/purging 

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### Lungs

Shortness of breath

\_\_\_\_\_ at rest     walking on flat ground     on stairs/hills 

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Home Oxygen Therapy 

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Asthma 

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COPD (emphysema, chronic bronchitis) 

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Pulmonary embolism (blood clot in the lungs) 

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### Sleep

Sleep Apnea     C-PAP     BiPAP 

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Please answer the below if you do NOT have a diagnosis of Sleep Apnea. Based on your answers we will let you know if you need a sleep study as part of your pre-operative evaluation.

Do you have a history of snoring that is disruptive to others?	YES	NO
Has anyone ever told you that you stop breathing during sleep?	YES	NO
Do you ever awaken choking or gasping for air at night?	YES	NO

Rate how likely you are to doze off or fall asleep in the following situations? This refers to your usual way of life in recent times.

**0 - No chance of dozing**

**1 - slight chance dozing**

**2 - moderate chance dozing**

**3 - high chance of dozing**

<input type="checkbox"/> Sitting and reading	<input type="checkbox"/> Being a passenger in a motor vehicle for an hour or more
<input type="checkbox"/> Watching TV	<input type="checkbox"/> Stopped for a few minutes in traffic while driving
<input type="checkbox"/> Sitting inactive in a public place	<input type="checkbox"/> Sitting quietly after lunch (no alcohol)
<input type="checkbox"/> Sitting and talking to someone	<input type="checkbox"/> Lying down in the afternoon

<hr/> <hr/> Total Score	0-6 minimal sleepiness
	7-8 Average
	>9 Excessive sleepiness

## Functional Health Status

\_\_\_\_\_ Independent- no assistance needed to complete activities of daily living

\_\_\_\_\_ Partially Dependant- some assistance needed

\_\_\_\_\_ Totally Dependant on other for self-care

## Past Surgical History

Please list all previous surgeries, including dates, location and anesthesia used.

Approximate Date	Surgery	Anesthesia Used (general, local, spinal, or epidural)	Location/Hospital
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## Non-Surgical Hospitalizations

Please list all inpatient hospitalizations, including psychiatric and substance abuse treatment.

Approximate Date	Problem	Location/Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## Weight History

Weight 1 Year Ago: \_\_\_\_\_ pounds      Are you at your highest weight ever?      yes      no

If you answered no, what was your highest weight? \_\_\_\_\_ pounds      When? \_\_\_\_\_

\_\_\_\_\_ Weight at age 21 (pounds)      \_\_\_\_\_ Lowest adult weight (pounds)

\_\_\_\_\_ Highest adult weight (pounds)      \_\_\_\_\_ Significant weight problem started at what age

Do you think there are particular events that have caused you to gain weight in the past?    \_\_\_Yes    \_\_\_No

Please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### In your opinion, what are the factors that contribute to your excess weight?

portion size	eating too much fats and/or carbs	emotional eating	lack of exercise
_____	_____	_____	_____
compulsive eating	stress	genetics	lack of knowledge about healthy living
_____	_____	_____	_____

## Previous Diet interventions

Please check all previous weight loss methods that you have tried. **Details are IMPORTANT for insurance purposes.**

Type of Diet	Number of weeks or months attempted	Pounds Lost	Length of time you kept weight loss off	Year
<b><u>Commercial Diet Programs</u></b>				
Weight Watcher				
Diet Workshop				
Jenny Craig				
OA				
TOPS				
LA Weight Loss				
Medifast				
Nutrisystem				
<b><u>Prescription Diet Medications</u></b>				
Redux (Dexfenfluramine)				
Pondimin (Fenfluramine)				
Fen - Phen				
Phentermine (Fastin, Adipex)				
Amphetamines				
Meridia (Sibutramine)				
Topiramate (Topamax)				
Xenical (Orlistat)				
<b><u>Liquid Diets</u></b>				
Optifast				
HMR				
Slimfast				
<b><u>Herbal and Nonprescription Remedies</u></b>				
Ephedra (Ma Huang)				
Metabolife				
Dexatrim				
Trimspa				
Laxatives				
Other over the counter diet aids/herbals:				
<b><u>Medical and Health Care Treatments</u></b>				
Nutrition/Dietitian visits				
PCP weight loss guidance				
Previous gastric surgery, stomach stapling				
Other surgery:				
Acupuncture				
Hypnosis				
<b><u>Therapy and Other Program</u></b>				
Behavior therapy				
Psychotherapy				
<b><u>Self Initiated Diets</u></b>				
Atkins				
South Beach Diet				
The Zone				

