GI Surgical Specialists

Bariatric Surgery Patient Information Packet

First Name:_____ Middle:_____ Last:_____
SSN:_____ Date of Birth:_____ Age:_____ Gender: F M
Marital Status: Married Single Divorced Separated Partnered Widowed Children_____
Height:_____ft _____in Weight:_____lbs BMI (if known):_____
Ethnicity: Caucasian African American Hispanic Native American Arabic Asian Other
Religious Affiliation:_____ Highest Level of Education:_____
Street Address:_____ City:_____ State:_____ Zip:_____
Country:_____ Email:_____
Work Phone:_____ Home:_____ Cell:_____
Employment Status: Full time Part time Retired Disabled Unemployed Student
If disabled, specify the year/cause: Year_____ Cause_____
Patient's occupation:_____ Employer:_____
Employer address:_____ Years employed:_____
Spouse's Name:_____ Spouse's Date of Birth:_____ Spouse's SS#:_____
Spouse's employment status: Full time Part time Retired Disabled Unemployed Student
Spouse's occupation:_____ Spouse's employer:_____
Spouse's employer's address:_____

EMERGENCY CONTACT
Name:_____ Relationship:_____
Best phone numbers:_____

INSURANCE INFORMATION
Payment type: Insurance Self Pay
Insurance Company:_____
Policy number:_____ Group number:_____
Subscriber name:_____ Subscriber Date of Birth:_____

PRIMARY CARE PROVIDER
First name:_____ Last name:_____ MD DO PA-C ARNP
Street address:_____ City:_____ State:_____ Zip:_____
Phone:_____ Fax:_____

OTHER DOCTORS CARING FOR YOU
Specialty:_____ First name:_____ Last name:_____
Specialty:_____ First name:_____ Last name:_____
Specialty:_____ First name:_____ Last name:_____

HOW DID YOU HEAR ABOUT US?
Newspaper Radio TV Friend/family Internet Primary Care Provider Hospital Seminar
If you were sent to us by referral, who was your referring provider? _____

BLOOD CONSENT

You must be willing to accept blood or blood products before, during, or after surgery if your condition is such that the physician deems it necessary.

Patient Signature:_____ Date:_____

BARIATRIC HISTORY

How many years have you been overweight? _____ How many pounds overweight?_____

At what age did you start dieting?_____

Have you ever had previous weight loss surgery? Yes No

If yes, what surgery? _____ Date:_____

What is the most weight you have ever lost on a single diet? _____ lbs

How did you lose the weight?_____

How long did you sustain the weight loss? _____ months / years

Check the box pertaining to you:

PREVIOUS DIETS

- ☐ Body for Life / Bill Phillips
- ☐ Pritkin
- ☐ Gloria Marshall
- ☐ Richard Simmons
- ☐ Health spa
- ☐ Scarsdale
- ☐ Cabbage soup
- ☐ High protein
- ☐ Stillman diet
- ☐ Herbal Life
- ☐ Sugar Busters
- ☐ Low carbohydrate
- ☐ Slim Fast
- ☐ Fasting
- ☐ Low fat
- ☐ Mayo Clinic
- ☐ Calorie counting
- ☐ Atkins
- ☐ South Beach
- ☐ Other:_____

SUPERVISED DIETS

- ☐ Nutri System
- ☐ TOPS
- ☐ Diet center
- ☐ Jenny Craig
- ☐ Overeaters Anonymous
- ☐ LA Weight Loss
- ☐ Optifast / Medifast
- ☐ National Weight Loss
- ☐ Weight Watchers
- ☐ HMR
- ☐ Dash
- ☐ Other:_____

MEDICATIONS PRESCRIBED FOR WEIGHT LOSS

- ☐ Acutrim
- ☐ Phendiet
- ☐ Amphetamines
- ☐ Phentrol
- ☐ Anorex
- ☐ Plegine
- ☐ Xenical
- ☐ Pondimin / Fenfluramine
- ☐ Dexatrim
- ☐ Prozac
- ☐ Didrex
- ☐ Redux
- ☐ Fastin
- ☐ Sanorex
- ☐ Fen-Phen (# of months __)
- ☐ Phenteramine
- ☐ Ionamin / Adipex
- ☐ Wellbutrin
- ☐ Tenuate
- ☐ Byetta
- ☐ Meridia
- ☐ Other: _____

BEHAVIORAL TREATMENT FOR WEIGHT LOSS

- ☐ Hypnosis
- ☐ Residential programs
- ☐ Hospitalization
- ☐ Exercise
- ☐ Psychologist therapy
- ☐ Other:_____

EATING HABITS

Do you snack between meals? Yes No
Do you eat large meals? Yes No
Do you eat a lot of sweets? Yes No
Do you drink a lot of soda pop? Yes No
If yes, how many cans per day? _____
Do you drink coffee or other caffeine? Yes No
If yes, how many cups per day? _____
Do you drink carbonated beverages? Yes No
If yes, how many cans per day? _____

If you use eating as an emotional outlet, what will you substitute when your eating is restricted?
_____

What reasons do you feel contribute to you being overweight?

How do you personally account for why you have not been able to lose weight?
_____

Have you used any of the following to control your weight? Circle all that apply
Starvation Excessive exercise Bingeing and Purging Diuretics Bingeing then food restriction
Laxatives Vomiting

If so, when and how long was this period of behavior?_____

Have you ever forced yourself to vomit after eating (binge and purge)? Yes No

Do you currently force yourself to vomit after eating? Yes No

Why are you seeking weight loss surgery? _____
_____

Tell us why you believe you are overweight: _____
_____
_____

Tell us how your weight is interfering with your health and life: _____
_____
_____

Tell us why you feel you can be successful with weight loss surgery, acknowledging the extreme lifestyle and dietary changes required: _____
_____
_____

Is your primary care provider supportive? Yes No
Have you discussed weight loss surgery with your primary care provider? Yes No

MEDICAL HISTORY (check the box pertaining to you)

GENERAL

- ☐ Fevers / chills
- ☐ Night sweats
- ☐ Appetite change
- ☐ Weight gain / loss
- ☐ Insomnia
- ☐ Tired / no energy
- ☐ Hair loss
- ☐ Other:_____

HEAD AND NECK

- ☐ Wear contacts / glasses
- ☐ Sinus drainage
- ☐ Dentures: partial / full
- ☐ Regular ear infections
- ☐ Vision problems
- ☐ Nose bleeds
- ☐ Seasonal allergies
- ☐ Blurry / double vision
- ☐ Hearing problems
- ☐ Hoarseness
- ☐ Glaucoma
- ☐ Other:_____

CARDIOVASCULAR

- ☐ Previous heart attack
- ☐ Varicose veins
- ☐ Ankle / leg ulcers
- ☐ Clogged heart arteries
- ☐ Irregular heartbeat
- ☐ Congestive heart failure
- ☐ Chest pain upon activity
- ☐ High blood pressure
- ☐ Dyspnea on exertion
- ☐ High cholesterol
- ☐ Leg cramps while walking
- ☐ Rheumatic fever
- ☐ Palpitations / rhythm changes
- ☐ Ankle swelling
- ☐ History of DVT
- ☐ Atrial fibrillation
- ☐ Heart murmur
- ☐ Other:_____

RESPIRATORY

- ☐ Asthma
- ☐ Pneumonia
- ☐ Use CPAP / BiPAP
- ☐ Pulmonary embolism
- ☐ Emphysema / COPD
- ☐ Chronic cough
- ☐ Use home oxygen
- ☐ Sleep apnea
- ☐ Bronchitis
- ☐ Shortness of breath at rest
- ☐ Snoring
- ☐ Other:_____

GASTROINTESTINAL

- ☐ Heartburn
- ☐ Diarrhea
- ☐ Constipation
- ☐ Difficulty swallowing
- ☐ Rectal bleeding
- ☐ Abdominal pain
- ☐ Gallbladder problems
- ☐ Nausea / vomiting
- ☐ Barrett's esophagus
- ☐ Hiatal hernia
- ☐ Blood in stool
- ☐ IBS
- ☐ Hemorrhoids
- ☐ Black, tarry stools
- ☐ Enlarged liver
- ☐ Jaundice
- ☐ GERD
- ☐ Elevated liver enzymes
- ☐ Gastric ulcers
- ☐ Umbilical hernia
- ☐ Anal fissure / colon polyps
- ☐ Incisional hernia
- ☐ Cirrhosis / hepatitis
- ☐ Ventral hernia
- ☐ Pancreatic disease
- ☐ Crohn's / Ulcerative Colitis
- ☐ Other:_____

BLADDER AND KIDNEY

- ☐ Kidney stones
- ☐ Kidney failure
- ☐ Trouble starting urine
- ☐ Loss of bladder control
- ☐ Blood in urine
- ☐ Leak urine while coughing
- ☐ Burning on urination
- ☐ Chronic UTIs
- ☐ Urinary urgency
- ☐ Prostate problems
- ☐ Men: PSA test in last year?
- ☐ Other:_____

GYNECOLOGIC (women only)

- ☐ Infertility
- ☐ PCOS
- ☐ Heavy periods
- ☐ Number of pregnancies?
- ☐ Miscarriages / abortions
- ☐ Currently pregnant?
- ☐ Menstrual irregularity
- ☐ Last PAP smear?
- ☐ Number of children?
- ☐ Plan to have more children?
- ☐ Uterine / ovarian cancer
- ☐ Menstrual pain
- ☐ Post-menopausal
- ☐ Last menstrual period? __/__/_____
- ☐ Other:_____

BREAST

- ☐ Nipple pain
- ☐ Breast pain
- ☐ Fibrocystic disease
- ☐ Breast cancer
- ☐ Other:_____

MUSCULOSKELETAL

- ☐ Shoulder pain
- ☐ Hip pain
- ☐ Foot pain
- ☐ Plantar fasciitis
- ☐ Broken bones
- ☐ Muscle pain / spasm
- ☐ Steroid injections
- ☐ Neck pain
- ☐ Wrist pain
- ☐ Knee pain
- ☐ Heel pain
- ☐ Carpal tunnel
- ☐ Sciatica
- ☐ Fibromyalgia
- ☐ Elbow pain
- ☐ Back pain
- ☐ Ankle pain
- ☐ Osteoarthritis
- ☐ Lupus
- ☐ Rheumatoid arthritis
- ☐ Other:_____

NEUROLOGICAL

- ☐ Migraines
- ☐ Balance problems
- ☐ Stroke
- ☐ Concussions
- ☐ Dizziness
- ☐ Seizure / convulsions
- ☐ Pseudotumor cerebri
- ☐ Numbness / tingling
- ☐ Restless leg syndrome
- ☐ Weakness
- ☐ Multiple sclerosis
- ☐ Other:_____

PSYCHIATRIC

- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Substance abuse
- ☐ Taking medication?
- ☐ Seeing a counselor?
- ☐ Past hospitalization?
- ☐ Attempted suicide
- ☐ Victim of mental / physical abuse
- ☐ Chemical dependency program
- ☐ Other:_____

ENDOCRINE

- ☐ Parathyroid problems
- ☐ Low blood sugar
- ☐ Pre-diabetes
- ☐ Goiter
- ☐ Gout
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Excessive thirst
- ☐ Abnormal facial hair
- ☐ Excessive urination
- ☐ Endocrine tumor
- ☐ Diabetes on insulin
- ☐ Diabetes on pills
- ☐ Other:_____

BLOOD

☐ Low platelets
☐ Bruise easily
☐ Bleeding disorder
☐ Lymphoma
☐ B12 anemia
☐ Low iron
☐ Blood transfusion
☐ Leukemia
☐ HIV / AIDS
☐ Swollen lymph nodes
☐ Blood thinning medication
☐ Other:_____

SKIN

☐ Psoriasis
☐ Keloids
☐ Hair / nail changes
☐ Rosacea
☐ Frequent skin infections
☐ Poor wound healing
☐ Rash under breasts
☐ Other:_____

MEDICATIONS		
NAME OF MEDICATION	**DOSAGE**	**HOW OFTEN TAKEN**

ALLERGIES (circle yes / no and list reaction)

Medication Yes No Name / Reaction:_____
Name / Reaction:_____
Name / Reaction:_____
Latex Yes No Reaction:_____
Tape Yes No Reaction:_____
Iodine Yes No Reaction:_____
IV contrast Yes No Reaction:_____
Foods Yes No Type / Reaction:_____

SURGICAL HISTORY (check the box pertaining to you and write in the year)

- ☐ Gallbladder (open / laparoscopic) _____
- ☐ Appendectomy _____
- ☐ Hysterectomy (vaginal / abdominal) _____
- ☐ D&C _____
- ☐ Ovary surgery _____
- ☐ Tubal ligation _____
- ☐ Cesarean section _____
- ☐ Inguinal hernia _____
- ☐ Umbilical / incisional hernia _____
- ☐ Colon resection _____
- ☐ Kidney surgery _____
- ☐ Endoscopy _____
- ☐ Colonoscopy _____
- ☐ Weight loss surgery _____
- ☐ Tonsillectomy _____
- ☐ Ear surgery _____
- ☐ Eye surgery _____
- ☐ Oral surgery _____
- ☐ CABG / stents _____
- ☐ Valve replacement _____
- ☐ Pacemaker _____
- ☐ Back surgery _____
- ☐ Knee surgery (right / left) _____
- ☐ Breast biopsy (right / left) _____
- ☐ Other: _____

ANESTHESIA PROBLEMS (check the box pertaining to you)

- ☐ Nausea
- ☐ Vomiting
- ☐ Difficulty waking up
- ☐ Heart stopped
- ☐ Stopped breathing
- ☐ Difficulty urinating
- ☐ Other:_____

SOCIAL HISTORY

Do you smoke now? Yes No How many packs per day? _____
Have you smoked in the past? Yes No If you have quit, for how long? _____
Do you use snuff or chew? Yes No If yes, how frequently do you use? _____

Do you consume alcohol now? Yes No If yes, how many drinks per week?_____
For how many yrs do/ did you drink? _____ If you have quit, for how long? _____
Is anyone concerned about the amount you drink? Yes No

Do you use street drugs now? Yes No If you have quit, for how long?_____
If yes, what drugs? _____
If yes, how frequently do you use drugs? _____

Is your family supportive of surgery? Yes No
On a scale of 1 to 5 (1 least satisfied, 5 very satisfied), rate the following situations in your life:

Married life 1 2 3 4 5
Present job 1 2 3 4 5
Overall satisfaction with yourself 1 2 3 4 5

What hobbies do you have that are important to you?_____
How many hours a day do you watch TV? _____
Could someone help care for you if you were seriously ill? Yes No
Are there people for whom you are the primary care giver? Yes No Who? _____

FAMILY HISTORY						
DISEASE	**MOTHER**	**FATHER**	**MATERNAL GRANDMOTHER**	**MATERNAL GRANDFATHER**	**PATERNAL GRANDMOTHER**	**PATERNAL GRANDFATHER**
MORBID OBESITY						
DIABETES						
HIGH BLOOD PRESSURE						
STROKE						
HEART ATTACK						
HEART DISEASE						
SLEEP APNEA						
CANCER						
CAUSE OF DEATH						
AGE IF LIVING						

ADDITIONAL QUESTIONS / COMMENTS:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Thank you for fully completing this form. It will allow us to take better care of you before, during, and after surgery.

GI Surgical Specialists
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Fort Myers, FL 33912
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Fax: (239) 244-9957
Email: gisurgical@gmail.com

NO SHOW POLICY

I, _____, understand that there is a $25.00 fee if I neglect to call and cancel or reschedule 24 hours prior to my appointment with GI Surgical Specialists. I understand the amount of $25.00 is expected to be paid in full upon arrival at my next office visit. I also understand that there is a $25.00 fee per each appointment that is no-showed by me. For every consecutive appointment that is no-showed by me, an additional $25.00 is expected to be paid in full at the time of arrival at the next appointment. I understand that the $25.00 fee does not go toward any co-pay or any other charge that is pending or services that I have received and that it is a new charge. I understand that if I cannot pay the no-show fee(s) at the next appointment that I cannot be seen in the office until it is paid in full unless otherwise worked out with GI Surgical Specialists.

Signature Date

Name

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your home or cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed: _____

Signature Date

Name