Minimally Invasive Gastrointestinal Surgery

Name: First: _____ M.I.: _____ Last: _____Date: _____

Date of Birth: _____

Height: _____ Weight: _____

Address: _____

_____

Home Phone: _____ Work Phone: _____

Best time to reach you during the day: _____ Where should we call? _____

Insurance Type: _____ Medicaid _____ Medicare_____

Are you interested in the gastric bypass _____ adjustable gastric band _____ or sleeve _____ or are you uncertain_____?

How did you hear about us? Website: _____ Friend: _____ Patient Referral: _____

Printed Material: _____ Doctor Recommended: _____

What type of research have you done about weight loss surgery?

Doctor Information: _____ Talked to a Patient: _____ Friend: _____ Website: _____

Who do you want to see? Dr. Hooks _____

Education: Graduated High School/GED College Post-graduate

Employer: _____

Please circle the appropriate response and answer all questions completely.

Yes No Have you ever had stomach ulcers?
Yes No Do you have gallstones?
Yes No Have you been diagnosed with (circle all that apply)
HIV AIDS Hepatitis B Hepatitis C
Yes No Do you snore?
Yes No Do you wake up with a headache?
Yes No Have you ever fallen asleep while driving?
Yes No Do you have to take a nap every day?
Yes No Do you feel rested when you wake up in the morning?
Yes No Do you ever wake from a deep sleep choking, coughing or grasping for breath?
Yes No Has anyone ever told you that you stop breathing while you are sleeping?
Yes No Do you have frequent nightmares?
Yes No Have you ever had a sleep study? If yes, did you have sleep apnea?
Yes No If you have sleep apnea, do you use c-pap or bi-pap? Settings _____
Yes No Do you have swellings in your legs?
Yes No Have you ever had an ulcer or non-healing sore on your leg?

Yes No Have you ever seen a heart specialist for cardiac problems or had a heart attack? If yes, please list physician's name, date of work up, test(s) done and findings: Please include copies of test/notes from cardiologist.

_____

Yes No Have you ever had a blood clot in your legs or lung?

Yes No Do you currently take aspirin products, motrin, ibuprofen, or blood-thinners?

Yes No Are you currently seeing a psychologist, psychiatrist or therapist for treatment? If yes, who is treating you? _____

Yes No Have you been hospitalized for depression, anxiety, or other related problems? If yes, please give date(s) and reason(s):

_____

_____

Yes No Have you ever had surgery for weight loss? If yes, please list surgeon's name, type of surgery done and the year of surgery:

_____

_____

List ***all*** of the medications you currently take:

Name of Medication	Dose	How Often	Reason for taking

What type of exercise are you currently doing? _____ How many times or hours per week? _____

What exercise do you intend to do after surgery? _____

Please list ***all*** diet programs you have done ***in the past 5 years***.

DIET Program	Year	For How Long	Total Weight Loss	Pounds Regained
Worked with Dietitian				
Physician-Supervised				
Phen-fen (redux)				
Xenical				
Meridia				
Richard Simmons				
Weight Loss Forever				
Nutra System				
Jenny Craig				
Overeaters Anonymous				
Herbal Life/Metabolife				
Diet Center				
Weight Watchers				
LA Weight Loss				
Optifast/Medifast				
Atkins				
Slimfast				
Hypnosis				
BHCG				
Phentermine				
Portion Control Diet				
Others:				
Exercise Equipment				
Treadmill				
Weights				
YMCA				
Curves				
Other Gym				

What is your highest adult weight? _____ When? _____

Weight for last five years: (required information)

1 Year Ago _____
2 Years Ago _____
3 Years Ago _____
4 Years Ago _____
5 Years Ago _____

Please circle your eating habits:

Skip meals Eat out Salty Craving Read Food labels Binge

Sweet craving Snack Eat late at night Watch my calorie and "fat" intake

Below is a list of problems and complaints people sometimes have. **After you read the list**, use the scale below to describe how much the problem has bothered you during the past 2 weeks, including today.

Not at all	a little bit	moderately	quite a bit	extremely
0	1	2	3	4

_____ 1. Nervousness or shakiness inside.
_____ 2. Unwanted thoughts, words, or ideas that won't leave your mind
_____ 3. The idea that someone else can control your thoughts.
_____ 4. Feeling others are to blame for most of your troubles.
_____ 5. Trouble remembering things
_____ 6. Feeling easily annoyed or irritated
_____ 7. Feeling afraid in open spaces or on the street
_____ 8. Thoughts of ending your life
_____ 9. Hearing voices that other people do not hear
_____ 10. Feeling that most people cannot be trusted
_____ 11. Crying easily
_____ 12. Feeling of being trapped or caught
_____ 13. Suddenly scared for no reason
_____ 14. Temper outbursts that you could not control
_____ 15. Feeling afraid to go out of your house alone
_____ 16. Feeling blue
_____ 17. Worrying too much about things
_____ 18. Feeling fearful
_____ 19. Other people being aware of your private thoughts
_____ 20. Feeling afraid to travel on buses, trains, or airplanes
_____ 21. Having to avoid certain things, places or activities because they frighten you
_____ 22. Your mind going blank
_____ 23. Feeling hopeless about the future
_____ 24. Trouble concentrating
_____ 25. Having thoughts that you are not on your own
_____ 26. Having urges to beat, injure, or harm someone
_____ 27. Having urges to break or smash things
_____ 28. Having ideas or beliefs that others do not share
_____ 29. Spells of terror or panic
_____ 30. Getting into frequent arguments
_____ 31. Feeling nervous when you are left alone
_____ 32. Feeling so restless you couldn't sit still
_____ 33. Feelings of worthlessness
_____ 34. Feeling that familiar things are strange or unreal
_____ 35. Shouting or throwing things
_____ 36. The idea that you should be punished for your sins
_____ 37. The idea that something is wrong with your mind