

SACRAMENTO ADVANCED LAPAROSCOPIC SURGERY ASSOCIATES

BARIATRIC EVALUATION

Today's Date: _____

My Name: Miss Mrs. Ms. Mr. Dr. _____

Birthday: _____ / _____ / _____ Age: _____

I am currently thinking about getting: Gastric Bypass Gastric Band Not sure yet

I was referred to be evaluated for possible Weight Loss Surgery by:

Physician: _____ MD

Other Healthcare Provider: _____ PA/NP

Friend: _____

It is my own idea to pursue Weight Loss Surgery.

Prior to now, have you ever been referred to, or been evaluated by ANY doctor and/or surgeon, psychologist, or ANY other medically related professional in order to have weight loss surgery of any kind? No Yes

If "YES" please provide their name and address:

Why was surgery NOT performed? _____

Are/were your parents morbidly obese? Mother (is / was) Father (is / was)
 Neither I was adopted or didn't know my biologic parents

How many brothers do you have? _____ How many brothers are morbidly obese? _____

How many sisters do you have? _____ How many sisters are morbidly obese? _____

As a child, between ages 5 and 10, I was about _____ pounds overweight.

Between ages 5 and 10, I employed the following weight loss techniques:

As an adolescent, between ages 10 and 20, I was about _____ pounds overweight.

Between ages 10 and 20, I employed the following weight loss techniques:

As an adult I estimate that my weight has ranged between a low of _____ pounds to my highest (the most I have ever weighed in my life) of _____ pounds.

My most stable adult weight was about: _____ pounds lasting approximately _____ years at age(s) _____

My current weight is _____ pounds. My most accurate height is _____ feet, _____ inches **BMI =** _____

I feel I felt my best at a weight of _____ pounds when I was _____ years-of-age.

My realistic goal is to reach and maintain a weight of approximately _____ pounds after surgery.

Three accomplishments I hope to achieve as I attain my weight loss goal:

1. _____

2. _____

3. _____

1
I have answered all questions on this page as completely as possible.

Please Initial: _____

I CONSIDER MY AVERAGE MEAL SIZE TO BE:

- Small Medium Large

MY DIET CONSISTS MOSTLY OF (CHECK ALL THAT APPLY):

"Normal Food"..... I eat a variety of food groups similar to the food eaten by my family, friends and co-workers

"Healthy Food" I make an effort to buy, prepare, and eat food that is low in sugar and fat

"Fast food"..... Much of my food is eaten "on the run" or purchased at a "drive-thru window"
Type of restaurants: _____

"Junk food"..... I snack a lot, mostly at: Home Work

On the average WORKDAY, I eat _____ meals and _____ snacks

On days when I am not at work, I eat _____ meals and _____ snacks

MY SNACK FOOD CONSISTS MOSTLY OF:

- Sugar and Sweets Chocolate Salty food Sandwiches Leftovers
 Whatever is available Other: _____

SITUATIONS:

- I mostly eat only when I am hungry
 I often eat even when I am not hungry
 I tend to eat when I am bored
 I think I eat more if I am in a stressfull situation which usually comes from (Please Describe):

Work: _____
Home: _____
Family: _____
Other: _____

After surgery, when I am bored, instead of eating I will: _____

EATING HABITS:

- I binge eat by eating a lot of food within a few hours
 I keep food hidden at home or work so I have access to food to eat throughout the day
 I try to eat when I know no one else can see me eating
 I have a fairly constant craving for sweets or surgary foods

In preparation for possible surgery, I have already committed to making the following changes in my diet or eating behavior:

THE FOLLOWING ARE MEDICAL, PHYSICAL, AND PSYCHOLOGICAL PROBLEMS OFTEN ASSOCIATED WITH SEVERE OBESITY.
PLEASE BE AS DETAILED AND COMPLETE AS POSSIBLE AND FILL IN EVERY PAGE.

PLEASE ANSWER ALL QUESTIONS FULLY!!

SECTION A • DO YOU HAVE DIABETES?

NO, I do NOT have a history of Diabetes. (Please skip to the next section)

YES, I do have:

- Type I or "Juvenile" or "Insulin Dependent" Diabetes
- Type II or "Adult Onset" or "Non-Insulin Dependent" Diabetes
- I had **Diabetes** while I was pregnant but not since

I was diagnosed in approximately (month) _____ / (year) _____ at age _____

I have other problems related to my **Diabetes** including: (check all that apply)

- Vascular (blood vessel) disease
- Neuropathy (numbness or nerve pain)
- Diabetic Keto-Acidosis (DKA)
- Nephropathy (kidney problems)
- Retinopathy (eye problems)
- Other: _____

I have been to an emergency room or admitted to the hospital because of complications of **Diabetes**

Date: _____ Reason: _____
Date: _____ Reason: _____

I am currently under the care of a physician for my **Diabetes**:

Doctor: _____
Specialty: _____
Address: _____

My doctor is currently treating my **Diabetes** by:

- I have been instructed to control my diet and see if that helps
- I take Oral Medications to control my blood sugars

Medicine	Dosage/milligrams	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____

I take insulin (Type and Dose):

I take _____ Units of _____ in the morning
I take _____ Units of _____ in the evening

I take insulin based on my sliding scale blood sugar

I check my own blood sugar levels by testing my:

- Blood finger sticks
- Urine dip sticks

My Blood Sugar usually runs between _____ and _____

My doctor says that the control of my blood sugar is:

- Good
- Fair
- Poor
- Uncontrolled

When I gain weight, my blood sugar level is:

- Harder to control
- About the same regardless of what I weigh

Weight loss by dieting or surgery has been recommended

Additional comments concerning my **Diabetes**: _____

**D
I
A
B
E
T
E
S**

SECTION B • DO YOU HAVE HIGH BLOOD PRESSURE?

- NO, I do NOT have a history of having High Blood Pressure. (Please skip to the next section)
- YES, I do have High Blood Pressure

I was diagnosed in approximately (month) _____ / (year) _____ at age _____

Medical complications I have had that are due to the effects of **High Blood Pressure** include: (check all that apply)

- Stroke
- Kidney problems
- Heart problems
- Vascular disease (poor circulation)
- Other: _____

- I have been to an emergency room or admitted to the hospital because of complications of **High Blood Pressure**
 Date: _____ Reason: _____
 Date: _____ Reason: _____

- I am currently under the care of a physician for my **High Blood Pressure**:
 Doctor: _____
 Specialty: _____
 Address: _____

My doctor is currently treating my **High Blood Pressure** by:

- Observation and repeat testing
- I have been instructed to control my diet and see if that helps

I take the following medicines to control my **High Blood Pressure**:

Medicine	Dosage/milligrams	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

When I am **ON** Medication my **Blood Pressure** is usually “_____ over _____” (i.e. 140/85 = “140 over 85”)

When I am **OFF** medication my **Blood Pressure** is usually “_____ over _____”

I have been told by a medical doctor that my **High Blood Pressure** is due to:

- Unknown reasons; I just “have it”
- Being severely overweight
- Due to another medical condition called: _____

My doctor says that the control of my **High Blood Pressure** is:

- Good
- Fair
- Poor
- Uncontrolled

When I gain weight, my **High Blood Pressure** is:

- Harder to control
- About the same regardless of what I weigh

- Weight loss by dieting or Surgery has been recommended**

I have physical limitations due to my **High Blood Pressure** that include: _____

Additional comments concerning my **High Blood Pressure**: _____

**B
L
O
O
D

P
R
E
S
S
U
R
E**

SECTION D • DO YOU HAVE LUNG OR BREATHING DISEASE?

NO, I do NOT have a history of Lung or Breathing Diseases such as Asthma, Bronchitis, Emphysema or Pulmonary Hypertension. (Please skip to the next section)

YES, I Do Have Lung or Breathing Disease

My specific lung or breathing condition is called: _____

I was diagnosed in approximately (month) _____ / (year) _____ at age _____

I have had Asthma emergencies 'Status Asthmaticus' (describe below):

My asthma has been or is being treated with Steroids

Oral steroids: (when?) _____

Intravenous (IV) steroids (when?) _____

I have been to an emergency room or admitted to the hospital for complications of Lung or Breathing Disease:

Date: _____ Reason: _____

Date: _____ Reason: _____

I am, or have been under the care of a physician for my Lung or Breathing Diseases:

Doctor: _____

Specialty: _____

Address: _____

My doctor is currently treating my Lung or Breathing Disease with:

Observation and further testing

Other treatments: _____

I take the following medicines for my Lung or Breathing Disease:

Medicine	Dosage/milligrams	Times per Day
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have been told by a medical doctor that my Lung or Breathing Disease is due to:

I had asthma in childhood only

Past illness that affected my lungs or ability to breathe well called: _____

My weight

Another medical condition called: _____

I was exposed to chemicals (asbestos, toxic fumes) at my job: (what?) _____

Cigarette or Cigar Smoking

I still smoke _____ packs or _____ cigars each day and have for _____ years

I no longer smoke, but averaged _____ packs or _____ cigars each day for _____ years

Other: _____

Other Medical complications I have had that are due to the effects of Lung or Breathing Disease include:

My doctor says that the control of my Lung or Breathing Disease is:

Good

Fair

Poor

Uncontrolled

My asthma is made worse by:

My weight

Exercise

Pollen, dust, seasonal allergies, etc.

Aspirin containing medications

Additional comments concerning my Lung or Breathing Disease: _____

**L
U
N
G
-
A
S
T
H
M
A**

SECTION E • DO YOU HAVE **OBSTRUCTIVE SLEEP APNEA?**

NO, I do **NOT** have a history of Sleep Apnea (Sleep Apnea is when you stop breathing when asleep) or Obesity Hypoventilation Syndrome. (Please skip to the next section)

I have been told that I 'stop breathing' when I am asleep but have not had a Sleep Apnea evaluation.

I have been recommended to undergo a Sleep Apnea Evaluation but I haven't done it yet.

YES, I Have been diagnosed with Sleep Apnea

I was diagnosed in approximately (month) _____ / (year) _____ at age _____

I am, or have been under the care of a physician for my Sleep Apnea:

Doctor: _____

Specialty: _____

Address: _____

I do not use a CPAP or BiPAP machine

I use a BiPAP or CPAP machine: Every night Most nights Some nights Never

When I use the machine, I use it All night Most of the night Only a few hours a night

My BiPAP or CPAP machine settings are: _____

***** You will need to bring your mask and machine to the hospital on the day of your surgery*****

I have been told by a medical doctor that my Sleep Apnea is due to:

My weight

Genetic or family predisposition

The shape of my neck or chin

The Size of my tongue

Other: _____

Medical complications I have had or have that are due to the effects of Sleep Apnea include:

I have been to an emergency room or admitted to the hospital for complications of Sleep Apnea:

Date: _____ Reason: _____

Date: _____ Reason: _____

My doctor says that the control of my Sleep Apnea is:

Good

Fair

Poor

Uncontrolled

Additional comments concerning my Sleep Apnea: _____

**S
L
E
E
P

A
P
N
E
A**

SECTION F • DO YOU HAVE **HIGH CHOLESTEROL** AND/OR **HIGH TRIGLYCERIDES?**

NO, I do NOT have a history of high Cholesterol or Triglycerides. (Please skip to the next section)

YES, I do have:

- High Cholesterol
- High Triglycerides

I was diagnosed in approximately (month) _____ / (year) _____ at age _____

Before any treatment my **Cholesterol Level** was usually around (number): _____

Before any treatment my **Triglyceride Level** was usually around (number): _____

I am, or have been under the care of a physician for my **High Cholesterol/Triglycerides**:

Doctor: _____

Specialty: _____

Address: _____

My doctor is currently treating my **High Cholesterol/Triglycerides** by:

- Observation and repeat testing
- I have been instructed to control my diet and increase my exercise to see if that helps
- I have been told I need to lose weight
- I take the following medicines for my **High Cholesterol/Triglycerides**:

Medicine	Dosage/milligrams	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____

With this Treatment:

My **Cholesterol Level** is now around (number) _____

My **Triglyceride Level** is now around (number) _____

I have been told by a medical doctor that my **High Cholesterol/Triglycerides** are due to:

- Genetic or family predisposition
- Due to my diet
- Other: _____

My doctor says that the control of my **High Cholesterol/Triglycerides** is:

- Good
- Fair
- Poor
- Uncontrolled

When I gain weight, my **High Cholesterol/Triglycerides** are:

- Harder to control
- About the same regardless of what I weigh

Medical complications I have had or have that are due to the effects of **High Cholesterol/Triglycerides** include:

- Coronary Artery Disease (clogged heart vessels)
- Stroke
- Vascular disease (poor circulation)
- Other: _____

Additional comments concerning my **High Cholesterol/Triglycerides**: _____

**C
H
O
L
E
S
T
E
R
O
L**

SECTION G • DO YOU HAVE **FEMALE HORMONE PROBLEMS?**

NO, I do NOT have Female Hormone Problems. (Please skip to the next section)

YES, I do have Female Hormone Problems

My specific condition is called: _____

I was diagnosed in approximately (month) _____ / (year) _____ at age _____

Medical complications I have had or have that are due to the effects of **Female Hormone Problems** include:

- Infertility Irregular or no periods Excess menstrual bleeding
- Excess hair growth particularly on the face
- Other: _____

I am, or have been under the care of a physician for my **Female Hormone Problems**:

Doctor: _____
 Specialty: _____
 Address: _____

I have been told by a medical doctor that my **Female Hormone Problems** are due to:

- Genetic or family predisposition: _____
- Due to another medical condition called: _____
- My weight: _____
- Other: _____

My doctor is currently treating my **Female Hormone Problems** by:

- Observation and repeat testing
- I have been instructed to lose weight and see if that helps
- I take the following medicines for my **Female Hormone Problems**:

Medicine	Dosage/milligrams	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have had surgery performed on my ovaries and/or uterus:

- I had one Ovary removed (reason/date): _____
- I had both Ovaries removed (reason/date): _____
- I had my Uterus removed (reason/date): _____

My doctor says that the control of **Female Hormone Problems** is:

- Good Fair Poor Uncontrolled

I have been to an emergency room or admitted to the hospital because of my **Female Hormone Problems**

Date: _____ Reason: _____
 Date: _____ Reason: _____

When I gain weight, my **Female Hormone Problems** are:

- Harder to control About the same regardless of what I weigh

Additional comments concerning my **Female Hormone Problems**: _____

F
E
M
A
L
E

H
O
R
M
O
N
E
S

SECTION H • DO YOU HAVE GALL BLADDER DISEASE?

- NO, I do NOT have a history of Gall Bladder Disease. (Please skip to the next section)
- My gall bladder has already been removed through:
 - A traditional or "open" or "large" incision
 - Laparoscopically

My gall bladder was removed in (month) _____ / (year) _____ at age _____

- Yes, I currently have problems with my Gall Bladder

My specific condition is/was called: _____

I was diagnosed in approximately (month) _____ / (year) _____ at age _____

- I found out I had gall stones during routine evaluation for weight loss surgery
- I have had jaundice (yellow skin) because of **Gall Bladder Disease**
- I have had problems with my pancreas due to my **Gall Bladder Disease**
- I have been to an emergency room or admitted to the hospital because of my **Gall Bladder Disease**

Date: _____ Reason: _____

Date: _____ Reason: _____

- I am, or have been under the care of a physician for my **Gall Bladder Disease**:

Doctor: _____

Specialty: _____

Address: _____

My doctor is currently treating my **Gall Bladder Disease** by:

- Observation; I have stones but they cause no problems
- I have been instructed to control my diet and see if that helps
- Surgical removal of my Gall Bladder has been recommended
- Other: _____
- I take the following medicines for my Gall Bladder Disease:

Medicine	Dosage/milligrams	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have been told by a medical doctor that my **Gall Bladder Disease** is due to:

- Gall Stones
- "Spasm" of the Gall Bladder (Biliary Dyskinesia)
- Genetic or Family Predisposition
- My Weight
- Another medical condition called: _____

Other medical complications I have had because of my **Gall Bladder Disease** include:

When I gain weight, my **Gall Bladder Disease** is:

- Harder to control
- About the same regardless of my weight

Additional comments concerning my **Gall Bladder Disease**: _____

**G
A
L
L

B
L
A
D
D
E
R**

SECTION I • DO YOU HAVE HEARTBURN/REFLUX? (GERD)

- NO, I do NOT have a history of Heartburn/Reflux Disease. (Please skip to the next section)
- YES, I do have a history of Heartburn/Reflux Disease

My specific condition is called: _____

I was diagnosed in approximately (month) _____ / (year) _____ at age _____

- I have had specific tests to evaluate my Heartburn/Reflux Disease
 - X-Rays (barium swallow, Upper GI, CT, MRI)
 - A camera was put down my esophagus to look in my stomach (endoscopy)
 - A biopsy revealed that I had a condition called "Barrett's Esophagus"
 - I had a test to check the amount of acid in my esophagus (24-Hour pH Study)

I have been told by a medical doctor that my Heartburn/Reflux Disease is due to:

- A hiatal hernia
- My weight
- Due to another medical condition called: _____
- I have been told that I have Achalasia or an enlarged esophagus
- I am, or have been under the care of physician for my Heartburn/Reflux Disease:

Doctor: _____
 Specialty: _____
 Address: _____

My doctor is currently treating my Heartburn/Reflux Disease by:

- Observation and repeat testing
- I have been instructed to control my diet and see if that helps
- I have already had a surgical procedure to fix my reflux on (month) _____ / (year) _____
- I take the following medicines for my Heartburn/Reflux Disease:

Medicine	Dosage/milligrams	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical complications I have had or have that are due to the effects of Heartburn/Reflux Disease include:

- Reflux esophagitis (inflammation of the esophagus)
- Esophageal Stricture (narrowing/scarring of the esophagus)
- Esophageal Cancer
- Frequent pneumonias or chronic cough
- Other: _____

- I have been to an emergency room or admitted to the hospital because of complications of Heartburn/Reflux:
 - Date: _____ Reason: _____
 - Date: _____ Reason: _____

My doctor says that the control of my Heartburn/Reflux Disease is:

- Good
- Fair
- Poor
- Uncontrolled

When I gain weight, my Heartburn/Reflux is:

- Harder to control
- About the same regardless of my weight

Additional comments concerning my Heartburn/Reflux Disease: _____

H
E
A
R
T
B
U
R
N

SECTION J • DO YOU HAVE BLADDER INCONTINENCE ? (LEAKY BLADDER)

NO, I do NOT have urinary Bladder Incontinence. (Please skip to the next section)

YES, I do have Bladder Incontinence

I have a leaky bladder but I have NOT had a specific evaluation of it.

My specific condition is called: _____

I was diagnosed in approximately (month) _____ / (year) _____ at age _____

I am, or have been under the care of a physician for my Bladder Incontinence:

Doctor: _____

Specialty: _____

Address: _____

I have had a specific evaluation for my Bladder Incontinence by a:

Urologist

Gynecologist

Special Studies: _____

I have been told by a medical doctor that my Bladder Incontinence is due to:

Pregnancy or childbirth

Due to being severely overweight

Genetic or familial predisposition

Due to another medical condition: _____

My doctor is currently treating my Bladder Incontinence by:

Observation and repeat testing

Weight loss has been recommended

Surgery has been recommended to correct my Bladder Incontinence

I have already had a surgery to fix my Bladder Incontinence on (month) _____ / (year) _____

Describe surgery: _____

I take the following medicines for my Bladder Incontinence:

Medicine	Dosage/milligrams	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____

When I gain weight, my Bladder Incontinence is:

Harder to control

About the same regardless of my weight

Additional comments concerning my Bladder Incontinence: _____

**I
N
C
O
N
T
I
N
E
N
C
E**

SECTION K • DO YOU HAVE A **HERNIA?**

- NO, I do NOT have a history of Hernia. (Please skip to the next section)
- YES, I do have a history of having a Hernia

The Type and locations of my Hernia(s) is/are:

Groin Hernia

- Left side Right side

Diagnosed in, or present since _____ / _____ at age _____

Surgically repaired in _____ / _____ at age _____ Was mesh used? Yes No

Did hernia return after repair? No Yes: Repaired again in _____ / _____ Was mesh used? Yes No

Hernia in a surgical incision

Diagnosed in, or present since _____ / _____ at age _____

At which incision? _____

Surgically repaired in _____ / _____ at age _____ Was mesh used? Yes No

Did hernia return after repair? No Yes: Repaired again in _____ / _____ Was mesh used? Yes No

Hernia at my belly button

Diagnosed in, or present since _____ / _____ at age _____

Surgically repaired in _____ / _____ at age _____ Was mesh used? Yes No

Did hernia return after repair? No Yes: Repaired again in _____ / _____ Was mesh used? Yes No

Hernia between my breastbone and belly button

Diagnosed in, or present since _____ / _____ at age _____

Surgically repaired in _____ / _____ at age _____ Was mesh used? Yes No

Did hernia return after repair? No Yes: Repaired again in _____ / _____ Was mesh used? Yes No

Hiatal Hernia (usually associated with heartburn)

Diagnosed in, or present since _____ / _____ at age _____

Surgically repaired in _____ / _____ at age _____ Was mesh used? Yes No

Did hernia return after repair? No Yes: Repaired again in _____ / _____ Was mesh used? Yes No

I am, or have been referred to a doctor specifically for my **Hernia:**

Doctor: _____

Specialty: _____

Address: _____

I have had a specific evaluation for my **Hernia:**

By a surgeon: _____

Special studies: _____

Other: _____

I have been to an emergency room or admitted to the hospital because of complications of my **Hernia:**

Date: _____ Reason: _____

Date: _____ Reason: _____

Current treatment for my **Hernia:**

Observation and treat if I develop problems

Weight loss has been recommended

Surgery has been recommended to repair my **Hernia:** _____

When I gain weight, my **Hernia** is

Bigger but does not feel different: _____

Bigger and is more uncomfortable: _____

Is about the same regardless of my weight: _____

Additional comments concerning my **Hernia:** _____

**H
E
R
N
I
A**

SECTION L • DO YOU HAVE ARTHRITIS?

NO, I do NOT have Arthritis. (Please skip to the next Section)

YES, I do have Arthritis

My specific condition is called: _____

I was diagnosed in approximately (*month*) _____ / (*year*) _____ at age _____

List affected areas from most affected to least affected (describe pain, limited movement, etc.):

I am, or have been under the care of a physician for my **Arthritis**:

Doctor: _____
 Specialty: _____
 Address: _____

I have been told by a medical doctor that my **Arthritis** is due to:

- An Injury: _____
- Changes as I get older
- Rheumatoid Arthritis
- Another medical condition called: _____

I have had a specific evaluation for my Arthritis:

- Evaluation by a Rheumatologist: Dr. _____
- Evaluation by an Orthopedic surgeon: Dr. _____
- Special X-Ray studies: _____
- Special blood tests: _____

I have had a joint replacement operation on my _____ joint(s) in (year(s) _____

I have been told by an Orthopedic surgeon that I need to/will need to have a joint replacement operation
 Joint: _____

I take the following medicines for **Arthritis**:

Medicine	Dosage/milligrams	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____

Besides taking medicine, treatment for my **Arthritis** includes:

- Observation and repeat testing
- Weight loss has been recommended
- Other treatments: _____

When I gain weight, my Arthritis is:

- Worse; I have more pain and less function of the affected areas
- About the same regardless of my weight

I have been to an emergency room or admitted to the hospital because of complications of **Arthritis**:

Date: _____ Reason: _____
 Date: _____ Reason: _____

Additional comments concerning my **Arthritis**: _____

**A
R
T
H
R
I
T
I
S**

SECTION M • DO YOU HAVE LIVER DISEASE?

NO, I do NOT have a history of Liver Disease. (Please skip to the next section)

YES, I do have a history of Liver Disease

My specific condition is called: _____

I was diagnosed in approximately (month) _____ / (year) _____ at age _____

I am, or have been under the care of a physician for my Liver Disease:

Doctor: _____

Specialty: _____

Address: _____

Complications I have had due to my Liver Disease:

- I have been diagnosed with portal hypertension
- I have had bleeding from my esophagus and/or stomach caused by liver disease
- I have had Jaundice (yellow skin and eyes) caused by my liver disease

I have been to an emergency room or admitted to the hospital due to complications of Liver Disease:

Date: _____ Reason: _____

Date: _____ Reason: _____

I take the following medicines for Liver Disease:

Medicine	Dosage/milligrams	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____

Besides taking medicine, treatment for my Liver Disease includes:

- Observation and repeat testing
- My viral count is monitored
- Weight loss has been recommended
- Other: _____

I have been told by a medical doctor that my Liver Disease is due to:

- Genetic or family predisposition: _____
- Excessive alcohol consumption: I quit drinking _____ years ago I still drink about _____ drinks/day
- Hepatitis B
- Hepatitis C
- Primary Biliary Cirrhosis
- Sclerosing Cholangitis
- Obesity
- Other: _____

When I gain weight, my Liver Disease is:

- Worse
- About the same regardless of my weight

Additional comments concerning my Liver Disease: _____

**L
I
V
E
R

D
I
S
E
A
S
E**

SECTION N • DO YOU HAVE PROBLEMS WITH YOUR **BLOOD VESSELS** OR DO YOU HAVE ANY **BLOOD DISEASES?**

NO, I do NOT have a history of problems with my Veins and do NOT have any Blood Disease.
(Please skip to the next section)

I have had Blood Clots form in my legs (Deep Vein Thrombosis or DVT)
 After surgery: (when/what surgery) _____
 For some other reason: _____

I have had Blood Clots from my legs go up into my lungs ("Pulmonary Embolism")
 I have had a Vena Cava filter placed
 I am on Coumadin I have been on Coumadin in the past (when/why): _____

I have had members of my immediate family have problems with Blood Clots: (Who?) _____

I have had problems bleeding too much
 I have had problems bleeding after surgical or dental procedures
 I get a lot of bloody noses
 I bruise very easily
 My doctor told me I have a bleeding disorder called: _____

I have been told that I have a high white blood cell count. How high? (number): _____

I have had blood transfusions
 I have been given approximately _____ units ("Pints") in my lifetime.
 Please describe circumstances: _____

I received blood and now have a disease from it called: _____

I have another blood disorder called: _____

I have Venous Stasis Ulcers

I take the following medicines for **Vein/Blood Disease**:

Medicine	Dosage/milligrams	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____

Besides taking medicine, treatment for my **Vein/Blood Disease** includes:

- Observation and repeat testing
- Weight loss has been recommended
- I wear compression stockings
- Other: _____

I have been told by a medical doctor that my **Vein/Blood Disease** is due to:

- Obesity
- Genetic or family predisposition: _____
- Due to another medical condition called: _____

When I gain weight, my **Vein/Blood Disease** is

- Worse; Describe: _____
- About the same regardless of my weight

Additional comments concerning my **Vein/Blood Disease**:

**B
L
O
O
D
-
&
-
V
E
S
S
E
L
S**

SECTION O • DO YOU HAVE ANY PROBLEMS WITH VARICOSE VEINS?

NO, I do NOT have varicose veins. (Please skip to the next section)

YES, I do have Varicose Veins in:

- Both legs Right leg Left leg

I would like more information on treatment options for my Varicose Veins

I was diagnosed in approximately _____ (month) / _____ (year) at age _____

I have or had problems in my legs related to my **Varicose Veins** including: (check all that apply)

- Swelling Pain Heaviness
 Ulcers Skin color changes Itching
 My veins can be seen "sticking out" under my skin

My symptoms usually occur:

- When I wake up in the morning When I walk At the end of the day

I am, or have been under the care of a physician for my **Varicose Veins**:

Doctor: _____
 Specialty: _____
 Address: _____

I have been told by a medical doctor that my **Varicose Veins** are due to:

- Blood clots in my legs (Deep Vein Thrombosis)
 Pregnancy
 Prolonged standing
 Obesity
 Genetic or family predisposition
 Due to another medical condition called: _____

I have had other members of my immediate family have problems with **Varicose Veins**:

(Who?): _____

Do you sit or stand for long periods of time? No Yes: _____ hours/day

I take the following medicines for my **Varicose Veins**:

Medicine	Dosage/milligrams	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have had other treatments for my **Varicose Veins** including:

- Compression stockings:
 Year: _____ Length of treatment: _____
 Elevation of my legs. If so, do you get relief? Yes No
 Casts or "Unna Boot"
 Weight loss has been recommended

I have had surgery for my **Varicose Veins**.

- Type: Vein stripping/ligation Laser
 Radio frequency ablation Sclerotherapy

When I gain weight, my **Varicose Veins** are:

- Worse; Describe: _____
 About the same regardless of my weight.

**V
A
R
I
C
O
S
E
V
E
I
N
S**

SECTION P • DO YOU HAVE A PSYCHIATRIC CONDITION?

NO, I do NOT have a Psychiatric Condition. (Please skip to the next section)

YES, I do have a Psychiatric Condition

My specific condition is called: _____

I was diagnosed in approximately _____ (month) / _____ (year) at age _____

I am, or have been under the care of a doctor or therapist who specializes in the treatment of **Psychiatric Conditions**

Doctor: _____

Specialty: _____

Address: _____

I take the following medicines for my **Psychiatric Condition**:

Medicine	Dosage/milligrams	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name of physician who is prescribing the above medications: _____

Specialty: _____

Besides taking medicine, treatment for my **Psychiatric Condition** has included:

- Therapy
- Observation by my doctor with no specific treatment at this time
- Weight loss has been recommended
- Other: _____
- I have had specialized psychiatric procedures (describe): _____

I have been to an emergency room or admitted to a hospital due to complications of my **Psychiatric Condition**:

Date: _____ Reason: _____

Date: _____ Reason: _____

I have tried to commit suicide or thought about doing it

I have been told by a medical doctor that my **Psychiatric Condition** is due to:

- Obesity
- Genetic or family predisposition: _____
- Due to another medical condition called: _____
- Other: _____

When I gain weight, my **Psychiatric Condition** is:

- Worse; Describe: _____
- About the same regardless of my weight: _____

Additional comments concerning my **Psychiatric Condition**: _____

**M
E
N
T
A
L

H
E
A
L
T
H**

SECTION Q • HAVE YOU EVER HAD CANCER?

NO, I do NOT have a history of Cancer. (Please skip to the next section)

YES, I have had Cancer

My specific Cancer is/was called: _____

I was diagnosed in approximately _____ (month) / _____ (year) at age _____

I am, or have been under the care of a physician for my **Cancer**.

Doctor: _____

Specialty: _____

Address: _____

I have been to an emergency room or admitted to the hospital due to complications of **Cancer**:

Date: _____ Reason: _____

Date: _____ Reason: _____

I had my cancer removed surgically on (month) _____, (year) _____ at age _____

The surgical procedure was called: _____

During the surgery the surgeon removed and/or operated on the following organs:

After surgery I had Radiation therapy (describe): _____

After surgery, I had Chemo therapy (describe): _____

I currently take the following medicines for my **Cancer**:

Medicine	Dosage/milligrams	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have been considered "Cancer Free" for _____ years.

I have had breast biopsies that turned out to be non-cancerous

I have had _____ biopsies of my **Left Breast** (year of biopsies:) _____

I have had _____ biopsies of my **Right Breast** (year of biopsies:) _____

I have been told by a medical doctor that my **Cancer** is due to:

No obvious reason

Genetic or family predisposition: _____

Environmental or industrial exposure to a cancer causing agent called: _____

Due to another medical condition called: _____

Obesity

Other: _____

Describe any evaluations you have had for suspected cancer that have turned out to show no cancer: _____

**C
A
N
C
E
R**

SECTION R • DO YOU HAVE A HISTORY OF SKIN INFECTIONS?

NO, I do NOT have any skin conditions. (Please skip to the next section)

YES, I have had problems with Skin Infections

My specific condition is/was called: _____

I was diagnosed in approximately _____ (month) / _____ (year) at age _____

What parts of the body are affected? _____

Describe the appearance of the affected skin areas: _____

I am, or have been under the care of a physician for my Skin Infections:

Doctor: _____

Specialty: _____

Address: _____

I take the following medicines for Skin Infections:

Medicine	Dosage/milligrams	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have been on **Steroids** intravenously or by pills (please describe and give dates): _____

Besides taking medicine, treatment for my Skin Infections includes:

- Observation and repeat testing
- Weight loss has been recommended
- Other: _____

I have been told by a medical doctor that my Skin Infections are due to:

- Obesity
- Genetic or family predisposition: _____
- Due to another medical condition called: _____

I have been to an emergency room or admitted to the hospital due to complications of my Skin Infections:

Date: _____ Reason: _____

Date: _____ Reason: _____

When I gain weight, my Skin Infections are:

- Worse; Describe: _____
- About the same regardless of my weight

Additional comments concerning my Skin Infections:

**S
K
I
N
I
N
F
E
C
T
I
O
N
S**

SECTION S • DO YOU HAVE PSEUDOTUMOR CEREBRII?

NO, I do NOT have Pseudotumor Cerebrii. (Please skip to the next section)

YES, I do have Pseudotumor Cerebrii

I was diagnosed in approximately _____ (month) / _____ (year) at age _____

I am, or have been under the care of a medical doctor who specializes in the treatment of **Pseudotumor Cerebrii**:

Doctor: _____

Specialty: _____

Address: _____

I take the following medicines for **Pseudotumor Cerebrii**:

Medicine	Dosage/milligrams	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____

Besides taking medicine, treatment for my Pseudotumor Cerebrii:

- Observation and repeat testing
- Weight loss has been recommended
- Surgery and or shunt placement: (when) _____
- Other: _____

I have been told by a medical doctor that my **Pseudotumor Cerebrii** is due to:

- Genetic or family predisposition: _____
- Obesity
- Due to another medical condition: _____

I have been to an emergency room or admitted to the hospital due to complications of **Pseudotumor Cerebrii**:

Date: _____ Reason: _____

Date: _____ Reason: _____

When I gain weight, my **Pseudotumor Cerebrii** is:

- Worse; Describe: _____
- About the same regardless of my weight

Additional comments concerning my **Pseudotumor Cerebrii**:

**N
e
u
r
o
l
o
g
i
c
a
l**

SECTION T • DO YOU HAVE A HISTORY OF THYROID DISEASE?

NO, I do NOT have a history of Thyroid Disease. (Please skip to the next section)

YES, I do have a history of Thyroid Disease.

My specific condition is called: _____

I was diagnosed in approximately (*month*) _____ / (*year*) _____ at age _____

I am, or have been under the care of a physician for my **Thyroid Disease**:

Doctor: _____

Specialty: _____

Address: _____

I have had treatments for my **Thyroid Disease** such as:

Surgery (full/partial thyroid removal): _____

Radiation therapy: _____

Iodine therapy: _____

Other: _____

I have been diagnosed with thyroid nodules: Left Right Both

Biopsy performed: _____

Findings: _____

My doctor is currently treating my Thyroid Disease by:

Observation and repeat testing

I take the following medicines for my **Thyroid Disease**:

Medicine	Dosage/milligrams	Times per day
----------	-------------------	---------------

I have been to an emergency room or admitted to the hospital due to complications of **Thyroid Disease**:

Date: _____ Reason: _____

Date: _____ Reason: _____

My doctor says that the control of Thyroid Disease is:

Good

Fair

Poor

Uncontrolled

Additional comments concerning my **Thyroid Disease**: _____

**T
H
Y
R
O
I
D**

SECTION U • DO YOU HAVE A HISTORY OF KIDNEY DISEASE?

NO, I do NOT have a history of Kidney Disease. (Please skip to the next section)

YES, I have a history of Kidney Disease

My specific condition is/ was called: _____

I was diagnosed in approximately (*month*) _____ / (*year*) _____ at age _____

My serum Creatinine is usually about: (number) _____ Don't know

I have been told by a medical doctor that my **Kidney Disease** is due to:

- High Blood Pressure
- Diabetes
- Infection
- Obesity
- Injury: _____
- Autoimmune disorder: (type?): _____
- Genetic or family predisposition: _____
- Other medical condition called: _____

I am, or have been under the care of a physician for my **Kidney Disease**:

Doctor: _____
 Specialty: _____
 Address: _____

I take the following medicines for my **Kidney Disease**:

Medicine	Dosage/milligrams	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____

Besides taking medicine, treatment for my **Kidney Disease** includes:

- DIALYSIS** has been recommended or performed: _____
- Kidney transplant has been recommended or performed
- Observation and repeat testing
- Weight loss has been recommended
- Other: _____

I have been to an emergency room or admitted to the hospital due to complications of **Kidney Disease**:

Date: _____ Reason: _____
 Date: _____ Reason: _____

When I gain weight, my **Kidney Disease** is:

- Worse; Describe: _____
- About the same regardless of my weight

Additional comments concerning my **Kidney Disease**: _____

KIDNEY DISEASE

SECTION V • DO YOU HAVE A HISTORY OF GASTROINTESTINAL DISEASES (GI)?

- NO, I do NOT have a history of Gastrointestinal Disease. (Please skip to the next section)
- YES, I do have a history of Gastrointestinal (GI) Disease.

My specific condition is/was called: _____

I was diagnosed in approximately _____ (month) / _____ (year) at age _____

- I am, or have been under the care of a physician who for my Gastrointestinal Disease:

Doctor: _____
 Specialty: _____
 Address: _____

I have had the following problems (describe):

- Stomach Ulcers: _____
- Esophageal Varices/Bleeding _____
- Esophageal stricture: _____
- Barrets Esophagitis: _____
- Esophageal spasms: _____
- Stomach Bleeding: _____
- Stomach cancer: _____
- Gastroparesis: _____
- Inflammatory Bowel Disease: _____
- Crohn's Disease: _____
- Ulcerative Colitis: _____
- Diverticulitis: _____
- Colon Bleeding: _____
- Colon Polyps: _____
- Appendicitis: _____
- Hemorrhoids: _____
- Constipation: _____
- Diarrhea: _____
- Irritable Bowel Syndrome: _____

I have had the following surgical procedures on my stomach, intestines, colon, or rectum:

Date: _____ Surgery: _____
 Date: _____ Surgery: _____

- I have been to an emergency room or admitted to the hospital due to complications of the GI Tract:

Date: _____ Reason: _____
 Date: _____ Reason: _____

I take the following medicines for diseases of my GI Tract:

Medicine	Dosage/milligrams	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____

Besides taking medicine, treatment for my GI Tract Disease:

- Observation and repeat testing: _____
- Weight loss has been recommended: _____
- Surgery has been recommended: _____

When I gain weight, my GI Tract Disease is:

- Worse; Describe: _____
- Is about the same regardless of my weight

**I
N
T
E
S
T
I
N
E
S**

SECTION W • DO YOU HAVE ANY RESTRICTED ACTIVITIES OF DAILY LIVING DUE TO YOUR OBESITY?

NO, I do **NOT** have any restriction in my daily activities because of my weight. (Please skip to the next section)

YES, I do have restrictions of my daily activities because of my weight

I have **Physical Limitations** due to my obesity including:

- Pain
- Difficulty fitting into chairs
- Difficulty fitting on airplanes
- Difficulty fitting in movie theatres
- Difficulty beginning tasks
- Difficulty completing normal everyday tasks
- I am restricted to my home to some degree (describe): _____
- Physical restriction due to my obesity has impaired my marital, professional, or social relationships or responsibilities. Describe: _____

I have **Psychological Effects** due to my obesity including:

- Public humiliation
- Fear of embarrassment for self or family
- Difficulty in social situations

I have had some Restricted Activities of Daily Living since (year) _____

Or since I have weighed approximately _____ pounds.

I have had treatment specifically related to the direct or indirect physical or psychological effects of my obesity:

Date: _____ Describe: _____

Date: _____ Describe: _____

When I gain weight the Restrictions on my Activities of Daily Living are:

- Worse; Describe: _____
- About the same regardless of my weight

Additional comments concerning my Restricted Activities of Daily Living:

SECTION X • DO YOU HAVE A HISTORY OF SUBSTANCE ABUSE?

NO, I do **NOT** have a history of Substance Abuse. (Please skip to the next section)

YES, I do have a history of Substance Abuse

I was addicted to: _____

I was addicted from (month) _____ to (year) _____

I stopped because: _____

I was able to stop:

- On my own: _____
- I was admitted to a rehabilitation center: _____
- I was incarcerated: _____
- I am currently in a 12 step recovery program
- I have been clean/sober since: (month) _____ / (year) _____
- I think I currently have a problem controlling my use of the following substances: _____

**D
R
U
G
S**

I have had the following SURGICAL procedures during my lifetime:
 For EACH procedure PLEASE indicate: Which side; If performed with a laparoscope; If there was any difficulty or concern with placing the breathing tube for anesthesia; Bleeding; Infection; etc

PROCEDURE:	YEAR/AGE:	COMMENTS:
<input type="checkbox"/> Tonsils	___/___	<input type="checkbox"/> I had excessive bleeding
<input type="checkbox"/> Tooth Extraction	___/___	<input type="checkbox"/> I had excessive bleeding
<input type="checkbox"/> Appendix	___/___	This was done <input type="checkbox"/> With a laparoscope <input type="checkbox"/> With an open incision <input type="checkbox"/> The appendix was "burst" <input type="checkbox"/> Complications? _____
<input type="checkbox"/> Gall Bladder	___/___	<input type="checkbox"/> The surgery was scheduled electively <input type="checkbox"/> The surgery was urgent <input type="checkbox"/> My pancreas was inflamed at the time This was done <input type="checkbox"/> With a laparoscope <input type="checkbox"/> With an open incision <input type="checkbox"/> A drain was placed after the surgery <input type="checkbox"/> Complications? _____
<input type="checkbox"/> Caesarian Section ("C-Section")	___/___ ___/___ _____	The incision is <input type="checkbox"/> a side-to-side "bikini-line" type <input type="checkbox"/> in the middle "up and down" <input type="checkbox"/> Complications? _____
<input type="checkbox"/> Hysterectomy	___/___	This was performed for <input type="checkbox"/> Cancer: _____ <input type="checkbox"/> Bleeding: _____ <input type="checkbox"/> Fibroids: _____ <input type="checkbox"/> Other: _____ The incision is <input type="checkbox"/> a side-to-side "bikini-line" type <input type="checkbox"/> in the middle "up and down" <input type="checkbox"/> Transvaginal approach <input type="checkbox"/> Other procedures were performed at the time: _____ <input type="checkbox"/> Complications? _____
<input type="checkbox"/> Ovary removal	___/___	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both This was performed for <input type="checkbox"/> Cancer: _____ <input type="checkbox"/> Cysts: _____ <input type="checkbox"/> Other: _____ This was done: <input type="checkbox"/> With a laparoscope <input type="checkbox"/> With an Open Incision <input type="checkbox"/> As part of another operation: _____ <input type="checkbox"/> Complications? _____

OTHER SURGICAL PROCEDURES: (Please indicate left / right / both)

PROCEDURE:	YEAR/AGE:	COMMENTS:
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have been involved in the following accidents:

Accident:	Year:	Injuries/Treatment:
_____	_____	_____
_____	_____	_____
_____	_____	_____

I am, or have been, treated by the following physicians:

Name:	City:	Specialty:	Check the box of each MD that you would like to receive a copy of our consultation
_____	_____ / _____	_____	<input type="checkbox"/>
_____	_____ / _____	_____	<input type="checkbox"/>
_____	_____ / _____	_____	<input type="checkbox"/>
_____	_____ / _____	_____	<input type="checkbox"/>
_____	_____ / _____	_____	<input type="checkbox"/>
_____	_____ / _____	_____	<input type="checkbox"/>
_____	_____ / _____	_____	<input type="checkbox"/>

Which of the following cause you any illness, difficulties, or concerns? (please explain)

Head / Brain: _____

Eyes / Vision: _____

Ears / Hearing: _____

Nose / Sinuses: _____

Mouth / Throat: _____

Neck: _____

Spine: _____

Lungs / Breathing: _____

Heart: _____

Stomach: _____

Intestines: _____

Liver: _____

Gall Bladder: _____

Spleen: _____

Pancreas: _____

Kidney: _____

Bladder: _____

Men: Prostate: _____

Testes: _____

Women: Ovaries: _____

Uterus: _____

Other: _____

Rectum / Anus: _____

Skin: _____

Breasts: _____

Arms: _____

Legs: _____

Arteries / Veins: _____

Bones: _____

Glands (Pituitary, Thyroid, Adrenal, etc): _____

Infectious Diseases (Hepatitis, HIV, Herpes, etc): _____

Personal Information

Employment: _____

Job Description: _____

Marital Status: _____

Children / Ages: _____

Tobacco use: I do not smoke and never have
 I used to smoke _____ packs/day for _____ years, but I stopped in (month) _____ of (year) _____
 I still smoke _____ packs/day and have for _____ years

Alcohol use: _____

SUPPORT SYSTEM:

Currently my support system consists of (spouse/family/partner etc): _____

Describe how supportive they are of your Weight Loss Surgery effort: _____

Do you know anyone who has had weight loss surgery? No Yes, who? _____

What are the support systems you have in place for your post-operative phase and long-term recovery?

What do you think we should know about you that we have not asked about?

Please review and initial all sections to assure completeness. Incomplete answers or sections WILL delay your pre-operative course.

THANK YOU FOR YOUR TIME



SACRAMENTO ADVANCED LAPAROSCOPIC SURGERY ASSOCIATES

S · A · L · S · A