BRISTOL HOSPITAL

Bariatric Surgery PROGRAM

PATIENT INFORMATION SHEET

DATE: _____ **FAMILY PHYSICIAN:** _____

PATIENT NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE: HOME _____ **CELL:** _____ **WK:** _____

EMAIL: _____ **DOB:** _____ **AGE:** _____

SS#: _____ **MARITAL STATUS:** M S D W **SEX:** M F

PLACE OF EMPLOYMENT: _____

HOW DID YOU HEAR ABOUT US:_____

CONTACT INFORMATION IS VERY IMPORTANT. PLEASE UPDATE INFORMATION IF YOU MOVE. FOLLOW UP OF OUR PATIENTS IS VERY IMPORTANT TO US AND DOES CONCERN YOUR WELFARE. PLEASE PROVIDE US WITH AT LEAST TWO CONTACTS THAT WILL BE ABLE TO CONTACT YOU IF YOU SHOULD MOVE, ETC..

NEXT OF KIN: _____ **RELATION:** _____
ADDRESS: _____
CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE: _____

CONTACT # 2: _____ **RELATION:** _____
ADDRESS: _____
CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____
ADDRESS: _____ **CITY:** _____ **STATE:** _____
ZIP: _____ **PHONE:** _____ **GROUP #:** _____
SUBSCRIBER'S NAME: _____ **SUBSCRIBER'S SS#:** _____
SUBSCRIBER'S DOB: _____ **SUBSCRIBER'S SEX:** M F

SECONDARY INSURANCE COMPANY: _____
ADDRESS: _____ **CITY:** _____ **STATE:** _____
ZIP: _____ **PHONE:** _____ **GROUP #:** _____
SUBSCRIBER'S NAME: _____ **SUBSCRIBER'S SS#:** _____
SUBSCRIBER'S DOB: _____ **SUBSCRIBER'S SEX:** M F

INSURANCE IS NOT GUARANTEED PAYMENT. BALANCE IS DUE WITHIN 90 DAYS OF THE INSURANCE CLAIM UNLESS ARRANGEMENTS HAVE BEEN MADE THROUGH OUR OFFICE.

FINANCIAL AGREEMENT

"THE INFORMATION STATED ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE. I, THE PERSON RESPONSIBLE FOR PAYMENT OF MEDICAL CARE FOR THE ABOVE PATIENT, AGREE TO PAY FOR THE OFFICE VISIT AND SERVICES THE DAY THE CARE IS PROVIDED. I AGREE TO PAY ANY BALANCE DUE ON OTHER CHARGES WITHIN 90 DAYS FROM THE DATE THAT SERVICE IS PROVIDED".

SIGNATURE: _____ **DATE:** _____

BRISTOL HOSPITAL

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BARIATRIC MEDICAL QUESTIONNAIRE

DATE TODAY: _____

LAST NAME: **FIRST NAME:** **MI:** **AGE:** **BIRTHDATE:**

MARITAL STATUS: **M** **S** **W** **D**

OCCUPATION: _____

The information you provide will help us with your treatment

PRIMARY HEALTH CARE PROVIDER (PLEASE LIST LAST 5 YEARS)

OK FOR US TO NOTIFY THIS PHYSICIAN?

1. PHYSICIAN NAME: _____
   ADDRESS: _____ **YES** **NO**
   PHONE NUMBER: _____
   DATES OF TREATMENT: _____

2. PHYSICIAN NAME: _____
   ADDRESS: _____ **YES** **NO**
   PHONE NUMBER: _____
   DATES OF TREATMENT: _____

3. PHYSICIAN NAME: _____
   ADDRESS: _____ **YES** **NO**
   PHONE NUMBER: _____
   DATES OF TREATMENT: _____

4. PHYSICIAN NAME: _____
   ADDRESS: _____ **YES** **NO**
   PHONE NUMBER: _____
   DATES OF TREATMENT: _____

5. PHYSICIAN NAME: _____
   ADDRESS: _____ **YES** **NO**
   PHONE NUMBER: _____
   DATES OF TREATMENT: _____

6. PHYSICIAN NAME: _____
   ADDRESS: _____ **YES** **NO**
   PHONE NUMBER: _____
   DATES OF TREATMENT: _____

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Nutrition Questionnaire

Name_____ DOB_____

Are you currently working? Yes No

If yes, what shift? _____

Is your job: Active Sedentary

Do you currently engage in regular physical activity? Yes No

If YES, describe: (example: walk 30 minutes, 3 times/week)

_____

What types of exercise programs have you tried in the past : _____

_____

Have you had previous weight loss surgery? Yes/No If yes, list date, surgeon, type of surgery: _____

_____

Do you drink alcoholic beverages?

If YES, list type, amount and frequency: _____

Do you drink carbonated drinks?

If YES, list type, amount and frequency: _____

Do you drink caffeinated beverages?

If YES, list type, amount and frequency: _____

List and herb, vitamins, minerals or other supplements you currently take: _____

How many people live in your household? _____ Who does grocery shopping? _____

Who cooks? _____

What was your weight 1 year ago? _____

What was your lowest adult weight? _____ At age: _____

What was your highest adult weight? _____ At age: _____

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Bariatric Surgery PROGRAM

Nutrition Questionnaire *continued*

Name_____ DOB_____

Weight Loss Attempts

Program	Date	Weight lost	Weight Regained	How Long to Regain?	Physician Supervised Y/N	Dietitian Supervised Y/N
Weight Watchers						
Jenny Craig						
Diet Center						
Atkins						
Southbeach						
Nutri-System						
Over-the-counter diet pills						
Prescription Diet pills (name)						
Slimfast or Similar						
Hypnosis, jaw wiring, acupuncture						
Conventional Low calorie						
Other						

BRISTOL HOSPITAL

Bariatric Surgery PROGRAM

Nutrition Questionnaire *continued*

Name_____ DOB_____

How many daily meals do you eat? _____

Do you snack between meals? Yes No
If YES, list types of snacks: _____

How many meals per week do you eat out? _____ How many meals are fast food? _____

What types of beverages do you drink? _____

How many cups of fluid do you drink per day? (1 cup = 8oz) _____

Are you an emotional eater? Yes No Describe: _____

Do you have cravings? Yes No What foods: _____ How do you handle: _____

When do you stop eating? (circle) stuffed full just right plate is cleaned still hungry

How fast do you eat? (circle) fast average slow

How would you rate your nutrition knowledge? (circle) good fair poor
If fair or poor, in what areas do you feel you need information or education? (check all that apply or list other)

Dining Out	
Label Reading	
Strategies for coping with cravings	
Portion sizes	
General low fat guidelines	
General low sugar guidelines	
Smart snacking	
Protein needs/guidelines	

Please use the enclosed food log to record 2-3 days of food intake. Write down everything you eat or drink and how much.

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HEALTH HISTORY
Have you had any of the following?
(Circle those that apply)

CARDIOPULMONARY
Heart attack
Heart cath
Heart Surgery
Heart valve prolapse
High blood pressure
Chest pain
Angina
Pain in arm
Abnormal heart beat
Swelling hands/feet
Leg cramps
Walking at night
Asthma
Emphysema
Abnormal chest x-ray
Tuberculosis
Frequent cough
Cough up blood
Lung surgery
Collapsed lung
Swelling of joints
Night sweats
Wake up with shortness of breath
Shortness of breath when:
- Walking several blocks
- One flight of stairs
- On laying down

HEENT
Frequen Headaches
Fainting spells
Dizziness
Unconscious spells
Blurred Vision
Spots Before Eyes
Change in Vision
Earaches
Wear glasses/ Contacts
Recurrent sores in mouth
Recurrent sore throat
Enlarged veins in legs
Persistent hoarseness
Gum soreness or bleeding
Recurrent Nose Bleeds

ENDOCRINE
Diabetes (insulin dependent)
Diabetes (non Insulin dependent)
Thyroid disease
Adrenal Disease
Growth in neck/throat
Hot flashes
Tiredness with no reason
Slow wound healing
Brittle nails
Inability to stand heat/cold
Skin rash

GENITOURINARY
Pain or burning w/ urination
Difficulty starting urination
Urinate at night?
- # of times?

Blood in urine
Full bladder feeling but urinate small amount?
Lose urine w/ cough?
Discharge from penis?
Kidney stones
Prostate problems
times urinate daily?

GASTROINTESTINAL
Reflux/hernia
Stomach ulcers
Gallbladder disease
Hepatitis/ Jaundice
Crohn's
Ulcerative Colitis
Hemorrhoids
Liver Disease
Food avoidance

MUSCULO-SKELETAL-NEURO
Recurrent back pain
Neuritis/neuralgia
Joint Pain
Sleep apnea
Redness or heat of joints
Tingling in hands or feet
Muscle spasms
Trembling of extremity
Broken bones
Ruptured disc
Neck injury
Arthritis/rheumatism
Paralysis
Stroke
Bipolar
Under care of psychiatrist now or past?
Depression
Fits of anger
Mood swings
Outpatient/Inpatient counseling or treatment for "mental disorder"?

Treatment for substance abuse

NUTRITIONAL
Poor growth
Anemia
Brittle nails
Dyspigmentation of skin
Easily bruise
Dark concentrated urine
Poor wound healing
Sores in mouth (recurrent)
Changes in taste
Glossy red tongue
Dental caries
Red swollen gums
Dry cracked lips
Dry scaly skin
Swelling in extremities
Dry brittle hair
Thin sparse hair
White spots on nails
Dry eyes
Sudden unexplained weight gain or loss

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7. PERSONAL HISTORY

Have you had or do you have? Circle if yes:

Measles
German measles
Mumps
Chicken pox
Whooping cough
Scarlet fever
Scarlentina
Diphtheria
Small pox
Polio
Gonorrhea
Hepatitus A
Hepatitus B
Hepatitus C
Tuberculosis
HIV positive

Bleeding chest
Anesthesia reaction
Blood transfusion reaction
Do you smoke cigaretttes? Y N
Packs per day? _____
# of years? _____

Use alcoholic beverages
Use "recreational or street drugs
Chew tobacco? Y N
# of years? _____

X-RAYS: Have you had and date

Chest _____
Stomach or colon _____
Gallbladder _____
Extremities _____
Back _____
Teeth _____
Other _____
Electrocardiagram _____
Cardiac catheter _____
Echocardiagram _____
MRI _____
CT scan _____

GYNECOLOGICAL HISTORY:

Age at onset on menses: _____
Number of pregnancies: _____
Number of children: _____
Vaginal deliveries: _____
C-sections: _____

BREAST MEDICAL HISTORY

Breast surgery of any type: Y N
Breast lump not operated: Y N
Breast cancer: Y N
Last mammogram: _____

DRUG ALLERGIES (LIST)

_____
_____

FOOD ALLERGIES (LIST)

_____
_____

CURRENT MEDICATIONS

MEDICATION	PURPOSE

HOSPITALIZATIONS (non surgical)

DIAGNOSIS	WHEN

SURGICAL HISTORY (CIRCLE AND LIST DATE OF SURGERY IF KNOWN)

_____ Appendectomy
_____ Back
_____ Breast cancer
_____ Cancer (any type)
_____ Colon/intestional surgery
_____ Gallbladder
_____ Hemorrhoids

_____ Heart
_____ Hernia (hiatal)
_____ Hernia (umbilical)
_____ Hernia (inguinal)
_____ Hernia (ventral)
_____ Knee
_____ Lung

_____ Ovaries
_____ Prostate
_____ Thyroid
_____ Tonsillectomy
_____ Tubal ligation
_____ Ulcers, stomach
_____ Uterus hysterectomy
_____ Other
_____

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Are You Being Treated For: (Circle if yes and complete)

Condition:	Doctor / Address / Phone #	Medication
Asthma		
Diabetes		
Heartburn (GERD)		
Hypertension		
Heart Disease Heart Attack Heart Surgery Stents		
Sleep Apnea		
Other		

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IT HAS BEEN PROVEN THAT 1 IN EVERY 3 AMERICANS SUFFER FROM A SLEEP DISORDER

DO YOUR SLEEP HABITS CONCERN YOU?

If your answer is YES, complete the following quiz and score yourself on the right.

- ☐ 1. I have been told that I snore
- ☐ 2. I have been told that I stop breathing while I sleep
- ☐ 3. I have gained weight
- ☐ 4. I suffer from high blood pressure
- ☐ 5. I feel fatigued during the day
- ☐ 6. I suffer from morning headaches
- ☐ 7. I have lost interest in sex
- ☐ 8. I sweat excessively during the night
- ☐ 9. I suddenly wake up unable to breathe
- ☐ 10. My family and friends say that they have noticed a change in my personality

- ☐ 11. I have been told that I kick in my sleep
- ☐ 12. I experience a "creepy, crawly" sensation in my legs
- ☐ 13. I have excessive daytime drowsiness
- ☐ 14. I have been told that I am a restless sleeper
- ☐ 15. I awaken with sore or achy muscles
- ☐ 16. I often have trouble staying asleep throughout the night

- ☐ 17. I have fallen asleep while driving
- ☐ 18. I experience vivid nightmares soon after falling asleep
- ☐ 19. No matter how hard I try to stay awake, I fall asleep
- ☐ 20. I fall asleep throughout the day
- ☐ 21. I feel paralyzed when I am waking up or falling asleep
- ☐ 22. I feel like I am hallucinating when I fall asleep

- ☐ 23. I feel afraid to go to sleep
- ☐ 24. I have trouble falling asleep
- ☐ 25. Thoughts run through my mind, preventing me from going to sleep
- ☐ 26. It often takes me an hour or more before I fall asleep
- ☐ 27. I wake up in the middle of the night unable to return to sleep

SCORES

Place the number checked from each of the following sections in the space provided below.

_____ *Questions 1-10*

If you marked three or more of these questions, you show symptoms that are associated with Sleep Apnea.

Sleep Apnea is a life threatening sleep disorder which frequently causes you to stop breathing. It can happen hundreds of times per night while you sleep and you may not even be aware it is happening.

_____ **Questions 11-16**

If you marked three or more of these questions, you show symptoms that are associated with Myoclonus or Restless Leg Syndrome.

Myoclonus or Restless Leg Syndrome is an unpleasant feeling that occurs in the legs when a person is setting or lying still, especially at bedtime.

_____ **Questions 17-22**

If you marked three or more of these questions, you show symptoms that are associated with Narcolepsy.

Narcolepsy is a lifelong disorder that is characterized by uncontrollable sleep attacks during the day.

_____ **Questions 23-27**

If you marked three or more of these questions, you show symptoms that are associated with insomnia.