BRISTOL HOSPITAL

Weight Loss Surgery

NAME: _____DOB: _____AGE: _____

HEALTH CARE PROVIDERS: Please list any providers you have seen in the past or currently

1. Primary PHYSICIAN: _____
   ADDRESS: _____
   PHONE NUMBER: _____

2. CARDIOLOGIST: _____
   ADDRESS: _____
   PHONE NUMBER: _____

3. PULMONOLOGIST: _____
   ADDRESS: _____
   PHONE NUMBER: _____

4. ENDOCRINOLOGIST: _____
   ADDRESS: _____
   PHONE NUMBER: _____

5. GASTROENTEROLOGIST : _____
   ADDRESS: _____
   PHONE NUMBER: _____

6. PSYCHIATRIST: _____
   ADDRESS: _____
   PHONE NUMBER: _____

7. SLEEP MEDICINE: _____
   ADDRESS: _____
   PHONE NUMBER: _____

8. OTHER PHYSICIAN: _____
   ADDRESS: _____
   PHONE NUMBER: _____

Name: _____ DOB: _____

Prior Weight Loss Attempts Lowest Adult Weight:_____ Age:_____

Program	Date Month/Year	# of Pounds	# of Pounds Regained	How Long to Regain? Weeks/Months	Physician Supervised Y/N	Dietitian Supervised Y/N
Weight Watchers						
Jenny Craig						
Diet Center						
Atkins						
South Beach						
Nutri-System						
Over-the-counter diet pills						
Prescription diet pills (name)						
Slimfast or similar						
Hypnosis, jaw wiring, acupuncture						
Conventional low calorie						
Other						

Do you currently engage in physical activity? Yes No If yes, describe: _____

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

Name: _____ **DOB:** _____

HEALTH HISTORY

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

CARDIOPULMONARY

Heart attack
Heart catheterization
Heart valve prolapse
High blood pressure
High cholesterol
Chest pain/Angina
Pain in arm
Abnormal heart beat
Atrial Fibrillation
Swelling hands/feet
Asthma
Emphysema/COPD
Tuberculosis
Frequent cough
Cough up blood
Collapsed lung
Night sweats
Wake up with shortness of breath
Sleep Apnea (CPAP/BiPAP)
Shortness of breath when:
- Walking several blocks
- One flight of stairs
- On laying down

GASTROINTESTINAL

Acid Reflux
Stomach ulcers
Gallbladder disease
Hepatitis
Jaundice
Crohn's Disease
Ulcerative Colitis
Diverticulitis
Fatty Liver Disease
Other: _____

HEMATOLOGY

Blood clots
Pulmonary embolism
HIV positive
Anemia

NEUROLOGICAL

Frequent headaches
Fainting spells
Dizziness
Blurred vision
Pseudotumor Cerebri

MUSCULO-SKELETAL

Recurrent back pain
Neuritis/neuralgia
Joint pain
Fibromyalgia
Redness or heat of joints
Tingling in hands or feet
Muscle spasms
Broken bones
Ruptured disc
Neck injury
Arthritis/rheumatism
Paralysis
Bipolar
Depression
Anxiety
Under care of psychiatrist now or past?
Outpatient/Inpatient counseling or treatment for "mental disorder?"
Treatment for substance abuse,

ENDOCRINE

Diabetes (insulin dependent)
Diabetes (non-insulin dependent)
Thyroid disease
Adrenal disease
Polycystic Ovarian Syndrome
Growth in neck/throat
Slow wound healing
Skin rash

GENITOURINARY

Blood in urine
Lose urine with cough?
Kidney stones
Prostate problems

VASCULAR

Lymphedema
- Leg: Right or Left
- Arm: Right or Left

NUTRITIONAL

Depigmentation of skin
Easily bruise
Poor wound healing
Dental caries
Red swollen gums
Dry cracked lips
Dry scaly skin
Dry brittle hair
Thin sparse hair
White spots on nail

Cancer History: Type _____; Location _____; Date _____
Treatment: _____

Current form of birth control/contraception in use:

☐ Barrier/Condom method
☐ IUD Name: _____
☐ Implant Name: _____
☐ Oral Contraception Pill:
  Medication Name: _____
☐ Nuva Ring
☐ Depo Provera Injections:
  Last injection date: _____
☐ Tubal Ligation
☐ Hysterectomy
☐ Other form: _____

Name: _____ **DOB:** _____

Anesthesia reaction Y N
Blood transfusion reaction Y N

Do you smoke cigarettes? Y N
Packs per day? _____
# of years? _____
Quit date? _____
Do you Vape? Y N
Nicotine Vape? Y N
Use alcoholic beverages? Y N
Type _____
Frequency _____
Use "recreational" or
"street drugs?" Y N
Type _____
Frequency _____
Medical Marijuana Card? Y N

Chew tobacco? Y N
# of years? _____

Gynecological History:

#of children: _____
# of pregnancies: _____
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: _____
Do you have any tattoos? Y N
If yes: Was your tattoo performed in a formal/commercial setting? Y N

Drug/Medication Allergies (List)

_____
_____

Food Allergies (List)

_____
_____

Current Medications

Name Dose Frequency
_____
_____
_____
_____
_____
_____

Recent Hospitalizations (non-surgical)

Diagnosis When
_____
_____
_____
_____

Surgical History *(Circle and list date of surgery if known)*

_____ Appendectomy
_____ Back
_____ Breast Surgery
_____ Colon/ intestinal surgery
_____ Gallbladder
_____ Heart
_____ Hernia (Hiatal)
_____ Hernia (Umbilical)
_____ Hernia (Inguinal)
_____ Hernia (Ventral)
_____ Knee
_____ Lung
_____ Ovaries
_____ Prostate
_____ Thyroid
_____ Tonsillectomy
_____ Tubal ligation
_____ Ulcers, stomach
_____ Uterus hysterectomy
_____ Other

Name: _____ DOB: _____

STOP BANG Questionnaire

Height _____ inches/cm Weight _____ lb./kg BMI _____

Age _____

Male/Female

Neck circumference* _____ cm (*will be measured at intake appointment)

1. Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
   Yes No
2. Do you often feel tired, fatigued, or sleepy during daytime?
   Yes No
3. Has anyone observed you stop breathing during your sleep?
   Yes No
4. Blood pressure Do you have or are you being treated for high blood pressure?
   Yes No
5. BMI more than 35 kg/m2?
   Yes No
6. Age over 50 yr. old?
   Yes No
7. Neck circumference greater than 40 cm?
   Yes No
8. Gender male?
   Yes No

* Neck circumference is measured by staff

High risk of OSA: answering yes to three or more items

Low risk of OSA: answering yes to less than three items

Adapted from: STOP Questionnaire A Tool to Screen Patients for Obstructive Sleep Apnea Frances Chung, F.R.C.P.C., Balaji Yegneswaran, M.B.B.S.,† Pu Liao, M.D.,‡ Sharon A. Chung, Ph.D.,§ Santhira Vairavanathan, M.B.B.S.,_ Sazzadul Islam, M.Sc.,_ Ali Khajehdehi, M.D.,† Colin M. Shapiro, F.R.C.P.C.# Anesthesiology 2008; 108:812–21 Copyright © 2008, the American Society of Anesthesiologists, Inc. Lippincott Williams & Wilkins, Inc.*

Name: _____ DOB: _____

Psychological Screening Questionnaire

Please mark each question in terms of whether you have experienced this behavior in the past or currently (within the last year).

1. Have you been treated for an emotional disorder (i.e.: depression, anxiety) by a mental health professional or your personal physician? ☐ No ☐ In the Past ☐ Currently

2. Have you been hospitalized for an emotional disorder? ☐ No ☐ In the Past ☐ Currently

3. Have you had suicidal thoughts on a regular basis or made a suicidal attempt? ☐ No ☐ In the Past ☐ Currently

4. Have you been treated as an outpatient for an alcohol or substance abuse program or attended a 12-step program such as AA? ☐ No ☐ In the Past ☐ Currently

5. Have you been hospitalized or treated in a residential program for an alcohol or substance abuse problem? ☐ No ☐ In the Past ☐ Currently

6. Have you been treated for an eating disorder such as anorexia, bulimia, or compulsive overeating? ☐ No ☐ In the Past ☐ Currently

7. Have you engaged in binge eating or purging (vomiting) after eating? ☐ No ☐ In the Past ☐ Currently

8. Have you been placed on disability or lost a job for an emotional or nervous disorder? ☐ No ☐ In the Past ☐ Currently

9. Have you been separated or divorced? ☐ No ☐ In the Past ☐ Currently

10. Have you been in a relationship within or outside the family that you considered abusive? ☐ No ☐ In the Past ☐ Currently

11. Have you been prescribed medication for an emotional or nervous disorder? ☐ No ☐ In the Past ☐ Currently