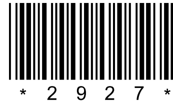
MR # DOB

NAME

DATE



BASSETT MEDICAL CENTER
Cooperstown, NY 13326-1394

BARIATRIC SURGERY CANDIDATE INFORMATION PACKET

H-2927 3/08;12/13;10/15 (d:\forms\hosp\.ofm)

PLEASE PRINT CLEARLY

NAME: ______________________ DATE OF BIRTH: ______________

MAILING ADRESS: ______________________________

____

____

PHONE:

☐ Cell: ____________ ☐ Home: ____________ ☐ Work: ____________

INDICATE PREFERRED CONTACT NUMBER BY CHECKING BOX.

PRIMARY CARE PROVIDER: ______________________________

Phone number of provider: ______________________________

Address: ______________________________

MENTAL HEALTH PROVIDER: ______________________________

Phone number of provider: ______________________________

Address: ______________________________

INSURANCE INFORMATION

NAME OF COMPANY: ______________________________

INSURANCE ID #: ______________________________

For Office Use Only

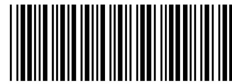
NPO: ______________ Initial appointment: ______________

PHQ-9: ______________ Provider: ______________

Moorehead Score: ______________ Epworth Score: ______________

Smoker: ______________

PATIENT SELF HISTORY



BASSETT MEDICAL CENTER
Cooperstown, NY 13326-1394

BARIATRIC SURGERY
CANDIDATE INFORMATION PACKET

NEW PATIENT HISTORY FORM

H-2927-A 3/08;6/13;10/15;10/18 (d:\forms\hosp\.ofm)

PLEASE PRINT CLEARLY
You must answer all sections

Name of person completing form: ______________________________

Name of person seeking evaluation: ______________________________

Highest Level of Education: ______________________________

Age at first diet: ______________________

Weight at puberty: *(check one)*

☐ skinny ☐ normal ☐ chubby

Current Height & Weight: ______________ BMI **(from table included in packet):** ______________

Do you consider yourself a "Binge Eater" *(eat to the point of severe discomfort followed by severe guilt 2 or more times a week)*

☐ Yes ☐ No

Describe typical episode: ______________________________

____

Pregnancies: Have you ever gained weight during pregnancy that you did not loose after giving birth? ☐ Yes ☐ No

What eating behavior best describe you? *(check one)*

☐ I eat to relieve stress

☐ I eat to comfort myself

☐ I eat to reward myself

☐ I come from a culture of eating

☐ Other *(please describe)* ______________________________

____

____

Have you ever used the following methods for weight loss?
(check all that apply and provide dates - describe)

☐ Vomiting ______________ ☐ Water Pills ______________ ☐ Ipecac ______________

☐ Laxatives ______________ ☐ Excessive Exercising ______________

PATIENT SELF HISTORY

Date of birth ______________________

Most Recent 5 year Diet History

We will need a detailed history from you if you expect this surgery will be covered by your insurance company.

At least a five-year history of dieting is required by most insurances.

YOU MUST COMPLETE THIS FORM WITH SPECIFIC DETAILS REQUESTED

For the last 5 years, counting back from the current year, please list what you have done to lose weight. Please include: Type of Diet, Dates and Amount of weight loss, and if regained pounds, number of pounds regained and how long after stopping the diet.

Example: *Year 2017: I joined Weight Watchers for 3 months and lost 12 pounds but regained 10 when I went off the program.*

Example: *Year 2016: Joined a gym for 6 months, lost 12 pounds but put it back on when I stopped going to the gym.*

Example*: Year 2015: I took over the counter diet pills for 6 months and lost about 18 pounds. When I stopped the pills, I gained all of it back.*

Example*: Year 2014: I stopped drinking soda & I ate smaller portions. Lost 18 pounds but I gained back 15 pounds since I started drinking soda again.*

Year _______

____

____

____

Year ______

____

____

____

Year ______

____

____

____

Year ______

____

____

____

Year ______

____

____

____

EPWORTH SLEEPINESS SCALE

What is the chance you will doze off in the following situations? *(Check one that best describes you)*

Sitting and reading

☐ 0 No chance of dozing ☐ 1 Slight chance of dozing ☐ 2 Moderate chance of dozing
☐ 3 High chance of dozing

Watching TV

☐ 0 No chance of dozing ☐ 1 Slight chance of dozing ☐ 2 Moderate chance of dozing
☐ 3 High chance of dozing

Sitting inactive in a public place, such as a theater or meeting

☐ 0 No chance of dozing ☐ 1 Slight chance of dozing ☐ 2 Moderate chance of dozing
☐ 3 High chance of dozing

As a passenger in a car for an hour without a break

☐ 0 No chance of dozing ☐ 1 Slight chance of dozing ☐ 2 Moderate chance of dozing
☐ 3 High chance of dozing

Lying down to rest in the afternoon when circumstances permit

☐ 0 No chance of dozing ☐ 1 Slight chance of dozing ☐ 2 Moderate chance of dozing
☐ 3 High chance of dozing

Sitting and talking to someone

☐ 0 No chance of dozing ☐ 1 Slight chance of dozing ☐ 2 Moderate chance of dozing
☐ 3 High chance of dozing

Sitting quietly after lunch without alcohol

☐ 0 No chance of dozing ☐ 1 Slight chance of dozing ☐ 2 Moderate chance of dozing
☐ 3 High chance of dozing

In a car, while stopped for a few minutes in traffic

☐ 0 No chance of dozing ☐ 1 Slight chance of dozing ☐ 2 Moderate chance of dozing
☐ 3 High chance of dozing

Sum: __________

MEDICAL HISTORY

Please indicate whether you have any of the following health problems: *(please check yes or no)*

Condition	Yes	No
Stroke	☐ Yes	☐ No
Seizure Disorder	☐ Yes	☐ No
Unconsciousness	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Other Mental Illness	☐ Yes	☐ No
Deep vein thromosis	☐ Yes	☐ No
Pulmonary Embolism (blood clot)	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Chronic obstructive pulmonary disease	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Gastroesophageal Reflux Disease	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No
Diverticulitis	☐ Yes	☐ No
Enlarged Heart	☐ Yes	☐ No
Congestive Heart Failure	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No
Heart Valve Disease	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Gallbladder Disease	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Blood Disorder	☐ Yes	☐ No
Kidney Stones	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Arthritis/ Gout	☐ Yes	☐ No
Infertility	☐ Yes	☐ No
Abnormal Menses	☐ Yes	☐ No
Urinary Incontinence	☐ Yes	☐ No

CURRENT LIST OF MEDICATIONS (use separate sheet of paper if needed)

Name	Dose	Frequency

ALLERGIES

Name	Reaction

PREVIOUS SURGERIES

Date	Name of Surgery

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Current Living Arrangements: ☐ Alone ☐ Spouse/Significant other ☐ Friend ☐ Parent/Other Family member ☐ School aged children

What is your occupation? ____

Do you enjoy your work? ____

Recreational activities/hobbies? ____

Have you ever been physically or sexually abused? ______________________________

Do you exercise? ☐ Yes ☐ No If so, what type: ______________________________
Number of times per week: __________________ How long: ______________________________

Do you use tobacco? ☐ Yes ☐ No ☐ Never type: _________ amt/years: __________ Quit/when: __________

Do you use alcohol? ☐ Yes ☐ No ☐ Never type: _________ amt/years: __________ Quit/when: __________

Do you use drugs? ☐ Yes ☐ No ☐ Never type: _________ amt/years: __________ Quit/when: __________

Do you use caffeine?
☐ Coffee/Tea ☐ Yes ☐ No ☐ Never type: ____________ amt/years: __________ Quit/when: __________
☐ Soda ☐ Yes ☐ No ☐ Never type: ____________ amt/years: __________ Quit/when: __________
☐ Chocolate ☐ Yes ☐ No ☐ Never type: ____________ amt/years: __________ Quit/when: __________

FAMILY HISTORY SHEET

Place a check in the boxes that apply to your family history.

	Mother	Father	Siblings #_____	Children #_____	Maternal Grand-mother	Maternal Grand-father	Paternal Grand-mother	Paternal Grand-father	Spouse
Height									
Maximum Weight									
Minimum Weight									
State of health if living/age									
Cause of death/age									
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Elevated BP	☐	☐	☐	☐	☐	☐	☐	☐	☐
DVT/PE (blood clot)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis/Gout	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eating Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐	☐
Physical/ Sexual Abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ulcers	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Alcohol/Drug Abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐

Do you have any questions or issues you would like to discuss with the health care provider regarding family history?

MR #

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NAME

BARIATRIC SURGERY
CANDIDATE INFORMATION PACKET

PATIENT HEALTH QUESTIONNAIRE – 9

H-2927-D 3/08;12/13 (d:\forms\hosp\.doc)

DATE

Over the last two weeks, how often have you been bothered by any of the following problems?
(Use ✓ to indicate your answer.)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3

For Office Coding 0 + ________ + ________ + ________

= Total Score ________

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Patient Signature: ________________________________ Date: ____________

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an education grant from Pfizer Inc.
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PATIENT SELF HISTORY

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NAME

BARIATRIC SURGERY
CANDIDATE INFORMATION PACKET

DATE

QUALITY OF LIFE QUESTIONNAIRE
SELF ESTEEM AND ACTIVITY LEVELS

H-2927-E 4/08 (d:\forms\hosp\.doc)

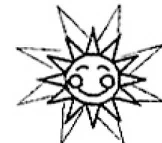
Please make a check in the box provided to show your answer.

1. Usually I Feel . . .

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Very Bad About Myself — Very Good About Myself

2. I Enjoy Physical Activities . . .



☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Not At All — Very Much

3. I Have Satisfactory Social Contacts . . .

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

None — Very Many

4. I Am Able To Work . . .

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Not At All — Very Much

5. The Pleasure I Get Out Of Sex Is . . .

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Not At All — Very Much

6. The Way I Approach Food Is . . .

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

I Live to Eat — I Eat to Live

PATIENT SELF HISTORY