Bariatric Services
Middle Tennessee Medical Center

Date _________________

Surgeon (circle one) Dr. Westmoreland Dr. Eckles

What surgery are you interested in? ____

Last name ______________________ First name ___________________ MI ________

Male Female Date of birth __________/_______/__________ Age _________
(month) (day) (year)

SS # _____ - _____ - _______ County you live in ______________________________

Address _____________________________________ City ______________________

State _________ Zip __________ E-mail address ______________________________

Phone numbers (home) _____________________ Cell __________________________

Work phone _________________________ (ext) ___________ May we call you? _____

Family MD _____________________________ Phone __________________________

Referring MD ___________________________ Phone __________________________

Address of family physician ____

Marital status ____________ Do you have children? Yes No

Employer ____________________________________ Job title ____________________

Address ____________________________________ phone ______________________

Do you do heavy lifting? Yes No Excessive walking? Yes No

Spouse/Next of Kin ______________________________ Relationship ______________

Address ____ Phone _________________

Emergency contact ________________________________ Phone _________________

Please initial each page _______

Please answer ALL questions in the questionnaire.

The reason you are seeing the doctor today?
____

Current height ___________________ Current weight __________________________

Allergic or Adverse Reactions

Includes all medications, tape, latex, creams, topical treatments, ect.

Type of Allergy Reaction

1.) ____

2.) ____

3.) ____

4.) ____

5.) ____

Previous Weight Loss Surgery if requesting a Revision

Procedure Type Surgeon Hospital Date of Surgery Weight Loss

1.) ____

2.) ____

Past Hospital Hospitalizations and Surgeries

Type of Surgery Date

1.) ____

2.) ____

3.) ____

4.) ____

5.) ____

6.) ____

Please initial each page __________

Past Hospitalizations and Surgeries continued

7.) ____

8.) ____

9.) ____

10.) ____

Current Medications

Please list ALL medications including over the counter, herbal, sinus, sleep and diet medications)

Name Dosage Reason for taking

1.) ____

2.) ____

3.) ____

4.) ____

5.) ____

6.) ____

7.) ____

8.) ____

9.) ____

10.) ____

11.) ____

12.) ____

13.) ____

14.) ____

15.) ____

16.) ____

Past Medical History

(please circle the disorder if appropriate, and give an explanation of each)

1. serious illness 2. allergies/asthma 3. cancer 4. diabetes 5. stroke

6. heart disease 7. high blood pressure 8. rheumatic fever 9. chest pain

10. cardiac testing 11. bleeding disorders 12. blood clots 13. HIV

14. pulmonary embolus 15. herpes 16. hepatitis 17. lupus 18. seizures

19. multiple sclerosis 20. grave's disease 21. ulcers 22. sleep apnea

23. sexually transmitted diseases 24. other disorders not listed

Number **Explanation**

____

____

____

____

____

____

____

____

____

____

____

____

____

____

Please initial each page _________

Do You…

Drink coffee or caffeinated drinks? NO YES Amount daily ____________

Drink beer, wine or other alcoholic beverages? NO YES Drinks per day _____

Use aspirin or Motrin (ibuprofen)? No YES Amount per day? _______________

Smoke cigarettes, cigars, or use chewing tobacco? No YES ___________ per day

Eat sweets frequently? NO YES Amount daily _________ weekly _________

Circle any condition that affects you currently

Genitourinary

bladder control problems blood in urine frequent urination stones

kidney disease night urination painful urination other _____________

Musculoskeletal

joint pain hip pain back pain neck pain knee pain gout

inability to walk use of walker use of wheelchair frequent falls

Hematological

abnormal bleeding anemia blood transfusion coumadin use (blood thinner)

AIDS history of cancer other disorders ______________________________

Respiratory

asthma/wheezing can't breath lying flat sleep apnea Bi-pap CPAP

pulmonary embolus frequent cough shortness of breath other _____________

Cardiovascular

chest pain heart attack heart disease high blood pressure high cholesterol

heart murmur pacemaker artificial valve irregular heart beat

rheumatic fever mitral valve prolapse fainting spells swollen ankles

Gastrointestinal

ulcers abdominal pain bloody/tarry stools prior colon cancer

bowel habit changes constipation diarrhea diverticulitis acid reflux

nausea hemorrhoids liver trouble hiatal hernia rectal bleeding

swallowing problems gallbladder problems milk intolerance

other ____

Women Only

menopause breast lumps change in periods hot flashes

Last period _____________ or hysterectomy (circle)
Last Pap Smear __________________
Last Mammogram ________________

Pregnant now YES NO Other ______________________________

Family Health History

(Place a check where appropriate)

	Father	Mother	Sibling	Grandmother	Grandfather
Heart attack					
Cancer					
Diabetes					
Gallbladder Disease					
High Blood Pressure					
Stroke					
Other					

Please initial each page ________

Thrombosis Risk Factor Analysis

Patient Name ____ Date _____________

Please read the list of risk factors below and check all the factors that apply to you.
Then total the number of points you have accumulated.

Each checked category is equal to 1 point

__________ **Age above 40**

__________ **Previous DVT (deep vein thrombosis or "leg clot")**

__________ **Immobilization or inability to walk more than a few steps**

__________ **Obesity**

__________ **Cardiac disease/CHF (congestive heart failure)**

__________ **Varicose veins**

__________ **Limb Trauma/Injury**

__________ **Undergoing surgery, including bariatric surgery**

__________ **Hormone replacement**

__________ **History of Autoimmune disease(Lupus, rheumatoid arthritis, SLE)**

__________ **Disease affecting the clotting of blood (Coagulopathy)**

SCORE

1 Risk Factor = Low Risk
2 Risk Factors = Moderate Risk
3 Risk Factors = High Risk
4 Risk Factors = Very High Risk

Nutritional Questionnaire

Please answer the following questions as completely and honestly as you can.

1.) Do you consider yourself a picky eater? YES NO

2.) How many meals do you each per day? ___________________________

3.) Do you awaken in the middle of the night and eat? YES NO

4.) How many snacks do you eat per day? ____________________________

5.) At what time of the day do you usually snack? ______________________

6.) What is your favorite snack? _____________________________________

7.) How many times per day/week/month do you consume the following foods?

______day ______week ______month candy
______day ______week ______month pastries/pies/cakes/doughnuts
______day ______week ______month ice cream/shakes
______day ______week ______month chips/pretzels/popcorn
______day ______week ______month fast food/restaurants
______day ______week ______month caffeine
______day ______week ______month carbonated beverages
______day ______week ______month alcohol
______day ______week ______month fruit
______day ______week ______month vegetables
______day ______week ______month deep fried foods

8.) How many ounces of water do you consume daily? _________________

9.) Please list any food allergies: _____________________________________

10.) Do you drink milk regularly? ____________ Do you like milk? ________

11.) Will you drink milk as part of your post op recovery period? _________

12.) Who prepares the meals in your home? ___________________________

13.) Who does your grocery shopping in your home? ___________________

14.) What is your personal goal weight? ______________________________

15.) Do you binge eat? _________ Do you vomit to control your weight? __________

16.) Have you been diagnosed with an eating disorder? ________________________

Please initial each page

17.) Do you exercise on a regular basis? Y N If so, what do you do? _________
____

18.) Why do you feel that you can make the lifestyle changes necessary to be successful after bariatric surgery vs. dieting in the past? ______________________
____
____

19.) Are you aware that you will have to follow a nutritional plan after surgery?
____

20.) Are you aware that you will not be able to eat the same foods after surgery that you are currently able to eat and expect to be successful long-term? _________
____

21.) Are you willing to follow the nutritional plan after surgery and long term? ___
____

22.) Are you aware that there are lifestyle changes that must made before and after bariatric surgery? ____

23.) Are you aware that you can gain weight following bariatric surgery? _______
____

24.) What has been your most successful attempt at weight loss in the past?
____
Why? ____

25.) Describe below the foods and beverages you consume on a typical day:
____
____
____
____
____
____

Patient Pledge

Initial

________ I agree to come to all of my follow up appointments with my surgeon

________ I agree to follow up with my Primary Care Physician regularly

________ I agree to attend support group meetings at least once a month

________ I agree to follow my post surgery nutritional plan & take my vitamins

________ I agree to follow my exercise regime on a weekly basis

________ I agree to follow up with my Dietitian/Nutritionist regularly

EPWORTH SLEEPINESS SCALE

= no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	____________
Watching TV	____________
Sitting inactive in a public place (e.g. a theater or a meeting)	____________
As a passenger in a car for an hour without a break	____________
Lying down to rest in the afternoon when circumstances permit	____________
Sitting and talking to someone	____________
Sitting quietly after a lunch without alcohol	____________
In a car, while stopped for a few minutes in traffic	____________

Total ____________