



# 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.) \_\_\_\_\_

## 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.)	_____	_____



**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**

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**Genitourinary**

bladder control problems blood in urine frequent urination stones  
kidney disease night urination painful urination other \_\_\_\_\_

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**Musculoskeletal**

joint pain hip pain back pain neck pain knee pain gout  
inability to walk use of walker use of wheelchair frequent falls

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**Hematological**

abnormal bleeding anemia blood transfusion coumadin use (blood thinner)  
AIDS history of cancer other disorders \_\_\_\_\_

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**Respiratory**

asthma/wheezing can't breath lying flat sleep apnea Bi-pap CPAP  
pulmonary embolus frequent cough shortness of breath other \_\_\_\_\_

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**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 \_\_\_\_\_

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## 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 \_\_\_\_\_

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## Family Health History

(Place a check where appropriate)

Father            Mother            Sibling            Grandmother    Grandfather

\_\_\_\_\_  
Heart attack

\_\_\_\_\_  
Cancer

\_\_\_\_\_  
Diabetes

\_\_\_\_\_  
Gallbladder  
Disease

\_\_\_\_\_  
High Blood  
Pressure

\_\_\_\_\_  
Stroke

\_\_\_\_\_  
Other

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## 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**

Please initial each page \_\_\_\_\_

## 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 eat 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? \_\_\_\_\_

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 be 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 \_\_\_\_\_