**BARIATRICS CENTER** AT NEBRASKA MEDICINE

## PERSONAL INFORMATION

Name: _____ Date of Birth: _____

Phone: _____ Who is your primary care physician? _____

What system does your primary care physician work within? _____

- **Have you had previous weight loss surgery? ☐ Yes ☐ No**
- **Current Height _____ Weight _____ BMI _____**
- **You MUST check with your insurance company PRIOR to returning this form to see if you have bariatric benefits, in the event you do not verify and benefits are not available visit may not be covered and will be your responsibility.**

**Please check the options that you are interested in:**

☐Surgical weight loss options

☐Medication supported weight loss options

☐New Directions Meal replacement program

List the two biggest reasons you would like to lose weight:

1._____

2._____

When do you feel weight gain started or when did weight become an issue for you? (Check all that apply and note approximate actual age)

☐ Before the age of 10 _____ ☐ Pre-teen years _____

☐ Teenager _____ ☐ Early adult (20's-30's) _____

☐ Adult (40's-50's) _____ ☐Later adult (60's+) _____

Would you describe your weight gain as gradual? ☐Yes ☐No

Has your weight been stable over the last 1 year? ☐Yes ☐No

Has your weight been stable over the last 5 years? ☐Yes ☐No

If weight has not been stable, how has your weight changed over the last year or 5 years? _____

What was your highest weight as an adult? _____

Lowest weight as an adult? _____

What do you think contributed to any time periods of weight gain or regain in your life (for example life events, medications, other changes)?

_____

Do you have a goal weight in mind? ☐Yes ☐ No If yes, what weight? _____

Please list any medications for weight loss and any diets or other weight loss methods you have tried:

| Year | Diet/Medication/Other method | Weight lost (lbs) | Weight regained (lbs) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

If took a medication to assist with weight loss, did you have any side effects from the medication? ☐Yes ☐No

If yes, what were the side effects? _____

Have you ever taken Phen-Fen? ☐Yes ☐No If yes, for how long? _____

Have you had a follow-up echocardiogram since you stopped using Phen-Fen? ☐Yes ☐No

Do you struggle with hunger? ☐Yes ☐No

Do you struggle with cravings? ☐Yes ☐No If both, which one is stronger? _____

Is there a certain time of day/week or situation in which you struggle with hunger or cravings? ☐Yes ☐No

If yes, what are those times/situations? _____

Does anyone else in your biological family have extra weight? ☐Yes ☐No

If yes, who? _____

If you live with other people, do they have extra weight? ☐Yes ☐No

If yes, who? _____

Has anyone in your family or anyone you know had weight loss surgery?: ☐ Yes No ☐

What did your family/friends/partner in life do that helped you lose weight the last time you tried to lose weight?_____

What did your family/friends/partner in life do that made it more difficult to lose weight the last time you tried to lose weight? _____

## MEDICAL HISTORY

Do you have any of the following medical conditions or diagnoses? Please check box.

| Yes | Medical condition or diagnosis | Years | Please describe condition |
|---|---|---|---|
| ☐ | Diabetes mellitus or pre-diabetes<br>Do you take insulin? ☐Yes ☐No | | |
| ☐ | Hypertension (high blood pressure) | | |
| ☐ | High cholesterol | | |
| ☐ | Heart disease, heart attack, heart stents, or heart rhythm problem | | |
| ☐ | Stroke | | |
| ☐ | Liver disease (hepatitis, cirrhosis or other) | | |
| ☐ | Kidney disease or kidney stones | | |
| ☐ | Respiratory (breathing) problems (COPD, asthma, sleep apnea, other) | | |
| ☐ | Thyroid disease | | |
| ☐ | Learning disability or needing extra help in school | | |
| ☐ | Gastrointestinal reflux (GERD or heartburn) | | |
| ☐ | Dysphagia (pain or trouble swallowing) | | |
| ☐ | Stomach ulcers | | |
| ☐ | Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis) | | |
| ☐ | Celiac disease | | |
| ☐ | Gallbladder problems | | |
| ☐ | Pancreatitis | | |
| ☐ | Blood clots (deep vein thrombosis or pulmonary embolism) | | |
| ☐ | Depression or bipolar disorder | | |
| ☐ | Prior suicide attempts | | |
| ☐ | Anxiety | | |
| ☐ | Anorexia or bulimia | | |
| ☐ | Joint pain, back pain or arthritis | | |
| ☐ | Fibromyalgia | | |
| ☐ | Glaucoma | | |
| ☐ | Anemia | | |
| ☐ | HIV disease | | |

| Yes | Medical condition or diagnosis | Years | Please describe condition |
|---|---|---|---|
| ☐ | Pseudotumor cerebri | | |
| ☐ | Cancer (if yes, what kind?) | | |
| ☐ | Head trauma or traumatic brain injury | | |
| ☐ | Medullary thyroid cancer or Multiple Endocrine Neoplasia | | |
| ☐ | Osteoporosis or broken bones | | |

Please list any other medical problems you have that are not noted above:
1. _____
2. _____
3. _____
4. _____

## WOMEN ONLY

| Yes | Medical condition or diagnosis | Years | Additional Comments |
|---|---|---|---|
| ☐ | Polycystic ovary syndrome (PCOS) | | |
| ☐ | Infertility | | |
| ☐ | Gestational Diabetes or Gestational Hypertension | | |
| ☐ | Stress incontinence | | |

Are you sexually active? ☐Yes ☐No

Do you use any type of pregnancy prevention? ☐Yes ☐No
If yes, what type? _____

Do you hope to become pregnant in the future? ☐Yes ☐No

Do you currently have menstrual cycles? ☐Yes ☐No
How often? _____

Do you consider your menstrual flow to be heavy, light, or normal flow? _____

What was the approximate date of the first day of your last period (of if in menopause, what age did you stop having periods)? _____

Approximately how old were you when you first started menstruating? _____

## SURGICAL HISTORY

Please list any surgeries (please include the year of surgery) you have had: _____

_____

_____

Do you have any religious or other objection to receiving a blood transfusion? ☐Yes ☐No

## MEDICATIONS

Please list **all medications** including oral and injectable medication **as well as any supplements** that you take (both over the counter and prescribed):

| Medication name | Medication dose | Last dose change (prior dose and updated dose, date) | Date medication was first started | If the medication is meant to be taken regularly, how many doses per day or week do you miss taking the medication, if any? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

(Please include any further medications on additional sheet of paper/back of this page)

## HEALTH MAINTENANCE SCREENINGS – (leave blank if have never completed)

| **Test** | **Approximate Date and where completed** | **Normal** | **Abnormal (please explain)** |
|---|---|---|---|
| Colonscopy | | | |
| Upper Endoscopy | | | |
| Women: | | | |
| • Mammogram | | | |
| • Pap smear | | | |
| Men: | | | |
| • PSA (prostate lab) | | | |

## FAMILY HISTORY (please provide any medical information for your immediate family)

| Relative | Age (or Age Deceased) | Medical problems (ex: high blood pressure, high cholesterol, diabetes, mental illness, thyroid disease, cancer, stroke, COPD, sleep apnea, obesity, medullary thyroid cancer. multiple endocrine neoplasia, pancreatic cancer, osteoporosis) |
|---|---|---|
| Mother | | |
| Father | | |
| Brothers | | |
| Sisters | | |
| Children | | |
| Grandparents | | |

## SLEEP HISTORY

Have you ever done a sleep study? ☐Yes ☐No
Have you been diagnosed with sleep apnea? ☐Yes ☐No
If you have been diagnosed with sleep apnea, do you use a C-PAP, Bi-PAP or V-PAP? ☐Yes ☐No
Do you snore loudly (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)? ☐Yes ☐No
Do you often feel tired, fatigued or sleepy during the daytime (such as falling asleep while driving)? ☐Yes ☐No
Has anyone observed you stop breathing or choking/gasping during your sleep? ☐Yes ☐No
For males, is your shirt collar 17 inches/43 cm or larger? ☐Yes ☐No
For females, is your shirt collar 16 inches/41 cm or larger? ☐Yes ☐No
What time do you usually wake up (range of times, different on week or non work days?) _____
What time do you go to sleep? _____

## EPWORTH SLEEPINESS SCALE

For the situation below, please rate your level of sleepiness according to the following scale:
0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

*Example: if you are sitting and reading and you feel you have a high chance of dozing, enter a 3 in the blank to the right*

| SITUATION | CHANCE OF DOZING |
|---|---|
| Sitting and reading | |
| Watching television | |
| Sitting inactive in a public place (at 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 | |
| TOTAL: | |

## SOCIAL HISTORY

Relationship Status: ☐Single ☐Dating ☐Married ☐Widowed ☐Divorced ☐Other

Live with: ☐Alone ☐Partner ☐Spouse ☐Children ☐Other

If you have kids, what are their ages?

_____

Are you employed? ☐Yes ☐No If yes, what is your occupation? _____

Is your job physically active for the majority of the day? ☐Yes ☐No

What is your work schedule? _____

What are your current life stressors? _____

Do you have a social support system (such as family/friends)? ☐Yes ☐No

Please describe: _____

Are you disabled? ☐Yes ☐No

If yes, date of onset of disability (approx.) _____

If yes, please share the reason of your disability _____

**Highest level of education:**

☐12th grade or less ☐Graduated high school/GED ☐Some college/post high school training

☐ Associate's degree ☐Bachelor's degree ☐Master's degree ☐Doctoral degree

How many hours per day do you use a computer or watch TV (combined work and home hours)? _____

Do you currently smoke cigarettes, cigars, use smokeless tobacco, or vape?? ☐Yes ☐No

If you used tobacco in the past, when did you quit? _____

Do you drink alcohol (any type)? ☐Yes ☐No

If yes, how many drinks per day? _____

Do you have a history of alcohol abuse or treatment for alcohol abuse? ☐Yes ☐No

Do you currently, or have you ever, used drugs that were not prescribed or available over the counter?

☐Yes ☐No

If yes, what drugs have you used? _____

If yes, are you currently using? How often? _____

If not currently using, when did you stop? _____

## REVIEW OF SYSTEMS

Please indicate with a check mark if you currently have or have experienced any of the following in the last six months:

| Symptom | Yes | No | Frequency of symptom/other comments |
|---|---|---|---|
| Fatigue? | ☐ | ☐ | |
| Dizziness? | ☐ | ☐ | |
| Fevers? | ☐ | ☐ | |
| Unintentional weight loss? | ☐ | ☐ | |
| Loss of consciousness/passing out? | ☐ | ☐ | |
| Chest pain? | ☐ | ☐ | |
| Heart palpitations? | ☐ | ☐ | |
| Swelling of feet/legs? | ☐ | ☐ | |
| Difficulty breathing? | ☐ | ☐ | |
| Cough? | ☐ | ☐ | |
| Reflux? | ☐ | ☐ | |
| Difficulty swallowing? | ☐ | ☐ | |
| Nausea (daily, weekly, or occasional)? | ☐ | ☐ | |
| Abdominal pain (daily, weekly, or occasional)? | ☐ | ☐ | |
| Constipation (daily, weekly, or occasional)? | ☐ | ☐ | |
| Diarrhea (daily, weekly, or occasional)? | ☐ | ☐ | |
| Rectal bleeding? | ☐ | ☐ | |
| Hernias? | ☐ | ☐ | |
| Back pain? | ☐ | ☐ | |
| Other joint pain? | ☐ | ☐ | |
| Muscle pain? | ☐ | ☐ | |
| Acne? | ☐ | ☐ | |
| Rashes/infections in skin folds? | ☐ | ☐ | |
| Frequent infections? | ☐ | ☐ | |
| New acne? | ☐ | ☐ | |
| Nail changes? | ☐ | ☐ | |
| Easy bruising? | ☐ | ☐ | |
| Abnormal bleeding? | ☐ | ☐ | |

| Symptom | Yes | No | Frequency of symptom/other comments |
|---|---|---|---|
| Hot flashes/flushes? | ☐ | ☐ | |
| Cold intolerance? | ☐ | ☐ | |
| Persistent facial redness? | ☐ | ☐ | |
| Change in ring or shoe size? | ☐ | ☐ | |
| Purple stretch marks? | ☐ | ☐ | |
| New stretch marks? | ☐ | ☐ | |
| New dark hair growth? | ☐ | ☐ | |
| New scalp hair loss? | ☐ | ☐ | |
| Feeling extra thirsty? | ☐ | ☐ | |
| Urinating large amounts? | ☐ | ☐ | |
| Muscle weakness? | ☐ | ☐ | |
| Migraines/other headaches (daily, weekly, or occasional)? | ☐ | ☐ | |
| Sudden vision changes? | ☐ | ☐ | |
| Memory difficulty? | ☐ | ☐ | |
| Speech difficulty? | ☐ | ☐ | |
| Seizures? | ☐ | ☐ | |
| Numbness? | ☐ | ☐ | |
| Tingling? | ☐ | ☐ | |

## NUTRITION AND EXERCISE

Answer the following questions about what is "typical" for you over the last several months.

How many meals do you eat in a typical day? _____

What times of day? _____

How many snacks do you eat in a typical day? _____

What times of day? _____

What foods do you usually eat for:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Do you have any specific dietary restrictions or preferences? ☐Yes ☐No

If yes, what are they? _____

What are your favorite sources of protein? _____
What are your favorite vegetables? _____
Who does the grocery shopping? _____
Who does the food preparation? _____
Do you ever worry about having enough money to buy food for you and your family? ☐Yes ☐No

Do you drink any of the following beverages? If so, how many cans, glasses or bottles per day?

| | | | | | |
|---|---|---|---|---|---|
| Regular soda | _____ | Diet soda | _____ | Coffee: | _____ |
| Milk: | _____ | Tea: | _____ | Juice: | _____ |
| Sports drink: | _____ | Energy drink: | _____ | Alcohol: | _____ |
| Water: | _____ | Other: | _____ | | |

How many meals per week do you eat out? (either fast food or restaurant) _____

Where are some typical places you eat out? _____

Do you eat after your evening meal? ☐Yes ☐No
If yes, what do you eat? _____

Do you ever eat in the middle of the night? ☐Yes ☐No
If yes, what do you eat? _____

Are you an emotional eater? Do you feel you eat more if you are sad, stressed, anxious, upset, bored, tired, or happy? If yes, which emotions and how often does this occur? _____
_____

In a 2 hour period of time, do you eat an amount of food that is definitely larger than most people would in a similar situation and time frame? ☐Yes ☐No
If yes:
Do you feel a sense of a lack of control over eating during that time? ☐Yes ☐No
How often does this occur? (for example once per week, once per month, etc) _____

During episodes:
-do you eat much faster than normal, normal pace, or slower than usual (circle one)
-do you eat until feeling uncomfortably full? _____
-do you feel hungry at the start of the episode? _____
-are you eating alone or with other people? _____
-do you feel a strong sense of guilt or depression after an episode? _____

**Exercise:**
Are you able to walk without assistance of a cane, walker, or other assistive device? ☐Yes ☐No

How far are you able to walk? _____

Do you exercise or get other physical activity? ☐ Yes ☐No
If yes, what do you do? _____
What days of the week? _____
What time of day? _____
How long? _____

What are some of the things that make it difficult to exercise? _____

What are some ways that you could overcome those things that make it more difficult to exercise?
_____

Do you have a usable body weight scale at home? _____

Do you have a usable blood pressure cuff at home? _____

**What is your race?**

☐Native Hawaiian and Pacific Islander ☐Asian ☐American Indian or Alaska Native

☐Black or African American ☐White ☐Other race

Are you of Hispanic or Latino origin? ☐Yes ☐No

## REQUIRED AGREEMENT FOR INDIVIDUALS INTERESTED IN SURGERY

We require all surgical patients to stop smoking, vaping, chewing tobacco, and use of all illegal drugs prior to their weight loss surgery. Individuals have a risk of serious complications during and after surgery if they continue with use of any of these. We ask you commit to understanding and agreeing to stop all forms of activities prior to your name being submitted for approval for surgery to your insurance company.

Your Bariatric provider will work with you during the process.

Your signature below indicates you understand this requirement as part of your surgical process. An e-signature is accepted if submitting the form electronically by typing your name in the appropriate spot.

Signature: _____

Date: _____