Boone Hospital Center BARIATRIC PROGRAM

Welcome!

Dear Prospective Patient:

Thank you for considering Boone Weight Loss Surgery to help you take control of obesity and your life. For people suffering from severe obesity and related health conditions, weight-loss surgery may be the solution you have been searching for. Studies demonstrate that weight-loss surgery, as compared to non-surgical treatments, yields the longest period of sustained weight loss in patients who have failed other therapies.

For the best results, patients need to actively participate in a multi-disciplinary weight-loss program, which includes nutritional, emotional, and exercise counseling. Our highly trained team is committed to providing the highest level of patient care every step of the way.

Please send back to by either of the following methods:

- **Fax**: 573-815-3816 Attn Bariatrics
- **Email**: Austin.Brawley@boone.health
- **Snail Mail**: 1701 E Broadway
  Plaza 3 Ste 204 BOX #3
  Columbia, MO 65201

You may reach us at the following Phone Number:
573.815.6447

BHC Bariatric Program
Important Insurance Information

Please fill out completely.

*Patient's Name:_____ *Date of Birth_____

*Subscriber Name:_____ *Date of Birth_____

*Insurance Company:_____ *Phone No:_____

*Policy No._____ *Group No._____

Name of person you spoke to_____ Today's Date_____

Please provide a copy of the front and back of your insurance card with this from. We will contact your insurance company to verify Bariatric Surgery Benefits and call you to review your benefits with you once we have completed the verification.

Boone Hospital Center
BHC Bariatric Program Registration Form

Date _____

Seminar Attended: Date: _____ Location: _____

_____
Last name **First name** **Middle Initial** **Date of birth** Age

Address: _____City: _____ State/Zip: _____

Sex: ☐ M / ☐ F / ☐ Non-Binary Social Security # _____ Hispanic Ethnicity ☐ Yes or ☐ No

Race: ☐ White / ☐ Black / ☐ American Indian or Alaska Native / ☐ Native Hawaiian or Other Pacific Islander / ☐ Asian / Other: _____

Religion: _____ Email Address:_____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____

Which is the best number to reach you during the day? _____ May we call you at work? ☐ Yes ☐ No

Emergency Contact Name: _____ Relationship: _____

Address/phone number: _____

I have had a previous weight loss procedure ☐ No ☐ Yes Which Procedure_____ Date_____

Interested Procedure: ☐ Band ☐ Bypass ☐ Sleeve ☐ Balloon ☐ Undecided Surgeon: _____

Please fill out as accurately as possible:

Height: _____ Current Weight: _____ lbs. BMI: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Partnered
For how long? _____

Highest Education Level: ☐ Grade School ☐ High School/GED ☐ Vocational Tech ☐ College ☐ Post-Graduate

Are you currently employed? ☐ No ☐ Yes, occupation: _____

☐ Full-time ☐ Part-time ☐ Volunteer

How long have you been employed? _____ Years, _____ months

Employer Name: _____

Employer Phone Number: _____

What level of activity does your job involve?
☐ Little (sedentary)
☐ Moderately active
☐ Very active (laboring, etc.)

How did you hear about our program?
☐ Doctor (who) _____ ☐ TV
☐ Radio (what one) _____ ☐ Word of mouth
☐ Newspaper (which one) _____
☐ Internet (which site) _____
☐ Other (please specify) _____

Boone Hospital Center
Patient Information and Nutrition Questionnaire **Patient Name:** _____

Primary Health Care Physician - please provide information about your primary doctor below:

Name Phone Number

Address City State Zip

How long has s/he provided medical care for you? _____

ARE you under the care of additional practitioners? Please provide details.

- Cardiologist ☐ No ☐ Yes _____
- Orthopedist ☐ No ☐ Yes _____
- Psychologist ☐ No ☐ Yes _____
- Other ☐ No ☐ Yes _____

Referring Physician – please provide information about the doctor who referred you**, if different** than your primary doctor

Name Phone Number

Address City State Zip

Preferred Pharmacy _____ **Location:** _____

Please list three things you hope to accomplish and how your life will change by having surgery:

1. _____
2. _____
3. _____

Boone Hospital Center
Patient Information and Nutrition Questionnaire **Patient Name:** _____

Dieting and Weight History

How long have you been at your current weight? _____

Highest weight and at what age? _____ Desired Goal Weight _____

Onset of Weight Problem? _____

Highest weight in the past year and date_____ Date _____

Please indicate your weight at the following times. Indicate if you consider your weight below average, average, above average, or very heavy in the boxes below.

	Below Average	Average Weight	Above Average	Very Heavy
Birth Weight	☐	☐	☐	☐
Weight at starting school (5-6 years)	☐	☐	☐	☐
Weight at beginning of high school (10-12 years)	☐	☐	☐	☐
Weight at end of high school (15-18 years)	☐	☐	☐	☐
Weight at age 21	☐	☐	☐	☐

Weight at **age 30**_____ lbs**. age 40**_____lbs **age 50**_____lbs **age 60**_____lbs

Was there a particular event that lead to a significant weight gain? _____

_____

What is the largest amount of weight you have lost on any one diet/medication?_____

Has a physician ever supervised your attempts to lose weight? ☐ No ☐ Yes

If yes, please list:

Doctor / Clinic	City	Treatment Dates	Type of Treatment

What would you say are the biggest problems with how you eat?_____

_____

How many meals do you eat daily? _____

How many snacks daily?_____

What are you favorite snacks? _____

Do you ever skip meals? ☐ No ☐ Yes If Yes, which meals?_____

Boone Hospital Center
Patient Information and Nutrition Questionnaire **Patient Name:** _____

Dieting and Weight History (Continued)

Eating Habits (Please Check All That Apply)

☐Scheduled regular meals	☐No set schedule/grazer	☐"Meat and Potatoes" Type
☐Sweet Eater	☐Binge eater/compulsive eater	☐Junk Food Eater
☐Large / Multiple Portions	☐Fast Food Eater	☐Emotional Eater
☐Night Eater	☐Snacker	☐Rapid Eater (meal in less than 10 min)
Do you plan meals in advance? ☐ Yes ☐ No		
Do you have food cravings? ☐Yes ☐ No If yes, what foods?		
Check all that apply: Do you eat while: ☐ watching T.V. ☐ on the computer ☐ in bed ☐ in car		

Food Frequency Check:

Please indicate **how many times a week** you consume the following foods/beverages:

Sweets:	Ice Cream:	Cheese/Yogurt:
Added fats: (i.e. butter, salad dressing, oil, mayonnaise)	Bread, Rice, Pasta:	Fried and High Fat Foods:
Fast food / Takeout :	Sit Down Restaurants:	Frozen Meals:
Meat/ Meat alternatives:	Fruit:	Vegetables:
Milk:	Water:	Sweet Tea:
Coffee:	Regular Soda:	Diet Soda:
Juice:	Alcohol: What type?:	

Historically, have you ever used any of the following to control your weight? ☐ Yes ☐ No If Yes, please check all that apply:

☐Binge eating and purging ☐ Binge eating followed by restriction ☐ Vomiting

☐Laxatives ☐ Diuretics

Who prepares your meals? _____

Who does the grocery shopping?_____

Do you like to cook? ☐Yes ☐No

Do you feel as if you frequently need to "eat on the run"? ☐Yes ☐No

Do you get up at night to eat? ☐ Yes ☐No If yes, what do you eat when you get up?_____

_____

If you use eating as an emotional outlet, what will you substitute when your eating is restricted?_____

_____

Boone Hospital Center
Patient Information and Nutrition Questionnaire **Patient Name:** _____

Food History
Record the amount of all food and beverages consumed/eaten over the last two days:

Meal	Day One		Day Two	
	Food Eaten	Amount	Food Eaten	Amount
Breakfast				
Snack				
Lunch				
Snack				
Dinner				
Snack				

Boone Hospital Center
Patient Information and Nutrition Questionnaire **Patient Name:** _____

Exercise History

How physically active are you? ☐ Very Active ☐ Active ☐ Average ☐ Inactive ☐ Very Inactive

What do you do for physical activity and how often do you do it?

Activity	Number of Times/Week	How Long
Walking		
Bicycling		
Swimming		
Water exercises		
Golf (circle if walking or cart)		
Tennis		
Aerobics		
Weight training		
Wii Fit		
Other:		
I am currently not exercising ☐		

How long have you been engaged in your current exercise regimen?_____

Is there anything that prevents you from being physically active?_____

_____

How do you feel when exercising? Rate from 1 (Awful) to 10 (Excellent) _____

How committed are you to incorporating exercise into your lifestyle?

Rate from 1 (not committed) to 10 (it will happen without a doubt) _____

Support System

What are the attitudes of the following people about your attempt(s) to lose weight?

	Negative	Indifferent	Positive
Spouse / Significant Other			
Children			
Parents			
Co-Workers			
Friends			

Do these attitudes affect your weight loss or gain? ☐ Yes ☐ No

If yes, please describe:_____

I have completed the entire information profile and medical questionnaire myself. I have accurately reported to the best of my knowledge, information pertaining to my previous and present medical health status. I understand my failure to report, or falsifying information could result in complications during or after my procedure.

Signature: _____ Date: _____

Boone Hospital Center
Patient Information and Nutrition Questionnaire **Patient Name:** _____

Do you now or have you recently had any problems related to the following systems? Circle YES or NO. If you mark yes to any of the following, please indicate which doctor is treating you for that problem. If you haven't seen a physician yet, please contact your Internist or Family Physician to address those issues.

Constitutional Symptoms:

Fever	☐	☐
Chills	☐	☐
Headache	☐	☐
Weight Loss	☐	☐
Weight Gain	☐	☐
Night Sweats	☐	☐

Other: _____

Respiratory:

Wheezing	☐	☐
Frequent cough	☐	☐
Chronic Cough	☐	☐
Shortness of breath	☐	☐

Other: _____

Cardiovascular:

Chest pain	☐	☐
Palpitations/Murmur	☐	☐
Leg swelling	☐	☐
Irregular Heartbeat	☐	☐

Other: _____

Gastrointestinal:

Abdominal pain	☐	☐
Nausea/Vomiting	☐	☐
Indigestion/Heartburn	☐	☐
Ulcer	☐	☐
Intolerance to Greasy Food	☐	☐
Blood in Stool	☐	☐
Colon/Rectal Polyps	☐	☐
Pain with Bowel Movement	☐	☐
Jaundice	☐	☐
Difficulty swallowing	☐	☐

Genitourinary:

Urine retention	☐	☐
Painful urination	☐	☐
Urinary frequency	☐	☐
Difficulty Urinating	☐	☐
PSA (prostate blood test)	☐	☐

Date_____ ☐ Normal ☐ Abnormal

Musculoskeletal:

Joint Pain	☐	☐
Neck Pain	☐	☐
Back Pain	☐	☐

Other: _____

Neurological:

Seizures	☐	☐
Tremors	☐	☐
Dizzy Spells	☐	☐
Numbness/Tingling	☐	☐

Other: _____

Psychological:

Do you suffer from depression?	☐	☐
Do you feel severely anxious or nervous?	☐	☐
Recent psychiatric treatment	☐	☐
Recent substance abuse	☐	☐
History of eating disorder	☐	☐

Other: _____

Endocrine:

Excessive Thirst	☐	☐
Too hot/cold	☐	☐
Tired/Sluggish	☐	☐

Other: _____

Hematological/Lymphatic:

Swollen glands	☐	☐
Blood clotting problem	☐	☐

Other: _____

Patient Name_____

HISTORY OF PRESENTING ILLNESS:

Height: _____Weight: _____ BMI:_____ Age: _____
Date of Birth: _____

HEALTH HISTORY:

Please list all surgeries:

	SURGERY	DATE	COMPLICATIONS
☐	Hernia		
☐	Gall Bladder		
☐	Appendectomy		
☐	Hysterectomy		
☐	Orthopedic Surgery		
☐	Previous Weight Loss Surgery		
☐	Other		
☐	Other		
☐	Other		

Please list all Hospitalizations:

HOSPITALIZATIONS	DATE	REASON

Patient Name: _____

Please Circle "Y" or "N" for any medical conditions YOU suffer from:

Anemia	☐	☐	Frequent Headache/Migraine	☐	☐	PCOS	☐	☐
Arthritis	☐	☐	Gall Bladder	☐	☐	Polio	☐	☐
Asthma	☐	☐	Heart Attack	☐	☐	PVD (peripheral vascular disease	☐	☐
Bladder/Prostate Problems	☐	☐	Heart Catheterizations	☐	☐	Rheumatic Fever	☐	☐
Blood Clots	☐	☐	Heart Problems	☐	☐	Sleep Apnea	☐	☐
Blood Transfusion	☐	☐	Hepatitis	☐	☐	C-PAP	☐	☐
Cancer - Breast	☐	☐	Hiatal Hernia/Reflux	☐	☐	Stress Incontinence	☐	☐
Cancer - Colon	☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐
Cancer- Other: _____	☐	☐	High Cholesterol	☐	☐	Thyroid Disorder	☐	☐
Colon/Rectal Polyps	☐	☐	Kidney Disorder	☐	☐	Tuberculosis	☐	☐
Diabetes	☐	☐	Liver Disease/Jaundice	☐	☐	Ulcers	☐	☐
Emphysema	☐	☐	Multiple Sclerosis	☐	☐	Varicose Veins	☐	☐
Epilepsy/Seizures	☐	☐	Pneumonia	☐	☐	Weakness or Paralysis	☐	☐

Please list any major or chronic illnesses not listed above: ☐ NONE

_____

_____

_____

Patient Name: _____

FAMILY HISTORY

Please Circle "Y" or "N" for any conditions YOUR FAMILY suffers from:

FAMILY MEMBER				FAMILY MEMBER			
Anemia				Heart Problems			
Asthma				Hepatitis			
Blood Clots				High Blood Pressure			
Blood Transfusion				High Cholesterol			
Cancer - Breast				Kidney Disorder			
Cancer - Colon				Liver Disease/Jaundice			
Cancer- Other: _____				Multiple Sclerosis			
Colon/Rectal Polyps				Problems with anesthesia			
Diabetes				PVD (peripheral vascular dis)			
Emphysema				Rheumatic Fever			
Epilepsy/Seizures				Stroke			
Gall Bladder				Thyroid Disorder			
Heart Attack /Surgery or Stents				Tuberculosis			

SOCIAL HISTORY:

Who lives in your home?_____

- Do you smoke? ☐YES ☐NO *How Much?* _____ Per Day *For How Long?* _____
- Have you quit? ☐YES ☐NO *When?* _____
- Do you drink over six cups of caffeinated beverages per day? ☐YES ☐NO
- Do you Drink Alcohol? ☐YES ☐NO
    - ***How much?*** ☐Weekly ☐Daily ☐Monthly ☐Rarely

Have you had a PSA or Prostate Exam? ☐YES ☐NO
If YES When? _____

Have you had a Mammogram? ☐YES ☐NO
If YES When and Where? _____

The above information is completed to the best of my knowledge

_____ _____ (*History for:* _____)
Patient Signature **Date** **(Print Name)**

CURRENT MEDICATION LIST

Last Name, First Name: _____ Date: _____

ALLERGIES	REACTION

PRESCRIPTION/OVER THE COUNTER MEDICATION NAME	DOSAGE	FREQUENCY	ROUTE/TOPICAL SITE
HERBAL MEDICATION NAME	**DOSAGE**	**FREQUENCY**	**ROUTE/TOPICAL SITE**

DIET HISTORY

Patient Name: _____

Has a physician ever supervised your attempts to lose weight: ☐ Yes ☐ No
If yes, please list:

Doctor	City	Treatment Dates	Type of Treatment

How long have you been overweight?_____
What do you think led to your being overweight? _____
What was your most successful diet program? _____
How much weight did you lose with this program? _____
How quickly did you gain weight afterwards? _____
Why do you think you failed the diet program? _____

WEIGHT LOSS HISTORY:

Name of Diet	Date started/stopped	Weight Loss
Dexatrim		
Metabolife		
Phen-Fen		
Meridia		
Herbal Life		
Atkins		
Dietician Supervised Diet		
Physician Supervised Diet		
Low Calorie Diet		
LA Weight Loss		
Optifast/Medifast		
Weight Watchers		
Jenny Craig		
American Diabetes Assoc. Diet		
Nutrisystem		

Patient Name _____ Age _____ Today's Date _____

Have you been diagnosed with sleep apnea ☐YES ☐NO

If NO , please fill out the survey in the next section. If YES, please fill out the questions below.

Do you require a C-PAP or Bi-PAP ☐YES ☐NO

If yes, do you wear a C-PAP or Bi-PAP ☐YES ☐NO

Definition of Obstructive Sleep Apnea (OSA)

- OSA is a serious potentially life-altering beathing disorder that occurs during sleep and may lead to life-threatening conditions
- The upper airway repeatedly collapses , causing cessation of breathing (apnea) or inadequate breathing (hypopnea) and sleep fragmentation
- Sleep fragmentation results in chronic daytime sleepiness

Prevalence

- Patients with impaired cardiac function may suffer from sleep-related breathing disorders
- 4% of men and 2% of women aged 30-60 (an estimated 20 million people) meet minimall diagnostic criteria for OSA with excessive daytime sleepiness. An even greater number of people have subclinical apnea/hypopnea during sleep
- The majority of OSA sufferers remain undiagnosed and untreated

Potential Risks if Left Untreated

- Decreased quality of life
- Hypertension
- Cardiac arrhythmias
- Myocardial Ischemia
- Myocardial Infraction
- Stroke
- Increased risk for motor vehicle and work related accidents due to sleepiness
- OSA patients prior to diagnosis and treatment consume 2 ½ times more health care resources than patients without OSA

If a patient has two or more of the following signs and symptoms, it may be an indication of unidentified obstructive sleep apnea.

Check the following that apply

- ☐ Snoring, interrupted by pauses in breathing (apnea)
- ☐ Excessive daytime sleepiness
- ☐ Gasping or choking during sleep
- ☐ Restless sleep
- ☐ Intellectual deterioration
- ☐ Poor judgement/concentration
- ☐ Irritability
- ☐ Hypertension
- ☐ Nocturnal angina
- ☐ Depression
- ☐ Obesity
- ☐ Large neck/girth (>17" men, >16" women)
- ☐ Oropharyngeal crowding
- ☐ Nocturia or frequent urination at night
- ☐ Morning headaches

Epworth Sleepiness Scale

How likely are you to doze or fall asleep in the following situations, in contrast to just feeling tired?

0= would never doze, 1= slight chance of dozing, 2= moderate chance of dozing, 3= high chance of dozing

Situation	**Chance of Dozing (0-3)**
Sitting and Reading	_____
Watching TV	_____
Sitting, inactive in a public place (theatre or meeting, etc)	_____
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 lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

_____ **TOTAL**