

Please Attend a Free Informational Seminar Before Submitting Packet for Review. A letter with the next available dates for this seminar is included in this packet.

Date received by Coordinator: _____ MRN _____

Name: First _____ MI. _____ Last _____ Date: _____
 Date of Birth: _____ Are you interested in the gastric bypass ____ or the adjustable gastric band ____ or are you uncertain ____?
 Age _____ Height: _____ Weight: _____
 Single: _____ Married: _____ Divorced: _____ Widowed: _____
 Address: _____

Home Phone: _____ Work Phone: _____
 Cell Phone: _____
 Insurance: _____ Medicaid _____ Medicare _____
 Best time to reach you during the day: _____ Where should we call ? _____
 How did you hear about us? Website: _____ Friend: _____ Patient Referral: _____
 Printed Material: _____ Doctor Recommended: _____

What type of research have you done about weight loss surgery?
 Doctor Information: _____ Talked to a Patient: _____ Magazine Article: _____
 Friend: _____ Website: _____ Our website is www1.wfubmc.edu/weightlossurgery

Education: Graduated High School/GED _____ College _____ Post-graduate _____
 Current Occupation: _____
 Employer: _____
 Year at this position: _____

Please circle the appropriate response and answer all questions completely.

- Yes No Do you smoke? If yes, how many cigarettes or packs per day? _____
- Yes No Have you quit smoking? If yes, when? _____
- Yes No Do you have high blood pressure?
- Yes No Do you take medications for arthritis?
- Yes No Do you have joint pain? Circle all that apply: back hips knees ankles feet shoulders neck
- Yes No Do you have diabetes? If yes, are you controlled with diet ____ or pills ____ or insulin? _____
- Yes No If you are a menstruating female, do you have irregular or abnormal menstrual cycles?
- Yes No Do you ever leak urine when you cough, sneeze or laugh?
- Yes No Do you have chronic and / or severe headaches?
- Yes No Have you ever had stomach ulcers ?
- Yes No Do you have gallstones?
- Yes No Have you been diagnosed with (circle all that apply) HIV AIDS Hepatitis B Hepatitis C
- Yes No Do you snore?
- Yes No Do you wake up with a headache?
- Yes No Have you ever fallen asleep while driving?
- Yes No Do you have to take a nap every day?
- Yes No Do you feel rested when you wake up in the morning?
- Yes No Do you ever wake from a deep sleep choking, coughing or gasping for breath?
- Yes No Has anyone ever told you that you stop breathing while you are sleeping?

Family History (Circle all that apply):

Obesity Diabetes Hypertension Heart Disease
 High cholesterol Arthritis Cancer Depression

Please list all diet programs you have done *in the past 5 years*.

DIET Program	Year	For How Long	Total Weight Loss	Pounds Regained
Worked with Dietitian				
Physician-Supervised				
Phen-Fen (Redux)				
Xenical				
Meridia				
Richard Simmons				
Weight Loss Forever				
Nutra System				
Jenny Craig				
Overeaters Anonymous				
Herbal Life/ Metabolife				
Diet Center				
Weight Watchers				
LA Weight Loss				
Optifast/Medifast				
Atkins				
Slimfast				
Hypnosis				
Others:				
Exercise Equipment				
Treadmill				
Weights				
Others				

What is your highest adult weight? _____ When? _____

Weight for last five years: 2008 _____
 (required information) 2007 _____
 2006 _____
 2005 _____
 2004 _____
 2003 _____

Please circle your eating habits:

Skip meals Eat out Salty craving
 Sweet craving Binge Snack
 Eat late at night Watch my calorie and "fat" intake
 Read food labels

Complete the following food diary as honestly as possible. Include one weekday and one weekend day, food, amount consumed, and how the food was prepared. Include snacks and beverages (with amounts consumed): THIS IS REQUIRED INFORMATION

Day 1 (weekday)	Day 2 (weekend)

Habits

Do you smoke? Yes No Quit _____ months/ years ago
Average daily tobacco habit: _____ packs/day for _____ years.

Do you drink alcoholic beverages? Yes No Quit _____ years ago

Beers per day: 1-2 3 or more

Liquor or wine per day 1-2 3 or more

Do you use recreational drugs like marijuana? Yes No Quit _____

Which drug(s)? _____

Do you have, or have you had, a problem with drugs or alcohol? Yes No

Please explain _____

Below is a list of problems and complaints people sometimes have. After you read the list, use the scale below to describe how much the problem has bothered you during the past 2 weeks, including today.

Not at all a little bit moderately quite a bit extremely
0 1 2 3 4

- ___ 1. Nervousness or shakiness inside
- ___ 2. Unwanted thoughts, words, or ideas that won't leave your mind
- ___ 3. The idea that someone else can control your thoughts
- ___ 4. Feeling others are to blame for most of your troubles
- ___ 5. Trouble remembering things
- ___ 6. Feeling easily annoyed or irritated
- ___ 7. Feeling afraid in open spaces or on the street
- ___ 8. Thoughts of ending your life
- ___ 9. Hearing voices that other people do not hear
- ___ 10. Feeling that most people cannot be trusted
- ___ 11. Crying easily
- ___ 12. Feeling of being trapped or caught
- ___ 13. Suddenly scared for no reason
- ___ 14. Temper outbursts that you could not control
- ___ 15. Feeling afraid to go out of your house alone
- ___ 16. Feeling blue
- ___ 17. Worrying too much about things
- ___ 18. Feeling fearful
- ___ 19. Other people being aware of your private thoughts
- ___ 20. Feeling afraid to travel on buses, trains, or airplanes
- ___ 21. Having to avoid certain things, places or activities because they frighten you
- ___ 22. Your mind going blank
- ___ 23. Feeling hopeless about the future
- ___ 24. Trouble concentrating
- ___ 25. Having thoughts that are not your own
- ___ 26. Having urges to beat, injure, or harm someone
- ___ 27. Having urges to break or smash things
- ___ 28. Having ideas or beliefs that others do not share
- ___ 29. Spells of terror or panic
- ___ 30. Getting into frequent arguments
- ___ 31. Feeling nervous when you are left alone
- ___ 32. Feeling so restless you couldn't sit still
- ___ 33. Feelings of worthlessness
- ___ 34. Feeling that familiar things are strange or unreal
- ___ 35. Shouting or throwing things
- ___ 36. The idea that you should be punished for your sins
- ___ 37. The idea that something is wrong with your mind