BAPTIST HEALTH
LEXINGTON

Patient Information Packet

Preferred Procedure:
- ❍ Laparoscopic Sleeve Gastrectomy
- ❍ Laparoscopic Greater Curvature Plication (LGCP)
- ❍ Laparoscopic Roux-en-Y Gastric Bypass

Please Choose a Surgeon:
- ❍ G. Derek Weiss, MD
- ❍ Paige Quintero, MD
- ❍ Undecided

Revision-Previous Weight Loss Surgery

Original Surgery:___________________________

Date of Surgery:______________________________

Surgeon: ____________________________________

Revision to
- ❍ Laparoscopic Sleeve Gastrectomy
- ❍ SIPS

Are you able to read, write and communicate in the English Language? ❍ YES ❍ NO

If not, what is your primary language?____

Please list any other barriers to communication, or special accommodations that you require:______________________

Patient Information:

First Name:______________________ Middle Name:______________________ Last Name:______________________

Social Security Number:________________ Date of Birth:____________ Age:_______ Gender: ❍ Female ❍ Male

Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Partnered ❍ Widow(er)

How many children do you have (please list ages)?_______________________________________

Ethnicity: ❍ African American ❍ Hispanic ❍ Native American or Alaska Native ❍ Choose not to specify
❍ Asian ❍ Caucasian ❍ Native Hawaiian / Other Pacific Islander ❍ Other:___________

Religious affiliation:________________________________Patient's level of Education:______________________

What is your height?_______ft ______in How much do you weigh?__________lbs. BMI:___________

Address Information:

Street Address:____

City:___________________________________ State:________________________ Zip Code:____________________

E-mail:____ Phone (home):______________________

Phone (work):____ Phone (cell):________________________

OK to leave message at: ❍ Home ❍ Work ❍ Cell

Patient Employment Information:

Employment status: ❍ Full Time ❍ Retired ❍ Disabled ❍ Student
❍ Part Time ❍ Unemployed ❍ Homemaker ❍ Leave of Absence

Patient's Current Employer:____ Years Employed:___________

Patient's Employer's address:____

Patient's Present or Former Occupation:____

Disabled? ❍ Yes ❍ No If Yes, specify the year and cause: Year:_______ Cause:____________________

Can you walk unassisted? ❍ Yes ❍ No How far before needing rest?______________________(Approximate # of feet)

If you need assistance walking, what device(s) do you use? ❍ Cane ❍ Walker ❍ Crutches ❍ Other:____________

Are you wheelchair bound and unable to stand at all? ❍ Yes ❍ No How long in wheelchair?______________(Month/year)

Do you have a Medical Surrogate, Power of Attorney or anyone who makes your medical decisions?

❍ **YES** ❍ **NO** If yes, who?________________________Relationship to you?__________

Spouse Information:

Spouse's Name:________________________ Spouse's Date of Birth:__________

Spouse's Employment Status: ❍ **Full Time** ❍ **Retired** ❍ **Disabled** ❍ **Student**
❍ **Part Time** ❍ **Unemployed** ❍ **Homemaker** ❍ **Leave of Absence**

Spouse's Occupation:__________________ Spouse's SSN:__________________

Spouse's Employer:________________________ Years Employed:__________

Spouse's Employer's address:__________________ Spouse's Cell Phone:__________________

Insurance Information: – (This section must be filled out in addition to sending in a copy of your insurance card)

Payment Type: ❍ Insurance ❍ Self Pay

Primary Insurance:

Insurance Company:____

Policy Number:________________________ Group #:__________________

Subscriber Name:________________________ Subscriber Date of Birth:__________

Customer Service Phone:________________________ Provider Phone:__________________

Secondary Insurance:

Insurance Company:____

Policy Number:________________________ Group #:__________________

Subscriber Name:________________________ Subscriber Date of Birth:__________

Customer Service Phone:________________________ Provider Phone:__________________

Emergency Contact:

First Name:________________________ Last Name:__________________

Relation to you:________________________ Phone:__________________

"I hereby authorize BHMG – Bariatric Surgery to discuss my process, diagnostic test results and any scheduled appointments with the following named person(s)":

Name:________________________ Relation to you:__________________

Name:________________________ Relation to you:__________________

Patient Signature:________________________ Date:__________________

Primary Care Physician:

First Name:__________________ Last Name:________________________

Street Address:____

City:__________________ State:________ Zip Code:__________ Phone:__________________

Have you discussed Weight Loss Surgery with your physician? ❍ Yes ❍ No is your physician supportive? ❍ Yes ❍ No

How did you hear about us? ☐ Radio ☐ TV ☐ Newspaper ☐ Family/Friend ☐ Internet ☐ Social Media
☐ Other (Please List):__________________

Medical History/Review of Symptoms: **(Check all that apply)**

General: ☐ **NONE**

☐ Fevers	☐ Weight Gain	☐ Tired / No Energy
☐ Night Sweats	☐ Insomnia	☐ Hair Loss
☐ Appetite Change	☐ Other:______	

Head and Neck: ☐ **NONE**

☐ Wear contacts / glasses	☐ Vision Problems	☐ Hearing Problems
☐ Sinus Drainage	☐ Nose Bleeds	☐ Hoarseness
☐ Dentures, Partial / Full	☐ Allergies	☐ Glaucoma
☐ Regular Ear Infections	☐ Blurred / Double Vision	☐ Other:______

Cardiovascular: ☐ **NONE**

☐ Heart Attack	☐ Chest Pain w/ Activity	☐ Rhythm Changes
☐ Congestive Heart Failure	☐ High Blood Pressure	☐ Palpitations
☐ Varicose Veins	☐ Dyspnea on Exertion	☐ Ankle Swelling
☐ Ankle / Leg Ulcers	☐ Elevated Triglycerides	☐ Phlebitis / DVT
☐ Clogged Heart Arteries	☐ Rheumatic Fever / Valve Damage / MVP	☐ Rapid Heart Beat
☐ Irregular Heart Beat	☐ Cramping in legs when walking	☐ Heart Murmur
☐ Atrial Fibrillation	☐ Elevated Cholesterol	☐ Other:______

Respiratory: ☐ **NONE**

☐ Asthma	☐ Emphysema / COPD	☐ Bronchitis
☐ Pneumonia	☐ Chronic Cough	☐ Shortness of Breath at Rest
☐ Use of Cpap / Bipap	☐ Use of Oxygen	☐ Snoring
☐ Pulmonary Embolism	☐ Sleep Apnea	☐ Other:______

Endocrine: ☐ **NONE**

☐ Parathyroid	☐ Hypothyroid	☐ Goiter
☐ Low Blood Sugar	☐ Excessive Thirst	☐ Endocrine Gland Tumor
☐ "Pre-Diabetes"	☐ Diabetes (Diet or Pills)	☐ Diabetes (Insulin Shots)
☐ Abnormal Facial Hair	☐ Excessive Urination	☐ Gout
☐ Other:______		

Gastrointestinal: ☐ **NONE**

☐ Heartburn	☐ Hiatal Hernia	☐ Ulcers
☐ Diarrhea	☐ Blood in Stool	☐ History of Liver Enzymes
☐ Constipation	☐ IBS	☐ Umbilical Hernia
☐ Difficulty Swallowing	☐ Hemorrhoids	☐ Fissure / Polyps
☐ Rectal Bleeding	☐ Black, Tarry Stool	☐ Ventral Hernia
☐ Abdominal Pain	☐ Enlarged Liver	☐ Cirrhosis / Hepatitis
☐ Gallbladder Problems	☐ Jaundice	☐ Pancreatic Disease
☐ Nausea / Vomiting	☐ GERD	☐ Incisional Hernia
☐ Barrett's Esophagus	☐ Other:______	

Bladder/Kidney:	☐ **NONE**	
☐ Kidney Stones	☐ Blood in Urine	☐ Prostate Problems
☐ Kidney Failure / Renal Insufficiency	☐ Leaking urine w/ cough/laugh/sneezing	☐ Men: PSA test in last year?
☐ Trouble starting urine	☐ Burning / Pain on urination	☐ Urinary Urgency/Frequency
☐ Overall Loss of Bladder Control	☐ Other:________________	

Gynecologic: (for women only)	☐ **NONE**	
☐ Problems Conceiving / Infertility	☐ Currently Pregnant	☐ Uterine / Ovarian Cancer
☐ PCOS	☐ Menstrual Irregularity	☐ Menstrual Pain
☐ Excessively Heavy Periods	☐ Plan to have more children	☐ Post Menopausal

Breast:	☐ **NONE**	☐ Cancer
☐ Pain	☐ Lumps / Fibrocystic Disease	☐ Other:________________

Musculoskeletal:	☐ **NONE**	
☐ Shoulder Pain	☐ Neck Pain	☐ Elbow Pain
☐ Hip Pain	☐ Wrist Pain	☐ Back Pain
☐ Foot Pain	☐ Knee Pain	☐ Ankle Pain
☐ Plantar Fasciitis	☐ Heel Pain	☐ Ball of Foot Pain
☐ Broken Bones	☐ Carpal Tunnel Syndrome	☐ Lupus
☐ Muscle Pain / Spasm	☐ Sciatica	☐ Rheumatoid Arthritis
☐ Fibromyalgia	☐ Other:________________	

Neurologic:	☐ **NONE**	
☐ Balance Disturbance	☐ Dizziness	☐ Restless Leg Syndrome
☐ Stroke	☐ Seizures or convulsions	☐ Weakness
☐ Knocked Unconscious	☐ Numbness / Tingling	☐ Multiple Sclerosis
☐ Pseudotumor Cerebri (loss of vision from high pressure in brain)		☐ Other:________________

Psychiatric: ☐ **NONE** **Are you currently under the care of a mental health provider? ☐ Yes ☐ No**

☐ Depression	☐ Anxiety
☐ Bipolar Disorder ("manic-depression")	☐ Seen a Psychiatrist or Counselor
☐ Alcoholism / Substance Abuse	☐ Been hospitalized for psychiatric problems
☐ Been in a chemical dependency program	☐ Attempted suicide
☐ Currently taking medications for psychiatric problems or for depression	☐ Victim of Mental/Emotional/Sexual/Physical Abuse
☐ Attention Deficit Disorder	☐ Other:________________

Blood/Lymphatic:	☐ **NONE**	
☐ Low Platelets (thrombocytopenia)	☐ Anemia	☐ HIV / AIDS
☐ Bruise Easily	☐ Lymphoma	☐ Swollen Lymph Nodes
☐ Bleeding/Clotting Disorder	☐ Blood thinning medicine use	☐ History of DVT / PE
☐ Prior blood Transfusion	☐ Other:________________	

Skin:	☐ **NONE**	
☐ Frequent Skin Infections	☐ Keloids (Excessively Raised Scars)	☐ Poor Wound Healing
☐ Psoriasis	☐ Rashes under Breasts / Skin Folds	☐ Rosacea
☐ Hair or Nail Changes	☐ Other:________________	

Family Medical History: (Check all that apply)

Disease	Mother	Father	Siblings (specify brother or sister)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Morbid Obesity							
Diabetes- Age Occurred							
High Blood Pressure							
Stroke- Age Occurred							
Heart Attack- Age Occurred							
Cardiovascular Disease							
Sleep Apnea							
Cancer: Type & Age Occurred							
Death- Age & Cause							
If Still Living, what age							

Social History:

Do you smoke now? ❍ Yes ❍ No If yes, how many packs per day?______________

Have you smoked in the past? ❍ Yes ❍ No If you have quit, how many years since?_______

For how many years did you use tobacco? ___________Years

Do you use snuff or chew? ❍ Yes ❍ No If yes, how frequently do you use?____________

Do you consume alcohol now? ❍ Yes ❍ No

If yes, how many times per week? ___________ If yes, how many drinks each time?___________

For how many years do/did you drink alcohol? ___________Years

Is anyone concerned about the amount you drink? ❍ Yes ❍ No If you have quit, how many years since?_______

Do you use street drugs now? ❍ Yes ❍ No If yes, what drugs?_________________________

If yes, how frequently do you use these drugs? ___________ If you have quit, how many years since?_______

Blood Consent:

*****You must be willing to accept blood or blood products during or after surgery if your condition is such that the physician deems it necessary. (❍ *If Jehovah's Witness please check)*

Patient Signature:____ Date:______________________________

Allergies: ☐ **NONE**

☐ Latex, Reaction:________________ ☐ Tape (adhesives), Reaction:________________

☐ Iodine, Reaction:________________ ☐ IV Contrast Dye, Reaction:________________

Medications (List any medications that you are allergic to and your reaction):________________

____

Foods (List foods and the reaction):________________

List Prescribed Medications:	Taken for what condition:	Dosage/How Often:
☐ **NONE**		
________	________	________
________	________	________
________	________	________
________	________	________
________	________	________
________	________	________
________	________	________
________	________	________

Surgical Procedure(s): ☐ **NONE**	**Year**		**Year**
Gallbladder: ❍ Open ❍ Laparoscopic	____	Tonsillectomy	____
Appendectomy: ❍ Open ❍ Laparoscopic	____	Mouth Surgery:________	____
Hysterectomy: ❍ Total ❍ Partial	____	Heart: ❍ CABG ❍ Stents ❍ Valve	____
Hernia: ❍ Hiatal ❍ Abdominal	____	Pacemaker	____
Tubal Ligation	____	Back:________	____
Cesarean Section	____	Knee: ❍ Right ❍ Left	____
Colonoscopy	____	Kidney Surgery	____
Endoscopy	____	Other:________	____
Nissen Fundoplication	____	Other:________	____

Previous Weight Loss Surgery (WLS): ________________

(We will need a copy of the Operation Report from your previous weight loss surgery.)

List any complications of WLS: ________________

Original Weight prior to Surgery: ________ ❍ Estimated ❍ Actual – Lowest Weight Achieved: ________ ❍ Estimated ❍ Actual

<u>Anesthesia Problems</u>: Please tell us about any problems that you have had with anesthesia: ❍ **NONE**

❍ Nausea
❍ Vomiting
❍ Difficulty Waking Up
❍ Heart Stopped
❍ Stopped Breathing
❍ Difficulty Urinating
❍ Woke up during procedure
❍ Other:________________

Weight Loss History:

What is your maximum lifetime weight?__________

How long have you been overweight?__________Years How long have you been 35 pounds overweight?_________Years

How long have you been 100 pounds or more overweight?__________Years When did you start dieting?___________Age

Have you ever had a "stomach stapling" or other gastric restriction procedure? ❍ Yes ❍ No

(If yes, please provide this information when entering in your previous surgical history.)

What is the most weight you have ever lost on a single diet?________lbs. How did you lose the weight?________________

How long did you sustain the weight loss?___________________________ ❍ No diet attempts of any kind

Check all that apply:

Unsupervised Diet Attempts: ❍ **NONE**

❍ Body for Life/Bill Phillips	❍ High Protein	❍ Low Fat	❍ Cabbage Soup
❍ Pritikin	❍ Stillman Diet	❍ Mayo Clinic	❍ Fasting
❍ Gloria Marshall	❍ Herbal Life	❍ Calorie Counting	❍ Scarsdale
❍ Richard Simmons	❍ Sugar Busters	❍ Atkin's Diet	❍ Slim Fast
❍ Health Spa	❍ Low Carbohydrate	❍ South Beach	❍ Other:_____________

Supervised Diet Attempts: ❍ **NONE**

❍ Nutri-System	❍ Overeaters Anonymous	❍ Weight Watchers	❍ Jenny Craig
❍ TOPS	❍ Optifast	❍ HMR	❍ DASH
❍ LA Weight Loss	❍ Diet Center	❍ Other:_________________________	

Over-the-Counter or Prescribed Medications for Weight Loss: ❍ **NONE**

❍ Acutrim	❍ Dexatrim	❍ Ionamin/Adipex	❍ Phendiet	❍ Prozac
❍ Wellbutrin	❍ Amphetamines	❍ Didrex	❍ Tenuate	❍ Phentrol

Thank you for taking the time to fill out our Patient Profile Packet.

Please mail completed packet and Insurance Card to the following address:

BHMG-Bariatric Surgery
2716 Old Rosebud Road, St. 350
Lexington, Kentucky 40509

Fax: 859-543-1637