

Weight Loss Surgery of Wyoming
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307-856-9962

Bariatric Patient Profile

The information requested in this profile is very important. To give you the best care, and to obtain your insurance approval, we must have complete answers. Please complete all information in black ink.

Date ____/____/____ Referred by: _____

Date of Seminar Attended: ____/____/____ Primary Care Physician: _____

Full Name _____ **Social Security #** _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Gender: Male/ Female

Age _____ Date of Birth ____/____/____ Marital Status: S M D W Number of Children _____

Race (Circle): Caucasian African-American Hispanic Asian Other _____

Height _____ Weight _____ BMI _____

(Information may be obtained off the receipt you were given at the seminar. If you do not have a receipt, please be as accurate as possible.)

Next of Kin or Emergency Contact _____ Phone # _____

Address _____ Relationship _____

Are You Employed? Y N Employer _____

Employer Address _____ Phone # _____

Job Title/Description of Work _____

Heavy Lifting Involved? Y N Disabled? Y N If yes, Why? _____

Primary Insurance Company _____ **Secondary Insurance Company** _____

Subscriber Name _____ *Subscriber Name* _____

Subscriber Date of Birth _____ Subscriber Date of Birth _____

ID # _____ Group # _____ ID # _____ Group # _____

Subscriber Employer _____ *Subscriber Employer* _____

How did you find out about our program? _____

Referred By: _____

Bariatric Patient Medical History

Patient Name _____ Date _____

Family Physician _____ Physician Phone _____

Address _____

Date of: Last Physical Exam _____ Last Visit to Family Physician _____

Current Medications:

Drug Name _____	Dosage _____	For _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any over the counter medications, vitamin or herbal supplements used:

Allergy Information: Allergic to any medication? Yes No If yes, please list medication and reaction.

Allergic to: **LATEX:** yes no **Surgical Tape:** yes no **Iodine:** yes no
Other allergies: _____

Are you currently smoking (using tobacco)? yes no **Frequency** () packs per day **How Long** () years.
Are you willing to quit? yes no
Did you ever smoke? yes no **When did you quit?** _____ **Frequency** () packs per day.
Do you use alcohol? yes no **Frequency** _____
Do you use recreational drugs? yes no **Please explain** _____

Bariatric Patient Medical History (page 2)

Patient Name _____

Date _____

Previous Surgery:

Procedure: _____

Date: _____

Physician: _____

Any Surgical Complications? (blood clots, infections, respiratory problems, blood pressure problems?)

Have you discussed Gastric Bypass/Gastric Banding with your physician?

Yes

No

Is your physician supportive of the surgery?

Yes

No

Have you discussed Gastric Bypass/Gastric Banding with your family?

Yes

No

Is your family supportive of the surgery?

Yes

No

Have you ever had Psychiatric Care or counseling sessions?

Yes

No

For what condition(s) were/are you under the care of a mental health counselor?

Are you currently taking medications as part of your mental health treatment?

Yes

No

If yes, please list:

Do you feel you have been the victim of violence, physical or mental abuse?

Yes

No

If yes, please briefly describe below:

All of our patients considering weight loss surgery will be scheduled for Psychological testing as a part of insurance and program requirements.

Bariatric Patient Medical History (page 3)

Patient Name _____

Date _____

All questions must be checked either yes or no. Leaving questions unanswered may cause a delay in the approval process by your insurance as this information may be requested by your insurance company.

Yes	No	(If YES, please describe):
___	___	Heart problems. chest pain (angina)? Ever see a cardiologist? Yes No
___	___	Palpitations, racing heart, skipping beats? Ever had an echocardiogram (ECHO) or Stress Test? _____
___	___	Frequent swelling of hands, ankles, or feet?
___	___	Respiratory Problems: Asthma, bronchitis, emphysema, pneumonia?
___	___	Shortness of Breath (SOB)? Number of stairs before SOB? _____ How far walking on flat land before you become SOB? _____ SOB at rest? YES NO
___	___	Easily fatigued? Please describe how this affects your life: _____ _____
___	___	Diabetic? Medications? YES NO Diet/Exercise Controlled YES NO Age Onset: _____
___	___	Elevated Triglycerides? Date last checked? _____ Value _____ Medication? YES NO
___	___	Elevated Cholesterol? Date last checked? _____ Value _____ Medication? YES NO
___	___	Hypertension/High Blood Pressure? How Long? _____ Medication? YES NO
___	___	Joint Pain? (knees, hips, ankles, feet) Ever seen an orthopedist? YES NO Date: _____
___	___	Back Pain: upper ___ lower ___ Ever seen an physician for this? YES NO Date: _____ Medication? YES NO Sciatica? YES NO
___	___	Numbness? Where? _____ Physician Treating? YES NO
___	___	Arthritis or degenerative Joint Disease? Where? _____ Medication? YES NO Physician Treating: _____

Bariatric Patient Medical History (page 4)

___ ___ Sleep disorder or problems? Ever has a sleep study performed? YES NO Date: _____

Where? _____ On CPAP or BIPAP? YES NO

___ ___ Varicose veins, Phlebitis? Ever Seen a physician for this? YES NO Name: _____

___ ___ Heartburn or reflux? How often? _____ Medication? YES NO
Treated by a physician? YES NO Name: _____
Ever had any diagnostic tests: Upper GI Series, Endoscopy? YES NO Date: _____

YES NO (If YES, please describe):

___ ___ Headaches, Migraines? How often? _____ Ever see a physician? YES NO

___ ___ Endocrine/Thyroid problems? Medications? YES NO

___ ___ Kidney/Bladder Problems? Urinary Stress Incontinence? YES NO

___ ___ Frequent Vaginal Infections? Last PAP Smear? _____ Physician Name _____

___ ___ Irregular Menses? How long since last period? _____ Medication? YES NO

___ ___ Fertility Problems? (trouble getting pregnant) Medication? YES NO

___ ___ Anemia/Increased Bleeding? Describe _____ Medication? YES NO

___ ___ Blood Clotting after surgery or other times? Describe: _____

___ ___ Depression? Related to Weight/Health? YES NO Receiving Treatment? YES NO

___ ___ Anxiety? Related to Weight/Health? YES NO Receiving Treatment? YES NO

___ ___ Ulcers? Type: _____ Medication? YES NO Ever required hospitalization? YES NO

___ ___ Hernia? (hiatal, ventral, umbilical) When diagnosed? _____ Surgical Repair? YES NO

___ ___ Neurological or Seizure Disorder? Describe: _____ Physician: _____

___ ___ Gallbladder Disease? How Diagnosed? Ultrasound Physical Exam Date: _____

___ ___ Kidney Stones?

___ ___ Any problems not listed? Describe: _____

___ ___ Any physician ever tell you a health problem requires permanent weight loss? Name: _____
For what problem: _____

ANY CONDITION LISTED ON THE ABOVE AND PRIOR PAGES REQUIRING MEDICATION MUST BE LISTED UNDER CURRENT MEDICATIONS ON MEDICAL HISTORY PAGE.

Bariatric Diet History

Patient Name _____ Date _____

Please be as specific as possible when completing this history as this information may be requested, and forwarded to your insurance company for the approval process.

General Questions:

How long have you been overweight? _____ years _____ months
 How long have you been 35 pounds overweight? _____ years _____ months
 How long have you been 100 pounds or more overweight? _____ years _____ months
 When did you start dieting? _____
 Have you ever had a "stomach stapling" or other gastric restriction procedure? YES NO
 If yes, please provide the date and type of operation: _____

What was your single greatest weight loss? _____ lbs. Did you regain the weight? YES NO

How was this weight loss obtained? (Be specific, i.e. Weight Watchers, Diet Pills, etc.)

How long did you sustain that weight loss? _____

How many times have you lost over 25 pounds? _____

Are you currently under a physician's care for weight loss? YES NO

Physician Name: _____

Address: _____

Please check and provide specific information for all diets that apply. Please submit documentation where applicable that supports diet attempts.

Medically Supervised Diet Programs	Number of Attempts	When (dates)	Length of Time	Weight Loss	Weight Regained	MC/Clinic/City
Medi-fast						
Opti-fast						
Fen/Phen						
Redux						
Meridia						
Xenical						
Behavior Mod/PSY Therapy						
Hypnosis						
Accupuncture						
Inpatient Wt. Clinic						
Prozac? Synthroid?						
Injections?						
Diabetic Diet by Nutritionist						

Bariatric Patient: Diet History (page 2)

Non-MD Supervised	Number of Attempts	When (dates)	Length of Time	Weight Lost	Weight Regained	MD/Clinic/City
Weight Watchers						
Nutri-Systems						
Jenny Craig						
TOPS						
Over Eaters Anony						
Other						
Liquid Diets						
Sego						
Slim Fast						
Metracal						
Sweet Success						
Liquid Protein						
Other						
Miscellaneous Diets						
Low Calorie						
Low Fat						
High Protein						
Self Imposed Fasts						
Dr. Atkins						
Scarsdale						
Pritikin						
Richard Simmons						
Susan Powter						
Heral Life						
Cambridge						
Metabolife						
Mayo Clinic Diet						
Zone Diet						
Other						
Diet Pills						
Accutrim/Dexatrim						
Diurex						
Other						
Exercise						
Health Club						
VCR Tapes						
Walking						
Other						
Other						
Other						

Is there a physician who can document your weight loss attempts for at least 6 months? YES NO

Patient Name _____ Date _____

Patient Signature _____

Reviewed with patient by: _____ Date _____

Bariatric Patient: Diet History (page 3)

Patient Name _____

Date _____

General Questions:

Do you snack between meals? YES NO

Do you eat large meals (gorge)? YES NO

Do you eat a lot of sweets? YES NO

Do you drink a lot of soda pop? YES NO Diet or Regular? _____

Have you ever forced yourself to vomit after eating? (binge and purge) YES NO

Do you currently force yourself to vomit after eating? YES NO

Please tell us why you believe you are overweight:

Please tell us how your weight is interfering with your health and life:

Please tell us why you feel you can be successful with weight loss after this surgery, despite the extreme lifestyle and dietary changes required:

How did you hear about our surgical weight loss program? _____

Patient Signature: _____

Date: _____

Bariatric Patient: Family History

Patient Name _____

Date _____

Please check all that apply:

Disease	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Morbid Obesity						
Diabetes						
Age: Diabetes Onset						
High Blood Pressure						
Stroke (age)						
Heart Attack (age)						
Cardiovascular Disease						
Sleep Apnea						
Cancer: Type and age of onset						
Death: List age and cause						

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.

Patient Signature _____