Tri-Rivers Healthcare PLLC

Bariatric Surgery Program

PATIENT INFORMATION PACKET

Bring completed packet to your first appointment along with a copy of your insurance card and photo id

Patient Information

Full Name (first, middle, last): _____

Social Security Number: _____ Date of Birth: _____ Age: _____

Gender (Circle): Female Male Marital Status: _____

Street Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____ Phone (home): _____

Phone (work): _____ Phone (cell): _____

Patient Employment Information

Employment Status (Circle): Full-time Part-time Retired Disabled
Student Unemployed Homemaker

Patient's Current Employer: _____

Patient's Employer's Address: _____

Occupation: _____

Disabled? Yes No If Yes, specify the year and cause: Year: _____

Cause: _____

Spouse Information

Spouse's Name: _____

Spouse's Employment Status: Full-time Part-time Retired Disabled
Student Unemployed Homemaker

Spouse's Occupation: _____ Spouse's SSN: _____

Spouse's Employer: _____ Years Employed: _____

Spouse's Cell Phone Number: _____

Insurance Information

Payment Type (Circle) Insurance Self-Pay

Primary Insurance Name: _____

Policy Number: _____ Group # _____

Subscriber Name: _____ Subscriber DOB: _____

Secondary Insurance Name: _____

Policy Number: _____ Group # _____

Subscriber Name: _____ Subscriber DOB: _____

Emergency Contact

First Name: _____ Last Name: _____

Relationship to you: _____ Phone: _____

"I hereby authorize Tri-Rivers Healthcare, PLLC to discuss my process, diagnostic test results and any scheduled appointments with the following named person(s), and further consent to the staff leaving messages for me on a voicemail/answering machine":

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

Patient Signature: _____ Date: _____

Blood Consent

You must be willing to accept blood or blood products during after surgery if your condition is such that the physician deems it necessary.

(If Jehovah's Witness please check ___)

Patient Signature: _____ Date: _____

Primary/Referring Physician

Physician Name: _____

Clinic Name: _____ Phone Number: _____

Weight Loss History

What is your height? _____ ft _____ in How much do you weigh? _____ lbs.

How long have you been overweight? _____ Years

How long have you been 35 pounds overweight? _____ Years

How long have you been 100 pounds overweight? _____ Years

When did you start dieting? _____ Age

Have you ever had a "stomach stapling" or other gastric restriction procedure?

Please circle Yes No If yes, name procedure: _____

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 weight loss? _____

_____ check here if you have never attempted to lose weight

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 Carb	____ 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
____ Redux	____ Byetta	____ Plegine	____ Sanorex	____ Meridia
____ Xenical	____ Diuretics	____ Pondimin	____ Phenteramine	____ Fen-Phen, #of months _____
Other: _____				

Behavioral Treatments for Weight Loss: ____ NONE

____ Hospitalization ____ Hypnosis ____ Physical Therapy ____ Residential Program

____ Psychological Therapy ____ Other: _____

Exercise: ____ NONE

____ Walking or Running ____ Stationary cycle or treadmill ____ Swimming

____ Weight Training ____ Team Sports ____ Other: _____

Eating Habits, Do you:

Snack between meals ____ Yes ____ No	Eat large meals? (gorge) ____ Yes ____ No
Eat a lot of sweets? ____ Yes ____ No	Drink carbonated beverages? ____ Yes ____ No If yes, how many cans/bottles per day? _____
Drink caffeine-containing drinks? ____ Yes ____ No If yes, how many cups per day? _____	

Have you used any of the following to control your weight? (Check all that apply)

____ Binging and Purging ____ Binging followed by food restriction ____ Vomiting

____ Excessive Exercise ____ Excessive Calorie Restriction/Fasting

If so, when and how long was this period of behavior? _____

Do you currently force yourself to vomit after eating? ____ Yes ____ No

Why do you feel you eat? (Check all that apply)

____ Physical Hunger ____ Loneliness ____ Anxiousness

____ Makes me happy ____ Bored

What reasons do you feel contribute to your weight? (Check all that apply)

____ Over consumption ____ Inactivity ____ Emotional Wellbeing

What else contributes to your weight struggle, i.e., how do you account for why you have been unable to lose weight and/or maintain?

_____

_____

_____

_____

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

_____

_____

_____

Why are you seeking weight loss surgery? _____

_____

_____

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

_____

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
____ CHF	____ 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
____ Use of Cpap/Bipap	____ Use of Oxygen	____ Snoring
____ Pulmonary Embolism	____ Sleep Apnea	____ 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: _____	

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

Bladder/Kidney ____ NONE

____ Kidney Stones	____ Blood in Urine	____ Prostate Problems
____ Kidney Failure/Renal Insufficiency	____ Leaking urine	____ Men: PSA 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

# of pregnancies have you had: _____ Date of Last Pap Smear? _____

# of miscarriages or abortions: _____ Date of last menstrual period: _____

Breast ____ NONE

____ Nipple Discharge	____ Lumps/Fibrocystic	____ Other: _____
____ Pain	____ Cancer	Date of last Mammogram: _____

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	____ Weakness
____ Knocked unconscious	____ Numbness/Tingling	____ Multiple Sclerosis

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

Psychiatric ____ NONE

Are you currently under the care of a mental health provider? ____ Yes ____ No

____ Depression/Anxiety	____ Borderline Personality Disorder
____ Bipolar Disorder	____ Multiple Personality
____ Schizophrenia	____ Seen a Psychiatrist or Counselor
____ Alcoholism/Substance Abuse	____ Been hospitalized for psychiatric Problems
____ Currently taking medications for Psychiatric problems or depression	____ Victim of Mental/Emotional/Sexual/ Physical Abuse
____ Attention Deficit Disorder	____ Other: _____

Endocrine ____ NONE

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

Blood/Lymphatic ____ NONE

____ Low Platelets	____ Anemia	____ HIV/AIDS
____ Bruise Easily	____ Lymphoma	____ Swollen Lymph Nodes
____ Bleeding/Clotting Disorder	____ Use Blood Thinning Medication	____ 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: _____	

Prescribed Medications	Condition Taken For	Dosage/How Often

List any Over-the-Counter medications, herbal supplements or vitamins that you take on a regular basis. ____ NONE

Product Name	Taken for what Purpose	Dosage/How Often

Allergies _____ None

___ Latex, Reaction: _____ ___ Tape, Reaction: _____

___ Iodine, Reaction: _____ ___ IV Contrast Dye, Reaction: _____

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

Foods (List any foods you are allergic to and your reaction:

Surgical Procedures		Year		Year
Gallbladder	(Open)	_____	Tonsillectomy	_____
Gallbladder	(Laparoscopic)	_____	D&C	_____
Appendectomy	(Open)	_____	Ear Surgery: _____	_____
Appendectomy	(Laparoscopic	_____	Mouth Surgery: _____	_____
Hysterectomy	(Vaginal)	_____	Heart Surgery: CABG/Stents	_____
Hysterectomy	(Abdominal)	_____	Valve Replacement	_____
Ovary Surgery		_____	Pacemaker	_____
Tubal Ligation		_____	Knee: __ Lt __ Rt	_____
Cesarean		_____	Breast Biopsy __Lt __Rt	_____

Surgical Procedures	Year		Year
Colonoscopy	_____	Kidney Surgery	_____
Anti-reflux procedure/Nissen	_____	Hemorrhoidectomy	_____
Colon Resection	_____	Endoscopy/EGD	_____
Back: _____	_____	Other: _____	_____

Previous Weight Loss Surgery: _____

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

Date of Surgery: _____ Surgeon: _____

List any complications from surgery: _____

Original Weight prior to Surgery: _____ Lowest Weight Achieved: _____

Anesthesia Problems (Check all that apply) ____ NONE

____ Nausea	____ Heart Stopped	____ Woke up during Procedure
____ Vomiting	____ Stopped Breathing	____ Difficulty Waking Up
____ Difficulty Urinating	____ Other: _____	

Social History	Yes	No		
Do you smoke now?			If yes, how many packs per day?	
Have you smoked in the past?			If you have quit, how many years since?	
For how many years did you use tobacco? _____				
Do you use snuff or chew?			If yes, how often do you use?	
Do you consume alcohol now?			If yes, how many drinks each time and how many times per week?	
For how many years do/did you drink alcohol? _____				
Is anyone concerned about the amount you drink?			If you have quit, how many years since?	
Do you use street drugs now?			If yes, what drugs? _____	
If yes, how often do you use these drugs? _____			If you have quit, how many years since? _____	

Family Medical History: (Check all that apply)

Disease	Mother	Father	Siblings	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Morbid Obesity							
Diabetes							
High Blood Pressure							
Stroke							
Heart Attack							
Cardiovascular Disease							
Sleep Apnea							
Cancer							
Death							
If still Living, Age							

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

You will be required to turn this packet
in at your first visit or you can mail in your packet to:

Salem Medical Clinic
141 Hospital Drive
Salem, KY 42078
ATTN: Bariatric Program

Please make sure to bring your insurance cards,
photo id and any previous bariatric surgery records with you to your first appointment as well.

We look forward to assisting you in your weight
loss goals and a healthier and happier future.