Department of General Surgery- Surgical Weight Loss Center
Lahey Hospital & Medical Center

Referring Physician (*Doctor who sent you to see us*):_____
Primary Care Physician (*Internist/Family doctor*):_____
Reason for visit: _____

Medication Allergies:

Drug	Reaction *(rash, hives, throat closing)*

Medical History: (*Circle those that apply, both current and past*)

Abdominal pain	Diarrhea	Palpitations
Abnormal ECG	Diverticulitis	Pancreatic cancer
Alcoholism	Fatigue	Pancreatitis
Anemia	Fatty liver	Peptic ulcer disease
Ankle pain	Fibrocystic disease	Polycystic ovary syndrome
Anorexia nervosa	Foot pain	Prediabetes
Anxiety	GERD	PTSD
Asthma	Gastrointestinal bleeding	Pulmonary arterial hypertension
Bipolar disorder	H. pylori infection	Pulmonary embolism (blood clot lungs)
Breast cancer	Headaches	Rectal bleeding
Breast mass	Heartburn	Seizures
Bulimia nervosa	Hepatitis	Sickle cell anemia
Burn injury	Hip pain	Sleep apnea
Cancer	HIV/AIDS	Small intestine cancer
Chest pain	Hyperlipidemia	Stroke
CHF	Hypertension	Substance abuse
Cholelithiasis (gallstones)	Iron deficiency	Thyroid disease
Cirrhosis	Irritable bowel syndrome	Thyroid nodule
Clotting disorder	Kidney disease	TIA (mini stroke)
Colon cancer	Knee pain	Tinea corporis (rash under belly)
Colon polyps	Liver cancer	Ulcers (GI) (stomach or intestines)
Constipation	Liver disease	Urinary incontinence
COPD	Low back pain	Vitamin B1 deficiency
Coronary artery disease	Lower extremity edema	Vitamin B12 deficiency
Deep vein thrombosis (blood clot legs)	Vomiting	Vitamin D deficiency
Depression	Myocardial infarction (heart attack)	Nausea
Diabetes mellitus	Osteoarthritis	Wound infection

Other:_____

Surgical History: (*circle those that apply*)

Abdomen surgery	Cholecystectomy (open)	Lap Band
Adenoidectomy	Colon surgery	Roux-en-Y (gastric bypass)
Appendectomy	Colonoscopy	Sleeve gastrectomy
Back surgery	Cosmetic surgery	Small intestine surgery
Biliopancreatic diversion (BPD)	Dilate and curettage	Spine surgery
Biliopancreatic diversion	Eye surgery	Thyroid surgery
with duodenal switch	Fracture surgery	Tonsillectomy
Breast surgery	Hernia repair	Tubal ligation
C-section	Hip replacement	Tonsillectomy
CABG (heart surgery)	Hysterectomy	Umbilical hernia
Cardiac catheterization	Joint replacement	Upper GI endoscopy
Carpal tunnel release	Knee arthroscopy	Valve replacement
Cesarean section low transverse	Knee surgery	
Cholecystectomy (lap)	Other: _____	

Anesthesia History: (*circle those that apply*)

Anesthesia awareness	Malignant hyperthermia	Prolonged awakening
Difficult intubation	PONV	Pseudocholinesterase deficiency

Social History:

Are you currently employed? Yes No Current or Former Occupation_____

Are you on disability? Yes No How long have you been on disability? _____

Are you married? Yes No

Who do you live with? _____

What is your highest level of education? _____

Are you on any food assistance programs (Food stamps, Meals-on-Wheels, WIC, etc)? Yes No

Tobacco use: Current smoker Former smoker Never a smoker
Type of tobacco: Cigarettes Pipe Cigars
Packs/day: _____ Years: _____
Quit date: _____

Drug use: Yes No
Type: _____
Use/week: _____

Alcohol Use: Yes No
Drinks/Week
_____ Glasses of wine
_____ Cans of beer
_____ Shots of liquor
_____ Drinks containing 0.5 oz of alcohol

Family History:

Problem	Relationship *(father, sister, etc,)*	Age at diagnosis
Obesity		
Heart disease		
Hypertension		
Diabetes		
Cancer (type)		
Alcohol/Drug abuse		
Other		

If you have anxiety, depression, bipolar disorder, PTSD, an eating disorder or other psychiatric diagnosis, please fill out the following:

Do you see a psychiatrist? Yes No If yes, who do you see? _____

Do you see a psychologist/social worker/therapist? Yes No If yes, who do you see? _____

Have you ever been hospitalized for any of these conditions? Yes No

If yes, when was your last hospitalization? _____

For Staff use Only:

Height: _____ Weight: _____ BMI: _____ BP: _____ Pain: _____

Which Procedure Are You Interested In (please circle)?

Gastric Bypass Sleeve Gastrectomy LAP Band Undecided

Weight History

LIFE EVENT	AGE	WEIGHT
High School Graduation		
Lowest weight in last 5 years		
Highest weight in last 5 years		

Dietary History

List **all** diets and diet programs that you have tried:

PROGRAM	WHEN?	HOW LONG?	WAS IT M.D. SUPERVISED?	WEIGHT LOST?
Supervised by Primary Care Physician				
Supervised by Endocrinologist				
Supervised by Registered Dietitian				
Circle all that apply: Fen Phen, Redux, Xenical, Meridia, Phentermine				
Weight Watchers				
Jenny Craig				
Nutri-System				
Atkins				
South Beach Diet				
LA Weight Loss				
Liquid Diet				
Diet Workshop				
Overeaters Anonymous				

How old were you when you first seriously started dieting? _____

Are you exercising right now? ☐NO/ ☐YES

Type (walking/biking/swimming,etc) _____

How long (30 minutes, 45 minutes, etc) _____

days/week _____

Do you have any exercise equipment at home?_____

Do you have a gym membership? ☐NO/ ☐YES

(Please answer the following questions if you are not already on CPAP therapy for sleep apnea)

OSA Screening Questionnaire (circle all that apply)

1. Do you snore >3 nights per week?	Yes (2)	No (0)	
2. Is snoring loud (hear through the walls)?	Yes (2)	No (0)	
3. Have you been told you stop breathing?	Frequently (5)	Occasionally (3)	Never (0)
4. Collar size?	Males:	>17 (5)	<17 (0)
	Females:	>16 (5)	<16 (0)
5. Treatment for hypertension?	Yes (2)	No (0)	
6. Do you doze during the day when not active?	Yes (2)	No (0)	
7. Do you doze while driving or at a stop light?	Yes (2)	No (0)	

OSA RISK (total points): High >9, Moderate 6-8, Low <5

Total Score:_____

Epworth Sleepiness Scale

Write the number of the most appropriate statement in the spaces provided below:

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

_____Watching TV
_____Sitting talking with someone
_____Sitting quietly after lunch without alcohol
_____Sitting, inactive in a public place (i.e. theatre or meeting)
_____Sitting and reading
_____As a passenger in a car for an hour without a break
_____In a car, while stopped for a few minutes in traffic
_____Lying down to rest in the afternoon when circumstances permit

Total Score: _____

How long have you had the symptoms/occurrences as reported above?_____