WOMACK ARMY MEDICAL CENTER
DEPARTMENT OF THE ARMY
WAMC STOP A
2817 REILLY ROAD
MXCX-DOS-GS - BARIATRICS
FORT BRAGG, NC 28310-7301

PHONE: (910)907-0787

SURGICAL WEIGHT LOSS PROGRAM

DATE: ___ /____/_____

Name_____

SPONSOR'S SS#_____ PATIENT'S SS#: _____

Gender: __male ___ female Date of Birth ____/____/_____

Race:
__ Caucasian __Hispanic __African American __Asian __Native American __Other

Address_____
Street City State Zip Code

TELEPHONE: Home _____Work _____Cell _____

Email address _____

Who Referred You? _____ Reason for Referral _____

Occupation:_____ Place of Employment: _____

Employment Status:

__Full time __Part time __Self-Employed __Homemaker __Student __Retired __Disabled

PEOPLE LIVING IN YOUR HOUSEHOLD

NAME	AGE	RELATIONSHIP

HEALTH CARE PROVIDERS/MEDICAL

Primary Care Physician: _____ Phone: _____
Address (if off-post): _____ Fax: _____

HEALTH CARE PROVIDERS – MENTAL HEALTH
Therapist or Mental health Counselor _____
Address: _____
Phone: _____ Fax: _____

Please list all other medical health providers and specialist. If you need more space, list additional providers' names, specialties, addresses, telephone and fax numbers on the back of this page.

Provider name: _____ Specialty: _____
Address: _____
Phone: _____ Fax: _____

Provider name: _____ Specialty: _____
Address: _____
Phone: _____ Fax: _____

Provider name: _____ Specialty: _____
Address: _____
Phone: _____ Fax: _____

Alcohol, Tobacco, and Non-prescription Drug History

Current use: List all alcohol, tobacco, and non-prescription drugs and the amounts that you currently use. List any additional products on the back of this page.

	Type of Product	Amount per day	Per Week
Alcohol:	_____	_____	_____
	_____	_____	_____
Tobacco:	_____	_____	_____
	_____	_____	_____
Drugs:	_____	_____	_____
	_____	_____	_____

When did you stop or plan to stop using?
Alcohol: _____ Tobacco: _____ Drugs: _____

Family History

Please list any relatives that have a history of any the following conditions:

Mother- M	**Maternal Grandmother- MGM**
Father- F	**Maternal Grandfather- MGF**
Brother – B	**Paternal Grandmother- PGM**
Sister- S	**Paternal Grandfather- PGF**

Obesity _____Diabetes _____ Heart Disease _____

Stroke_____ High Cholesterol/Triglycerides _____

Cancer _____

Prescription Medications, Supplements and Remedies
Please list all your current medications, supplements and remedies. If you need additional space, please continue on the back of this page.

Prescription drugs, dosages and purpose (including psychiatric medication and birth control. Please use back of form for additional space.)

Medication	**Dosage/How Often**	**Purpose**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Over the counter drugs:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Vitamins/supplements/herbal remedies:

_____ _____

_____ _____

_____ _____

Allergies to prescription medications:

Allergy	**Reaction**

HOSPITALIZATIONS

Please list all inpatient hospitalizations, including psychiatric and substance abuse treatment. If you need additional room, please continue on the back of this page.

Approximate Date	Problem	Hospital/Treatment Facility
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PREVIOUS NON-BARIATRIC SURGERIES

Procedure:

__ Anti-reflux procedure
__ Bowel resection
__ Breast cancer, mastectomy
__ Breast Cancer, biopsy
__Breast cancer, radiation
__ CABG
__ Removal of gallbladder
__Hip replacement
__ Hysterectomy
__ Knee replacement
__ Laminectomy
__Nissen Fundoplication
__ Peripheral vascular Procedure
__ Tubal ligation
__ Vasectomy
__ C-section
__ Other _____

PREVIOUS BARIATRIC SURGERIES

__ Bilopancreatic diversion (BPD)
__Gastric band, non-adjustable
__Gastric bypass, (Roux-en-Y) open
__ Sleeve gastrectomy
__Intestinal Bypass
__Vertical banded Gastroplasty
__Gastric banding, adjustable
__Gastric bypass(Roux-en-Y) laparoscopic
__Gastric bypass, mini loop
__Gastric bypass, banded
__BPD with duodenal switch
__Other (Please list) _____

Year: _____

Original weight: _____ lbs Estimated? ____ Actual?____

Lowest weight achieved _____ __lbs __ estimated __actual

Surgeon: _____

Have you ever had an adverse reaction to anesthesia/sedation? ___Y ___N
(If you answered yes, please comment) _____

Has any of your relative had an adverse reaction to anesthesia/sedation? __Y__N
(If you answered yes, please comment) _____

Current Medical Conditions

Please check box and add information.

Heart and Circulation:	**Comments**
___Chest pain/coronary artery disease/angina	_____
___Congestive Heart Failure	_____
___Irregular or rapid heart beat (arrhythmias)	_____
___Peripheral vascular disease	_____
___Leg swelling (edema)	_____
___Hypertension/high blood pressure	_____
___Stroke	_____
___Blood Clots/Deep Vein Thrombosis (DVT)	_____
___Other:_____	_____

Lungs:

___ Shortness of breath _____
___at rest ____walking on flat ground __on stairs/hills
___Asthma _____
___COPD (emphysema, chronic bronchitis) _____
___Pulmonary Embolism (Blood clot in the lungs) _____
___Sleep Apnea _____ CPAP settings_____ _____
___Pulmonary Hypertension _____
___ Other: _____ _____

Gastrointestinal/GI:

___Gastro Esophageal Reflux (GERD) _____
___ Heartburn _____
___Ulcers _____
___Crohn's Disease/Ulcerative Colitis _____
___ Frequent Diarrhea _____
___Frequent constipation _____
___Gallbladder ___stones ____removed _____
___Fatty liver _____
___Colon ___hemorrhoids ___polyps _____
___Liver ____hepatitis _____Cirrhosis _____
___Other: _____ _____

Endocrine:

___Diabetes _____
___High cholesterol, high triglycerides _____
___Infertility _____
___Menstrual irregularities _____
___Polycystic Ovarian Syndrome _____
___Thyroid ____Hypothyroidism (Underactive) _____
____Hyperthyroidism (Overactive) _____
___Excessive hot or cold feeling _____
___Visual Changes _____
___Changes in your voice _____
___Recent increase in thirst or urination _____
___Abnormal hair growth _____
___Numbness or tingling in your hands or feet _____
___Other: _____ _____

MEDICAL HISTORY

Blood: **Comments**

___Anemia _____
___Iron Deficiency _____
___Other:_____ _____

Musculoskeletal:

___Back pain _____
___Gout _____
___Arthritis type: _____ _____
___Fibromyalgia _____
___Other: _____ _____

Psychiatric:

___Depression _____
___Bi-polar Disorder _____
___Eating Disorder ___Anorexia ___Bulimia _____
___Anxiety _____
___Other: _____ _____

Other:

___Urinary Stress Incontinence _____
___Pseudotumor Cerebi _____
___Abdominal Skin/Pannus irritation/infection _____
___Abdominal Wall Hernia _____
___Kidney Disease _____
___Kidney Stones _____
___Other: _____

WEIGHT AND WEIGHT LOSS HISTORY

Current weight or best estimate _____ Current Height_____
Weight 1 year ago _____
Are you at your highest weight ever? ___Yes ___No
If your answered no, what was your highest weight and when? _____

Please check all previous weight loss methods that you have tried. List any additional

Commercial diet programs
___Weight Watchers
___Diet Workshop
___Jenny Craig
___OA
___TOPS
___Nutrisystem
___Other:_____
___Other:_____

Prescription diet medications
___Redu (dexfenfluraramine)
___Pondimin (fenfluramine)
___Phen-Fen
___Phentermine (Fastin,Adipex)
___Amphetamines
___Meridia (sibutramine)
___Other:_____
___Other_____

Liquid Diets
___Optifast
___HMR
___Slimfast
___Other: _____

Herbal and non-prescription remedies
___Epedra, ma huang
___Other herbals: _____
___Over the counter diet aids
___Other:_____

WEIGHT AND WEIGHT LOSS HISTORY

Therapy and Other Programs
___Behavior therapy
___Psychotherapy
___Exercise programs
___Feeding Ourselves
___Self initiated or fad diets. Please list:
_____

Medical and health Care Treatments
___Previous gastric surgery/stapling
___Jaw wiring
___Other surgery:_____
___Acupuncture
___Hypnosis
___Other: _____

Cardiac Questionnaire

Gastric bypass is an intermediate risk surgery according to the American Heart Association. In order to best prepare you for surgery please fill out the following questions appropriately. (Circle all that applies)

1. Have you had heart surgery within the last 3 years? **YES** **NO**

2. Have you been seen recently by your heart doctor? **YES** **NO**

3. Do you have a heart condition? If yes, please describe. **YES** **NO**

4. Do you get chest pain with exercise? **YES** **NO**

5. Have you ever had a heart attack? **YES** **NO**

6. Have you been treated for heart failure? **YES** **NO**

7. Do you have diabetes mellitus? **YES** **NO**

8. Can you carry groceries in from the car? **YES** **NO**

9. Can you vacuum the house? **YES** **NO**

10. Can you mow the lawn using a push mower? **YES** **NO**

11. Have you ever had a stroke? **YES** **NO**

12. Do you have high blood pressure? **YES** **NO**
    Is it treated? **YES** **NO** **N/A**

13. How fast can you walk a mile?

14. What is your age?

OBSTRUCTIVE SLEEP APNEA SCREENING QUESTIONAIRE

1. Do you snore loud enough to be heard through closed doors?

   Yes_____ No_____

2. Do you often feel tired, fatigued, or sleepy upon waking?
   Yes_____ No_____

3. Has anyone observed you stop breathing during your sleep?
   Yes_____ No_____

4. Do you have high blood pressure?
   Yes_____ (if yes) Are you being treated for it? Yes____No___
   No _____

5. Is your Body Mass Index more than 35?
   Yes_____ No_____
   (BMI= Your weight in pounds X 703/your height in inches X your height in inches)

6. Are you over 50 years old?
   Yes _____ No_____

7. Is your neck circumference greater than 40 cm?
   Yes_____ No _____

8. Are you a male?
   Yes _____ No_____

Bariatric Surgery Contract
Womack Army Medical Center
Fort Bragg, North Carolina

I, _____, agree to the following statements. I will abide by this contract for Bariatric Surgery. I know that it is in my best interest to follow these instructions and is expected by the Bariatric Surgery Service that each will be adhered to explicitly.

(Initial each line)

____I will attend at least one pre-operative support group meeting. I will attend post-op meetings for at least one year after surgery. Studies show that patients who participate in a support group have a higher success rate in the long term.

____I will have an exercise regimen that I initiate prior to my operation and will resume post operatively. I will provide a copy of my plan for my chart.

____I will adhere strictly to the pre-operative diet (low carb/high protein). This will start prior to my pre-op interview with the surgeon. I understand that this diet allows for shrinking of a fatty liver and therefore facilitates a smoother operation.

____I will adhere to a clear liquid diet for two (2) consecutive days prior to surgery.

____I will adhere strictly to the post op diet given to me. I understand the importance of following the rules of post op eating.

____I will follow up with the Bariatric Clinic as directed. The Bariatric Surgeon does not become my PCM.

____I am aware that I must stay in the area for 12 months following surgery in order to receive the best post-operative care.

____I will notify the bariatric clinic if, during the pre-op process, I find out that I am PCS'ing/ETS'ing.

____I will notify the bariatric clinic if, during the pre-op process, I find out that I am going to lose Tricare coverage.

____I am aware that it is my responsibility to call and schedule all post-operative appointments with the nutrition clinic as well as the bariatric clinic.

____I will see nutrition prior to all my bariatric post-operative appointments.

____I will take a multivitamin daily for the rest of my life.

Bariatric Surgery Contract
Womack Army Medical Center
Fort Bragg, North Carolina

____I will abstain from alcohol for at least one year.

____I will not use nicotine products. This includes Nicorette Gum, lozenges, E-Cigarettes, patches, chew or cigarettes. Nicotine is shown to have a direct effect on the incidence of ulcers.

____I will not become pregnant for at least 18 months after surgery. I will adhere to this time frame, so I am medically optimized for the health of my child.

____I will maintain a journal. Journal will consist of entries for diet, exercise and mood. I will bring this to my post op appointments.

____I am aware that I must not gain weight from the date of my orientation or I will not be cleared for surgery.

_____ _____
Signature Date

EXERCISE PLAN

NAME:
DATE:
SPONSERS LAST 4:

SUNDAY-

MONDAY-

TUESDAY-

WEDNESDAY-

THURSDAY-

FRIDAY-

SATURDAY-

Your exercise plan should consist of at least five days of workout and must not include house hold chores, walking the dog, etc.

PATIENT PRE-OP CHECKLIST FOR YOUR RECORDS

	NEEDED Y/N	DATE COMPLETED	NOTES
SIGNED CONTRACT	**Y**		
NUTRITION CLASS	**Y**		
1:1 NUTRITION APPT(2 minimum)	**Y**		
FULL PHYSICAL EXAM/ WELL WOMAN EXAM	**Y**		
SUPPORT GROUP MEETING (1 minimum)	**Y**		
EXERCISE PLAN	**Y**		
COMPLETED LABS	**Y**		Contact us 1 week after you have completed all labs to go over results.
PSYCH EVALUATION	**Y**		
MAMMOGRAM (Women over 40)			
COLONOSCOPY (50 & up)			
PULMONARY FUNCTION TEST (Depending on medical history)			
CARDIAC CLEARANCE/ STRESS TEST(Depending on medical history)			
SLEEP STUDY (Depending on medical history)			
EGD/GI/SWALLOW STUDY (Depending on medical history)			
PRE OP QUIZ	**Y**		
MEMMORANDUM(WE WILL PROVIDE)	**Y**		
PRE OP CLASS	**Y**		
PRE OP W/SURGEON (After everything is completed on checklist)	**Y**		

CONTACT THE BARIATRIC CLINIC AFTER YOU COMPLETE EACH ITEM ON THE CHECKLIST SO THAT WE CAN UPDATE YOUR FILE. YOU CAN CALL 910-907-0787/910-907-9927.