



Center of Excellence
BARIATRIC SURGERY

HARBIN CLINIC BARIATRIC CENTER
1825 Martha Berry Blvd. Rome, GA / (706) 378-8140 / 1-800-803-2065
Patient Information Packet (12 pages)

PATIENT DEMOGRAPHICS

Name: _____ DOB: _____ Age: _____ Sex: M F

Address: _____ Home Phone: _____

_____ Work Phone: _____

_____ Cell Phone: _____
City State Zip County

Email: _____ Social Security #: _____

Marital Status: _____ May we contact your spouse: Y N

Spouse's Name: _____

Emergency Contacts: _____
Name Relationship Phone Alternate Phone

Name Relationship Phone Alternate Phone

Are you employed? Y N If yes, Employer Name: _____
Full time Part time Student Homemaker Retired Self Employed

INSURANCE INFORMATION

Employer's Name: _____ Occupation: _____

Primary Insurance Carrier: _____

Address: _____ Policy Effective Date: _____

Customer Service #: _____

Policy or ID #: _____

Group #: _____
City State Zip

Policy Holder Name: _____ Relationship to Patient: _____

Secondary Insurance Carrier: _____

Address: _____ Policy Effective Date: _____

Customer Service #: _____

Policy or ID #: _____

Group #: _____
City State Zip

Policy Holder Name: _____ Relationship to Patient: _____

WEIGHT INFORMATION

Current Weight: _____ Max. Weight: _____ Lowest Adult Weight: _____
Height: _____ Date of Max. Wt: _____ Date of lowest Weight: _____
BMI: _____

How would you describe your current weight? _____

At what weight have you felt your best or *think* you would feel your best? _____

How does your weight affect your daily activities? _____

Why do you want to lose weight? _____

Why are you considering surgery to help you lose weight? _____

How do you think your life would change if you reach your weight goal? _____

Age when you first remember being overweight: _____
Age when you first began dieting: _____

Medication Prescribed by a Physician for Weight Loss

Medications may be listed as both generic and name brand. Check the one prescribed to you.

- | | | |
|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Acutrim | <input type="checkbox"/> Obalan | <input type="checkbox"/> Stacker 2 |
| <input type="checkbox"/> Adipex-P | <input type="checkbox"/> Orlistat | <input type="checkbox"/> Coritslim |
| <input type="checkbox"/> Anorex | <input type="checkbox"/> Phentermine | <input type="checkbox"/> Ephedrine |
| <input type="checkbox"/> Dexatrim | <input type="checkbox"/> Phentrol | <input type="checkbox"/> Relacore |
| <input type="checkbox"/> Dexfenfluramine | <input type="checkbox"/> Pondimin | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Didrex | <input type="checkbox"/> Redux | _____ |
| <input type="checkbox"/> Fastin | <input type="checkbox"/> Sanorex | _____ |
| <input type="checkbox"/> Fenfluramine | <input type="checkbox"/> Tepanol | |
| <input type="checkbox"/> Ionamin | <input type="checkbox"/> Topamax | |
| <input type="checkbox"/> Mazanor | <input type="checkbox"/> Tenuate | |
| <input type="checkbox"/> Meridia | <input type="checkbox"/> Xenical | |

WEIGHT LOSS HISTORY

Most insurance companies require documented evidence of previous weight loss attempts, so it is very important that you complete this in detail.

Method	Ages	Times tried	Weight lost	Comments/Weight Regain
Weight Watchers				
TOPS				
First Place				
Nutri-System				
Jenny Craig				
LA Weight Loss				
Richard Simmons				
Overeaters Anonymous				
Herbal Life				
Dietitian				
Slim Fast				
Liquid Diet				
Cabbage Soup Diet				
Mayo Clinic Diet				
Scarsdale Diet				
Atkins				
South Beach Diet				
Sugar Buster				
High Carbohydrate, Low Fat				
Starvation				
Behavior Modification				
Psychotherapy				
Hypnosis				
Surgery				
Diet Books				
Calorie Counting				
Dr. Vitkins				
Dr. Jagiella				
Dr. Martin				
Exercise				
Other (Please describe)				

Please enclose any documentation confirming your weight loss efforts.

MEDICAL HISTORY

Have **you** ever had any of the following medical problems?

(Choose **one** in each box that applies)

<p>Hypertension (high blood pressure)</p>	<ul style="list-style-type: none"> <input type="checkbox"/> No Personal History <input type="checkbox"/> Borderline, no medication <input type="checkbox"/> Diagnosis of hypertension, no medication <input type="checkbox"/> Treatment with single medication <input type="checkbox"/> Treatment with multiple medications <input type="checkbox"/> Poorly controlled by medication, organ damage
<p>Congestive Heart Failure</p>	<ul style="list-style-type: none"> <input type="checkbox"/> No personal history or symptoms of congestive heart failure <input type="checkbox"/> Symptoms with more than one ordinary activity <input type="checkbox"/> Symptoms with ordinary activity <input type="checkbox"/> Symptoms with minimal activity <input type="checkbox"/> Symptoms at rest
<p>Ischemic Heart Disease (Coronary Artery Disease, Ischemic means that the heart is not getting enough blood and oxygen)</p>	<ul style="list-style-type: none"> <input type="checkbox"/> No history of ischemic heart disease <input type="checkbox"/> Abnormal ECG, no active ischemia <input type="checkbox"/> History of heart attack or take medications to prevent it <input type="checkbox"/> Had surgeries or stents for heart attack <input type="checkbox"/> Active ischemia
<p>Chest Pain</p>	<ul style="list-style-type: none"> <input type="checkbox"/> No chest pain symptoms/angina <input type="checkbox"/> Chest pain with extreme exertion (running, swimming, etc.) <input type="checkbox"/> Chest pain occurs with moderate activity or exertion <input type="checkbox"/> Chest pain occurs with minimal exertion (walking across a room) "at rest" <input type="checkbox"/> Unstable chest pain/angina
<p>Peripheral Vascular Disease (A disease of the blood vessels characterized by narrowing and hardening of the arteries)</p>	<ul style="list-style-type: none"> <input type="checkbox"/> No symptoms of peripheral vascular disease <input type="checkbox"/> Cramping pain and weakness in the legs with medication <input type="checkbox"/> Transient ischemic attack (ie TIA or 'mini-stroke') <input type="checkbox"/> Procedure for peripheral vascular disease <input type="checkbox"/> Stroke, loss of tissue secondary to ischemia
<p>Lower Extremity Edema (swelling)</p>	<ul style="list-style-type: none"> <input type="checkbox"/> No symptoms of lower extremity edema <input type="checkbox"/> Intermittent lower extremity edema, not requiring treatment <input type="checkbox"/> Symptoms requiring treatment, diuretics, elevation or hose <input type="checkbox"/> Stasis ulcers <input type="checkbox"/> Disability, decreased function, hospitalization
<p>DVT/PE (Deep Vein Thrombosis/ Pulmonary Embolism)</p>	<ul style="list-style-type: none"> <input type="checkbox"/> No history of DVT/PE <input type="checkbox"/> History of DVT resolved with medication <input type="checkbox"/> Recurrent DVT long term medication <input type="checkbox"/> Previous pulmonary embolism <input type="checkbox"/> Recurrent pulmonary embolism, decrease function, hospitalization <input type="checkbox"/> Vena Cava filter placed
<p>Glucose Metabolism</p>	<ul style="list-style-type: none"> <input type="checkbox"/> No symptoms or evidence of diabetes <input type="checkbox"/> Elevated fasting glucose <input type="checkbox"/> Diabetes, controlled with oral medication <input type="checkbox"/> Diabetes, controlled with insulin <input type="checkbox"/> Diabetes, controlled with insulin and oral medication <input type="checkbox"/> Diabetes, with severe complications (retinopathy, neuropathy, renal failure, blindness)

Abnormal Lipids such as high cholesterol, high bad cholesterol	<input type="checkbox"/> Not present <input type="checkbox"/> Present, no treatment required <input type="checkbox"/> Controlled with lifestyle change <input type="checkbox"/> Controlled with single medication <input type="checkbox"/> Controlled with multiple medications <input type="checkbox"/> Not controlled
Gout/Hyperuricemia (excess uric acid in the blood)	<input type="checkbox"/> No symptoms of gout/hyperuricemia <input type="checkbox"/> Hyperuricemia, no symptoms <input type="checkbox"/> Hyperuricemia, medications <input type="checkbox"/> Joint disease due to gout <input type="checkbox"/> Destructive joints <input type="checkbox"/> Disability, unable to walk
Obstructive Sleep Apnea Syndrome	<input type="checkbox"/> No symptoms or evidence of sleep apnea <input type="checkbox"/> Sleep apnea symptoms (negative sleep study or not done) <input type="checkbox"/> Sleep apnea diagnosis by sleep study (no oral appliance) <input type="checkbox"/> Sleep apnea requiring oral appliance such as CPAP <input type="checkbox"/> Sleep apnea with significant hypoxia or oxygen dependent <input type="checkbox"/> Sleep apnea with complications (pulmonary hypertension, etc.)
Obesity Hypoventilation Syndrome	<input type="checkbox"/> No symptoms of obesity SOB (shortness of breath) <input type="checkbox"/> Lack of oxygen on room air <input type="checkbox"/> Severe SOB <input type="checkbox"/> Pulmonary Hypertension <input type="checkbox"/> Right heart failure
Pulmonary Hypertension	<input type="checkbox"/> No symptoms or indication of pulmonary hypertension <input type="checkbox"/> Symptoms associated with PH (tiredness, SOB, dizziness, fainting) <input type="checkbox"/> Confirmed Pulmonary Hypertension diagnosis <input type="checkbox"/> Well controlled on anticoagulants and/or calcium channel blockers <input type="checkbox"/> Stronger medications and/or oxygen
Asthma	<input type="checkbox"/> No symptoms of asthma <input type="checkbox"/> Intermittent mild symptoms, no medication <input type="checkbox"/> Symptoms controlled with oral inhaler (such as albuterol) <input type="checkbox"/> Well controlled with ongoing daily medication <input type="checkbox"/> Symptoms not well controlled with medication <input type="checkbox"/> Hospitalized within last 2 years or history of intubation
GERD (gastroesophageal reflux disease)	<input type="checkbox"/> No history of GERD <input type="checkbox"/> Intermittent or variable symptoms, no medication <input type="checkbox"/> Intermittent medication <input type="checkbox"/> Take prescribed medication (H2 blocker or low dose PPI) <input type="checkbox"/> Take high dose medications <input type="checkbox"/> Meet criteria for antireflux surgery, or prior surgery for GERD
Liver Disease	<input type="checkbox"/> No history of liver disease <input type="checkbox"/> Mild enlargement of the liver, normal liver function test, fatty change <input type="checkbox"/> Modest hepatomegaly, LFT alteration, fatty change <input type="checkbox"/> Moderate to marked hepatomegaly, fatty change <input type="checkbox"/> Mild inflammation, mild fibrosis <input type="checkbox"/> Definite NASH (nonalcoholic steatohepatitis), cirrhosis, hepatic dysfunction by LFT's <input type="checkbox"/> Hepatic failure, transplant indicated or done

Back Pain	<input type="checkbox"/> No symptoms of back pain <input type="checkbox"/> Intermittent symptoms not requiring treatment <input type="checkbox"/> Symptoms requiring non narcotic treatment <input type="checkbox"/> Degenerative changes or positive objective findings, symptoms requiring narcotic treatment <input type="checkbox"/> Surgical intervention done or recommended pending weight loss <input type="checkbox"/> Failed previous surgical intervention with existing symptoms
Musculoskeletal Disease (problems with muscle and bone such as joint disease)	<input type="checkbox"/> No symptoms of musculoskeletal disease <input type="checkbox"/> Pain with community ambulation <input type="checkbox"/> Non narcotic pain medication required <input type="checkbox"/> Pain with household ambulation <input type="checkbox"/> Surgical intervention required <input type="checkbox"/> Awaiting or past joint replacement or other disability
Fibromyalgia (chronic disorder with widespread pain, tenderness, and stiffness of muscles)	<input type="checkbox"/> No history of fibromyalgia <input type="checkbox"/> Treatment with exercise <input type="checkbox"/> Treatment with non narcotic medication <input type="checkbox"/> Treatment with narcotics <input type="checkbox"/> Treatment with narcotics; surgical intervention done or recommended <input type="checkbox"/> Disabling, treatment not effective
Polycystic Ovarian Syndrome (PCOS)	<input type="checkbox"/> No history of polycystic ovarian syndrome <input type="checkbox"/> Symptoms of PCOS, no treatment <input type="checkbox"/> Take birth control pills <input type="checkbox"/> Take Metformin (Glucophage) or TZD (thiazolidinedione) <input type="checkbox"/> Combination therapy <input type="checkbox"/> Infertility
Psychosocial Impairment	<input type="checkbox"/> No impairment <input type="checkbox"/> Mild impairment in psychosocial functioning but able to perform all primary tasks <input type="checkbox"/> Moderate impairment in psychosocial functioning and unable to perform some primary tasks <input type="checkbox"/> Severe impairment in psychosocial functioning and unable to perform most primary tasks <input type="checkbox"/> Severe impairment in psychosocial functioning and unable to function
Depression	<input type="checkbox"/> No symptoms of depression <input type="checkbox"/> Mild and episodic not requiring treatment <input type="checkbox"/> Moderate accompanied by some impairment, may require treatment <input type="checkbox"/> Moderate with significant impairment, treatment indicated <input type="checkbox"/> Severe, definitely requiring intensive treatment <input type="checkbox"/> Severe requiring hospitalization
Confirmed Mental Health Diagnosis	<input type="checkbox"/> None <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Anxiety/Panic Disorder <input type="checkbox"/> Personality disorder <input type="checkbox"/> Psychosis

Stress Urinary Incontinence (leaky urine when you laugh, cough, or sneeze)	<input type="checkbox"/> No history of stress urinary incontinence <input type="checkbox"/> Minimal and intermittent <input type="checkbox"/> Frequent but not severe <input type="checkbox"/> Daily occurrence, requires sanitary pad <input type="checkbox"/> Disabling <input type="checkbox"/> Operation ineffective
Pseudotumor Cerebri (benign intracranial hypertension. An abnormal condition such as headaches with dizziness, nausea, and/or pain behind the eyes)	<input type="checkbox"/> No symptoms of pseudotumor cerebri <input type="checkbox"/> Headaches with dizziness, nausea, and/or pain behind the eyes, no visual symptoms <input type="checkbox"/> Headaches with visual symptoms and/or controlled with diuretics <input type="checkbox"/> Patient has had MRI to confirm PTC, is well controlled with oral diuretics <input type="checkbox"/> Patient is well controlled with stronger medications <input type="checkbox"/> Patient requires narcotics or has had (or needs) surgical intervention

List all additional medical illness:

List all surgeries you have had:

Surgery	Date	Open or Laparoscopic

List allergies to any medications and include type of reaction and date of allergy:

Penicillin
 Latex
 Iodine

MEDICATIONS:

Medication	Dose & Frequency	Condition
Example: Prilosec OTC	30mg once a day	Heartburn

Please enclose an additional sheet if necessary to list ALL medications

Do you **CURRENTLY** have a problem with any of the following?

- | | | |
|--|--|--|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Snoring | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Last period: _____ |
| <input type="checkbox"/> Lethargy | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Breast |
| <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Nausea | <input type="checkbox"/> Trouble Walking |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Weakness in arms/legs |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Numbness/tingling |
| <input type="checkbox"/> Change in vision | <input type="checkbox"/> Bloating | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Sinuses | <input type="checkbox"/> Constipation | <input type="checkbox"/> Infection |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Bloody stool | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Change in stool | <input type="checkbox"/> Sadness |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Urination | <input type="checkbox"/> Fear |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Kidneys | |

SOCIAL HISTORY

Do you use tobacco currently? _____ How many packs/day? _____
 How many years have you smoked? _____ Have you tried to quit? _____

Did you smoke in the past? _____ How many packs/day? _____
 How many years did you smoke? _____ When did you quit? _____

Do you drink beer, liquor, or wine? _____ How many glasses per week? _____

Do you use any recreational drugs? _____ Which one(s)? _____
 Have you ever had an addiction to drugs? _____

SLEEP HISTORY

How likely are you to doze off or fall asleep in the following situations? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Please fill out the box below.

0= would never doze

2= moderate chance of dozing

1= slight chance of dozing

3= high chance of dozing

	0	1	2	3
Sitting and reading				
Watching TV				
Sitting, inactive in a public place (a theater, or in a meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after lunch without alcohol				
In a car, while stopped for a few minutes in traffic (at a traffic light)				

FAMILY HISTORY

	Father	Mother	Sibling	Aunt/Uncle	Grandparent
Obesity					
Diabetes					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Cancer					
Arthritis					
Early Death (Cause)					

PHYSICIANS

Please list all physicians that are currently or recently caring for you

Primary Care Physician _____

Gynecologist _____

Cardiologist _____

Pulmonologist _____

Psychiatrist / Psychologist _____

Orthopedic

Other

REFERRING PHYSICIAN

Referring Physician: _____ Phone Number: _____
Address: _____ Fax Number: _____

How did you hear about Harbin Clinic Bariatric Center? _____

PROCEDURE PREFERENCE

Which surgical procedure are you currently most interested in?

- Gastric Bypass
- Lap-Band
- Realize Band
- Sleeve Gastrectomy
- No Preference