UK HealthCare

Lexington, Kentucky

GENERAL SURGERY WEIGHT LOSS CLINIC
NEW PATIENT INFORMATION

(Patient Label Here)

Preferred Procedure:

q Laparoscopic Sleeve Gastrectomy

q Laparoscopic Roux-en-Y Gastric Bypass

q Date of Surgery: _____

Revision - Previous weight loss surgery:

Original Surgery: _____

Please Choose a Surgeon:

q Joshua Steiner, MD

q Scott Roth, MD

q William Inabnet III, MD

Revision to:

q Laparoscopic Sleeve Gastrectomy

q Laparoscopic Roux-en-Y Gastric Bypass

I would like information in this language: _____

Here are some other ways you can help me during my clinic/hospital visit: _____

_____

Patient Information:

First name: _____ Middle Name: _____ Last Name: _____

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

Gender: q Male q Female

Marital Status: q Married q Single q Divorced q Separated q Partnered q Widow(er)

How many children do you have (please list ages)? _____

Ethnicity: q African American q Hispanic q Native American or Alaska Native q Asian q Caucasian
q Native Hawaiian/Other Pacific Islander q Choose not to specify q Other: _____

Religious affiliation: _____ Patient's level of education: _____

What is your height: _____ ft. _____ in.

How much do you weigh? _____ LBS BMI: _____

Address Information:

Street Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Phone (home): _____

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

OK to leave message at: q Home q Work q Cell

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NEW PATIENT INFORMATION

(Patient Label Here)

Patient Employment Information:

Employment Status: q Full time q Part time q Retired q Disabled q Student
q Unemployed q Homemaker q Leave of Absence

Patient's Current Employer: _____ Years Employed: _____

Patient's Employer Address: _____

Patient's Present or Former Occupation: _____

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

Cause: _____

Do you need help walking? q Yes q No About how many feet can you walk before needing rest? _____

If you need help walking, what device(s) do you use? q Cane q Walker q Crutches
q Other: _____

Are you wheelchair bound and unable to stand at all? q Yes q No

How long have you needed a wheelchair? _____ (month/year)

Do you have someone who makes your medical decisions, like a medical surrogate or power of attorney? q Yes q No If yes, who? _____
Relationship to you? _____

Spouse Information:

Spouse's name: _____

Spouse's date of birth: _____

Spouse's employment status: q Full time q Part time q Retired q Disabled
q Student q Unemployed q Homemaker q Leave of Absence

Spouse's Occupation: _____

Spouse's SSN: _____

Spouse's Employer: _____

Years Employed: _____

Spouse's Employer address: _____

Spouse's Cell Phone: _____

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(Patient Label Here)

Insurance Information: (You must fill out this section AND send us a copy of your insurance card.)

Payment Type: q Insurance q Self Pay

Primary Insurance: _____

Policy Number: _____

Group#: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Customer Service Phone: _____

Secondary Insurance:

Insurance Company: _____

Policy Number: _____

Group #: _____

Subscriber Name: _____

Subscriber Date of Birth: _____

Customer Service Phone: _____

Provider Phone: _____

Emergency Contact:

First Name: _____ Last Name: _____

Relation to you: _____

Phone Number: _____

"I hereby authorize University of Kentucky Weight Loss Center - Bariatric Surgery to discuss my process, diagnostic test results and any scheduled appointments with the following named individual[s]":

Name: _____

Relation to you: _____

Name: _____

Relation to you: _____

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(Patient Label Here)

Primary Care Physician:

First name:_____ Last Name:_____

Street Address: _____

City: _____ State:_____ Zip Code: _____

Have you discussed Weight Loss Surgery with your physician? q Yes q No

Is your physician supportive? q Yes q No

How did you hear about us? q Radio q T q Newspap q Family/Frien

q Intern q Social Media q Other (Please List):_____

Medical History/Review of symptoms: (check all that apply)

General: q **NONE**

q Fevers
q Night Sweats
q Appetite Change
q Weight Gain
q Insomnia
q Other: _____
q Tired / No Energy
q Hair Loss

Head and Neck: q **NONE**

q Wear contacts / glasses
q Sinus Drainage
q Dentures, Partial / Full
q Regular Ear Infections
q Other:_____
q Vision Problems
q Nose Bleeds
q Allergies
q Blurred / Double Vision
q Hearing Problems
q Hoarseness
q Glaucoma

Cardiovascular: q **NONE**

q Heart Attack
q Congestive Heart Failure
q Varicose Veins
q Ankle / Leg Ulcers
q Clogged Heart Arteries
q Rapid Heartbeat
q Irregular Heartbeat
q Heart Murmur
q Atrial Fibrillation
q Chest Pain w/ Activity
q High Blood Pressure
q Dyspnea on Exertion
q Elevated Triglycerides
q Rheumatic Fever / Valve Damage / MVP
q Cramping in legs when walking
q Elevated Cholesterol
q Other: _____
q Rhythm Changes
q Palpitations
q Ankle Swelling
q Phlebitis / DVT

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(Patient Label Here)

Respiratory: q **NONE**

q Asthma
q Emphysema / COPD
q Bronchitis
q Pneumonia
q Chronic Cough
q Shortness of Breath at Rest
q Use of Cpap / Bipap
q Use of Oxygen
q Snoring
q Pulmonary Embolism
q Sleep Apnea
q Other
q Other: _____

Endocrine q **NONE**

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

Gastrointestinal: q **NONE**

q Heartburn
q Hiatal Hernia
q Ulcers
q Diarrhea
q Blood in Stool
q History of Elevated Liver Enzymes
q Constipation
q IBS
q Umbilical Hernia
q Difficulty Swallowing
q Hemorrhoids
q Fissure / Polyps
q Rectal Bleeding
q Black, Tarry Stool
q Ventral Hernia
q Abdominal Pain
q Enlarged Liver
q Cirrhosis / Hepatitis
q Gallbladder Problems
q Jaundice
q Pancreatic Disease
q Nausea / Vomiting
q GERD
q Incisional Hernia
q Barrett's Esophagus
q Other: _____

Bladder / Kidney q **NONE**

q Kidney Stones
q Blood in Urine
q Prostate Problems
q Kidney Failure / Renal Insufficiency
q Leaking Urine with cough/laugh/sneeze
q Men: PSA test in last year? _____
q Urinary Urgency / Frequency
q Trouble Starting Urine
q Burning / Pain on Urination
q Overall Loss of Bladder Control
q Other: _____

Gynecologic: (women only) q **NONE**

q Problems Conceiving / Infertility
q Currently Pregnant
q Uterine / Ovarian Cancer
q Polycystic Ovary Syndrome (PCOS)
q Menstrual Irregularity
q Menstrual Pain
q Plan to have more children
q Post Menopausal
q Excessively Heavy Periods

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(Patient Label Here)

Breast: q **NONE**

q Pain q Lumps / Fibrocystic Disease q Cancer

q Other: _____

Musculoskeletal: q **NONE**

q Shoulder Pain q Neck Pain q Elbow Pain

q Hip Pain q Wrist Pain q Back Pain

q Foot Pain q Knee Pain q Ankle Pain

q Plantar Fasciitis q Heel Pain q Ball of Foot Pain

q Broken Bones q Carpal Tunnel Syndrome q Lupus

q Muscle Pain / Spasm q Sciatica q Rheumatoid Arthritis

q Fibromyalgia q Other: _____

Neurological: q **NONE**

q Balance Disturbance q Dizziness q Restless Leg Syndrome

q Stroke q Seizures or convulsions q Weakness

q Knocked Unconscious q Numbness / Tingling q Multiple Sclerosis

q Pseudotumor Cerebri (loss of vision from high pressure in brain)

q Other: _____

Psychiatric: q **NONE**

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

q Depression q Anxiety

q Bipolar Disorder ("manic-depression") q Seen a Psychiatrist or Counselor

q Alcoholism / Substance Abuse q Been hospitalized for psychiatric problems

q Been in a chemical dependency program q Attempted Suicide

q Currently taking medicines for psychiatric problems or for depression

q Attention Deficit Disorder

q Victim of Mental / Emotional / Sexual / Physical Abuse

q Other: _____

Blood / Lymphatic: q **NONE**

q Low Platelets (thrombocytopenia) q Anemia q HIV / AIDS

q Bruise Easily q Blood Thinning Medicine Use

q Swollen Lymph Nodes q Other: _____

q Bleeding / Clotting Disorder

q History of DVT / PE

q Prior Blood Transfusion

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(Patient Label Here)

Skin: q **NONE**

q Frequent Skin Infections q Keloids (Excessively Raised Scars) q Rosacea

q Psoriasis q Rashes Under Breasts / Skin Folds

q Hair or Nail Changes q Other _____

Family Medical History: (Check all that apply)

Disease	Mother	Father	Siblings (specify brother or sister)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Morbid Obesity							
Diabetes (add age it started)							
High Blood Pressure							
Stroke (add age it happened)							
Heart Attack (add age it happened)							
Cardiovascular Disease							
Sleep Apnea							
Cancer (add type and age it happened)							
Death (add age and cause)							
If Still Living, What Age							

Social History:

Do you smoke now? q Yes q No If yes, how many packs per day? _____

Have you smoked in the past? q Yes q No If you have quit, how many years since? _____

For how many years did you use tobacco? _____ Years

Do you use snuff or chew? q Yes q No If yes, how often do you use? _____

Do you consume alcohol now? q Yes q No

If yes, how many times per week? _____ If yes, how many drinks each time? _____

For how many years do/did you drink alcohol? _____ Years

Is anyone concerned about the amount you drink? q Yes q No If you have quit, how many years since? _____

Do you use street drugs now? q Yes q No If yes, what drugs? _____

If yes, how often do you use these drugs? _____ If you have quit, how many years since? _____

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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. q (If Jehovah's Witness, please check box.)

Patient Signature: _____ Date: _____

Allergies: q NONE

q Latex, Reaction: _____

q Tape (adhesives), Reaction: _____

q Iodine, Reaction: _____

q IV Contrast Dye, Reaction: _____

Medicines: (List any medicines you are allergic to and your reaction): _____

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

List Prescribed Medicines	Taken for What Condition	Dosage / How Often

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Surgical Procedure(s): q **NONE**

If yes, please list year:

Gallbladder: q Open q Laparoscopic _____
Appendectomy: q Open q Laparoscopic _____
Tonsillectomy: _____
Mouth Surgery: _____
Hysterectomy: q Total q Partial _____
Heart: q Coronary Artery Bypass Graft (CABG) q Stents q Valve _____
Hernia: q Hiatal q Abdominal _____
Pacemaker: _____
Tubal Ligation: _____
Back: _____
Cesarean Section: _____
Knee: q Right q Left _____
Colonoscopy: _____
Endoscopy: _____
Kidney Surgery: _____
Nissen Fundoplication: _____
Other: _____

Previous Weight Loss Surgery (WLS): _____
(We will need a copy of the Operation Report from your previous weight loss surgery)

List any complications of WLS: _____

_____

_____

Original Weight Prior to Surgery: _____ q Actual q Estimated

Lowest Weight Achieved: _____ q Actual q Estimated

Anesthesia Problems: Please tell us about any problems you have had with anesthesia:

q **NONE**

q Nausea
q Vomiting
q Difficulty Waking Up
q Difficulty Urinating
q Heart Stopped
q Stopped Breathing
q Woke Up During Procedure
q Other: _____

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(Patient Label Here)

Weight Loss History

How long have you been overweight? _____Years. How long have you been 35 pounds overweight? _____Years
How long have you been 100 pounds or more overweight? _____Years. When did you start dieting? _____Age

Have you ever had a "stomach stapling" or other gastric restriction procedure? q Yes q No

(If yes, please provide this information when entering in your previous surgical history.)

What is the most weight you have ever lost on a single diet? _____lbs. How did you lose the weight? _____

_____

What is your maximum lifetime weight? _____

How long did you sustain the weight loss? _____

q No diet attempts of any kind

Check all that apply:

Unsupervised Diet Attempts: q **NONE**

q Body for Life/Bill Phillips q High Protein q Low Fat q Cabbage Soup q Pritikin q Stillman Diet
q Mayo Clinic q Fasting q Gloria Marshall q Herbal Life q Calorie Counting q Scarsdale
q Richard Simmons q Sugar Busters q Adkin's Diet q Slim Fast q Health Spa q Low Carbohydrate
q South Beach q Other: _____

Supervised Diet Attempts: q **NONE**

q Nutri-System q Overeaters Anonymous q Weight Watchers q Jenny Craig q TOPS q Optifast
q HMR q DASH q LA Weight Loss q Diet Center q Other: _____

Over-the-Counter or Prescribed Medicines for Weight Loss: q **NONE**

q Acutrim q Dexatrim q Ionamin/Adipex q Phendiet q Prozac q Wellbutrin q Amphetamines
q Didrex q Tenuate q Phentrol q Qsymia q Saxenda q Contrave q Belviq
q Other: _____

NOTE: Interpretive services **must** be offered for preferred languages other than English.

_____ _____
Patient Signature Date

_____ _____
Reviewed By Date / Time

_____
Interpreter Name or ID# In person or via Cyracom