



# Maimonides

MEDICAL CENTER

Bariatric Surgery Program – Intake and Enrollment Form

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## DIET HISTORY

Your diet history must include at least one significant effort every year for the past five years.

Please review your efforts with your supervising physician and document the year, amount of time, and weight lost and gained. All efforts are relevant, even those with minimal, or no weight lost.

Inpatient treatment, Jenny Craig, Nutri-System, Weight Watchers, Over the Counter Diet Pills, Optifast, Medifast, Diet Shots, T.O.P.S., Overeaters Anonymous, Fit America, L.A. Weight Loss, Diet Center, Herbalife, Metablife, Dr. Atkins, Calorie Counting, Nutritionist, Doctor prescribed pills, Xenical, Redux, Meridia, Phen-Fen, Gym/Trainer, Pritikin, Scarsdale, Richard Simmons, Dick Gregory, Susan Powter, 3 Day Heart Diet, Cabbage Soup, Vegetarian, Starvation, Liquid Protein, Accupuncture, Accupressure (balls behind the ears), Hypnosis, Diet Tea, etc.

NAME OF DIET	YEAR	LENGTH OF EFFORT	WEIGHT LOST	WEIGHT REGAINED
	This year			
	Last year			
	3 years ago			
	4 years ago			
	5 years ago			

Age at first diet: \_\_\_\_\_

Lowest weight in last five years \_\_\_\_\_ Highest weight in last five years \_\_\_\_\_

Have you worked with a nutritionist on weight issues? YES  NO

Have you been depressed due to weight issues? YES  NO

Have you consulted a mental health professional regarding weight related depression? YES  NO

**ALLERGIES:** YES  NO  Codeine, aspirin, penicillin, antibiotics? Seafood, eggs, iodine, nuts, milk?  
PLEASE DESCRIBE REACTION Latex? Tape?

### DENTAL

FALSE TEETH? YES  NO

PAINFUL TO CHEW? YES  NO

DIFFICULTY SWALLOWING? YES  NO

### ALCOHOL USE:

None

Socially

Daily – Amount \_\_\_\_\_

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OBESITY RELATED DISEASES

High Blood Pressure? YES  NO   
**Diabetes – Adult Onset?** YES  NO   
 Diabetes – Juvenile? YES  NO   
 Diabetes – with pregnancy? YES  NO   
 Diabetes-Borderline? Glucose Intolerance? YES  NO   
 Diabetic Neuropathy? YES  NO   
**Sleep Apnea?** YES  NO   
 Using CPAP or BiPAP? YES  NO   
**High Cholesterol? High Triglycerides?** YES  NO   
 Leakage of urine (laugh, cough, sneeze?) YES  NO   
 Gallbladder disease? YES  NO   
**Asthma?** YES  NO   
 Date of last ER visit due to Asthma:  
 Steroids in the last 2 years for Asthma? YES  NO   
 Gout? YES  NO

**Shortness of breath –severe?** YES  NO   
 Shortness of breath when climb stairs? YES  NO   
 Need assistance to ambulate? YES  NO   
 Cane, walker, wheelchair?  
 Frequent (more than 1X week) Heartburn, Reflux? YES  NO   
 Lower back pain? YES  NO   
 Pain/Arthritis – ankles/feet YES  NO   
 Pain/Arthritis – knees/hips YES  NO   
 Problems with circulation in legs? YES  NO   
 Severe Edema? YES  NO   
 Swollen Ankles/Feet? YES  NO   
 Severe varicose veins? YES  NO   
**Angina, Heart Attack, Palpitations?** YES  NO   
 Other heart conditions? YES  NO   
 Thyroid, adrenal, pituitary disease? YES  NO   
 Plantar Fasciitis? YES  NO

SLEEP ISSUES

SNORE? YES  NO   
 TROUBLE SLEEPING? YES  NO   
 AWAKEN FREQUENTLY? YES  NO   
 MORNING HEADACHES? YES  NO   
 HAS ANYONE EVER TOLD  
 YOU THAT YOU STOP  
 BREATHING IN YOUR SLEEP? YES  NO

DAYTIME DROWSINESS? YES  NO   
 SLEEP BETTER IN RECLINER THAN BED? YES  NO   
 DO YOU HAVE SLEEP APNEA? YES  NO   
 DO YOU USE A CPAP OR BIPAP? YES  NO

**SMOKE CIGARETTES OR CIGARS?** YES  NO

Have you ever smoked? YES  NO   
If so, when did you quit?

**ALL PATIENTS WHO SMOKE MUST QUIT AT LEAST 6 WEEKS PRIOR TO SURGERY.**  
**SIGN BELOW IF YOU UNDERSTAND THIS REQUIREMENT AND ARE WILLING TO COMPLY.**  
 Patients who do not quit understand that their surgery may be canceled or delayed.

Patient Signature:

Date:

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**YOUR PAST MEDICAL HISTORY**

Cancer? YES  NO   
 Tumors? YES  NO   
 Location:

Have you ever been evaluated by a cardiologist (heart doctor)?

Epilepsy/Seizures? YES  NO   
 Stroke? YES  NO   
 Tuberculosis? YES  NO   
 Pneumonia? Chronic Bronchitis? YES  NO   
 Severe Bladder/Kidney infections? YES  NO   
 Blood transfusions? YES  NO   
 Gastrointestinal ulcers? YES  NO   
 Difficulty Urinating? YES  NO   
 Frequent Urination? YES  NO   
 Frequent Diarrhea? YES  NO   
 Frequent Constipation? YES  NO   
 Use Laxatives Regularly? YES  NO   
 Bloody Stools? YES  NO   
 Colitis/Irritable bowel? YES  NO   
 Lupus? YES  NO   
 Bulimia – Excessive Vomiting? YES  NO   
 Rash/Dermatitis? YES  NO

Hepatitis? Cirrohsis? Liver disease? YES  NO   
 Kidney stones YES  NO   
 AIDS/HIV YES  NO   
 Bleeding abnormality YES  NO   
 Anemia YES  NO   
 Mumps? Measles? YES  NO   
 Rheumatic fever? YES  NO   
 Hemorrhoids? YES  NO   
 Abdominal Pain? YES  NO   
 Frequent Nausea? YES  NO   
 Frequent Leg Cramps? YES  NO   
 Depression? YES  NO   
 Other psychiatric diagnosis? YES  NO   
 Drug or alcohol addiction? YES  NO   
 Hospitalized for psychiatric diagnosis? YES  NO   
 Sexual Dysfunction? YES  NO   
 Hernia? YES  NO

**SURGERY**

Please list all previous surgeries and hospitalizations:

PROCEDURE/DIAGNOSIS	DATE	HOSPITAL/LOCATION

**PAST SURGICAL COMPLICATIONS**

PLEASE EXPLAIN:

Difficulty with anesthesia? YES  NO   
 Difficulty healing? YES  NO   
 Pneumonia? YES  NO   
 Embolism? YES  NO

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**WOMEN ONLY**

Abnormal Menstrual Cycle? YES  NO   
 Painful Menstrual Cycles? YES  NO   
 Excessive/Heavy Menstrual Bleeding? YES  NO   
 Birth Control Pills to manage cycle? YES  NO   
 Have you had difficulty getting pregnant? YES  NO   
 Are you using birthcontrol? YES  NO   
 Have you had hot flashes? YES  NO   
 Are you taking hormone replacement? YES  NO   
 Skin depressions on shoulders from bra straps? YES  NO   
 Shoulder pain or neck pain? YES  NO   
 Neck pain? YES  NO   
 Difficulty finding undergarments? YES  NO

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**FAMILY HISTORY (Mother/Father/Siblings/Grandparents)**

- |  |  |
|--|--|
| <input type="checkbox"/> Obesity             | <input type="checkbox"/> High Cholesterol                |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Lung disease, Asthma, Emphysema |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney disease                  |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Bleeding disorder               |
| <input type="checkbox"/> Cancer              |  |
- Type: \_\_\_\_\_

**PERSONAL PHYSICIANS**

Please list all the physicians under whom you receive medical care:

	Name	Address	Telephone
Psychologist			
Psychiatrist			
Gynecologist			
Cardiologist			
Pulmonologist			
Endocrinologist			
Gastroenterologist			
OTHER			

<b>Please list all the medications which you currently use:</b>	<b>DOSE AND FREQUENCY</b>
Are you now or have you ever taken blood thinners?	YES – NOW <input type="checkbox"/> YES – IN PAST <input type="checkbox"/> NO <input type="checkbox"/>

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Patient Name: \_\_\_\_\_

**NUTRITION EVALUATION**

Date: \_\_\_\_\_

Do you have a schedule for meals?	YES NO	Do you cook at home?	YES NO
Do you graze throughout the day?	YES NO	Do you eat out frequently?	YES NO
Are you an emotional eater?	YES NO	Do you wait until you are too hungry and then eat whatever is around?	YES NO
History of binge eating?	YES NO		
History of purging?	YES NO	Night eater?	YES NO
Sweet eater?	YES NO	Rapid eater?	YES NO

**Please indicate which foods you consume three times in an average week:**

- |                         |                                    |                          |
|-------------------------|------------------------------------|--------------------------|
| Soda/Soft drinks        | French Fries                       | Ice Cream                |
| Chips/Crackers/Pretzels | Cookies/Cake                       | Pasta                    |
| Chicken                 | Hamburger                          | Seafood                  |
| Steak                   | Fruit juices                       | Fast Food – specify:     |
| Alcoholic Beverages     | Chocolate                          |                          |
| Milk                    | Coffee                             | Salad                    |
| Yogurt                  | Cheese                             | Fruits and/or Vegetables |
| Pizza                   | Bread (toast, sandwiches, muffins) |                          |

What food do you have the most trouble "giving up?" \_\_\_\_\_

What is your "comfort" food? \_\_\_\_\_

How much water do you drink a day? \_\_\_\_\_

How much coffee/tea do you drink a day? \_\_\_\_\_

How much soda (diet or regular?) do you drink a day? \_\_\_\_\_

How many ounces of alcoholic beverages do you drink a day? \_\_\_\_\_  
 (Circle all that apply) Beer? Wine? Mixed Drinks?

Do you take vitamins, minerals or herbs? YES NO \_\_\_\_\_

**EXERCISE**

Have you exercised regularly in the past? YES  NO

How often do you exercise presently? \_\_\_\_\_times/week \_\_\_\_\_min/session

Are you limited during exercise by shortness of breath, dizziness, or chest discomfort? YES  NO

Are you limited during exercise by joint pain, swelling, muscle pain, back pain? YES  NO



# Maimonides

**MEDICAL CENTER**

**BARIATRIC SURGERY PROGRAM**

Jerzy Macura, MD

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## FOLLOW-UP REQUIREMENTS

1. Bariatric Surgery requires a serious and life-long commitment to self-care, and follow-up by medical professionals.
2. Bariatric Surgery is only recommended for patients who are at risk for serious medical complications due to clinically severe obesity.
3. Bariatric Surgery is not a cosmetic procedure.
4. Bariatric Surgery is an elective procedure.
5. All patients must comply with a significant number of medical, nutritional, and psychological requirements.
6. All patients undergoing Bariatric Surgery must agree to participate in ongoing follow-up care, including referrals to other specialists.
7. Blood levels for all patients, before and after surgery, should be forwarded to the Bariatric Surgery Program.
8. Patients not compliant with nutrition and vitamin guidelines as recommended by the Bariatric Surgery Program are at risk of serious metabolic disorders and nutritional deficits.
9. Patients who are continually non-compliant (three documented incidents) with follow-up requirements will receive a written warning. Further non-compliance will result in discharge from the Bariatric Surgery Program.

I have read the above and understand my obligations in this matter.

I understand this form will be kept in my permanent file.

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Patient Signature

Date

