Bariatrics

Lovelace Medical Group

Today's Date _____

First Name _____ **Middle Initial** _____ **Last Name** _____

Date of Birth _____ **Gender:** ☐Male ☐Female ☐Non-Binary

MEDICAL HISTORY: (Check any condition that applies to you)

- ☐ Acid Reflux/Heartburn
- ☐ Allergy to Medicine/Anesthesia
- ☐ Anemia/Iron Deficiency
- ☐ Arthritis/Back Pain
- ☐ Asthma
- ☐ Cancer
- ☐ Chest Pain
- ☐ Bleeding Disorder
- ☐ Blood clots
- ☐ Cirrhosis
- ☐ High Blood Pressure
- ☐ Heart Attack/Failure or Disease
- ☐ Home Oxygen use
- ☐ COPD
- ☐ Diabetes
- ☐ Difficulty Swallowing
- ☐ Gallbladder Disorder
- ☐ GI Ulcer
- ☐ High Cholesterol
- ☐ Irritable Bowel Syndrome
- ☐ Malignant Hyperthermia
- ☐ Osteoarthritis
- ☐ Polycystic Ovarian Syndrome
- ☐ Pseudotumor Cerebri
- ☐ Psychological Disorder (PTSD, Anxiety, Depression, etc)
- ☐ Shortness of Breath/on Exertion
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Swelling in Legs
- ☐ Thyroid Disorder
- ☐ Vitamin D Deficiency
- ☐ Other:_____

SURGICAL HISTORY: (Check any that applies to you)

- ☐ Appendectomy
- ☐ Bariatric Surgery
  - o Duodenal Switch
  - o Gastric Bypass
  - o Lap Band
  - o Sleeve Gastrectomy
- ☐ Cardio Defibrillator/Pacemaker
- ☐ Colon or Intestine Surgery
- ☐ C-section
- ☐ Gallbladder Removal
- ☐ Heart Surgery
- ☐ Hernia Repair
- ☐ Hysterectomy
- ☐ Joint Replacement
- ☐ Plastic Surgery
- ☐ Spine Surgery
- ☐ Other:_____

Mobility status: ☐ Poor ☐ Fair ☐ Good **Are you disabled?** ☐ Yes ☐ No

Reason Disabled: ☐ Motor Vehicle Accident ☐ Illness ☐ Work-related injury ☐ Other _____

Assistive Device(s): ☐ Cane ☐ Crutches ☐ Walker ☐ Sling ☐ Wheelchair ☐ Power Scooter | Years in assistive device(s) ____

Colon Cancer screening: ☐ Yes ☐ No Date of last screening: _____

Mammogram: ☐ Yes ☐ No Date of last mammogram: _____

SOCIAL HISTORY:

Alcohol/Drug Use:

Do you use alcohol? ☐ Yes ☐ No | How many drinks per week? Glasses of Wine ____ Cans of Beer ____ Shots of Liquor ____

Comments on alcohol use: _____

Have you used drugs for non-medicinal purposes? ☐ Yes ☐ No If yes, how many times per week?

Marijuana _____ Cocaine _____ Inhalants _____ Methamphetamine _____ IV ___ Other _____

Date last used _____ Comments on drug use: _____

Nicotine Use:

Former smoker? ☐ Yes ☐ No If so, what date did you quit? _____

Current smoker? ☐ Yes ☐ No How much/how long? _____

Chewing Tobacco/Snuff? ☐ Yes ☐ No Vape? ☐ Yes ☐ No

Are you currently pregnant? ☐ Yes ☐ No Are you on birth control? ☐ Yes ☐ No

Do you plan to become pregnant in the next two years? ☐ Yes ☐ No

Currently Employed? ☐ Yes ☐ No Company Name _____

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BARIATRIC SLEEP ASSESSMENT

Please estimate your risk of falling asleep in the following situations, using this scale:

0 = No chance 1 = Slight chance 2 = Moderate chance 3 = High chance

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting or inactive in a public place (theater or meeting)	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
Sitting in a car while stopped in traffic	
Sitting in a car for an hour without a break	
TOTAL	

Have you made previous weight loss attempts, including prescribed medication? ☐ Yes ☐ No

What medicines have you tried: _____

What type of weight loss surgery are you interested in?

☐ Unsure
☐ Duodenal Switch
☐ Gastric Bypass (RNY, Roux-N-Y)
☐ Sleeve Gastrectomy (Sleeve)
☐ Medical Weight Loss
☐ Revision Surgery
- What type of Bariatric surgery did you have previously? _____
- When was your previous surgery? _____
- Where was your previous surgery performed? _____
- Reason for seeking a revision: _____

RISK ASSESSMENT FOR BARIATRIC SURGERY		
Gender	M (1)	F (0)
Are you 60 years or older?	Yes (1)	No (0)
Is your BMI at least 50?	Yes (1)	No (0)
Have you ever had DVT or Pulmonary Embolism	Yes (3)	No (0)
Do you have a diagnosed clotting disorder? (Factor V Leiden, Factor II Mutation, etc)	Yes (3)	No (0)
Do you have severe venous insufficiency? (Blood flow problems in your legs, where skin is purple-brown or has ulcers?)	Yes (2)	No (0)
Have you been diagnosed with Congestive Heart Failure?	Yes (3)	No (0)
Do you have difficulty breathing, even while resting?	Yes (2)	No (0)
Are you paralyzed?	Yes (2)	No (0)
TOTAL		

Score of 3 – 4: 2-week course of Lovenox 40mg BID
Score of 5 or higher: 4-week course of Lovenox 40mg BID