

MR #

DOB



**BASSETT MEDICAL CENTER**  
Cooperstown, NY 13326-1394

NAME

**BARIATRIC SURGERY**  
**CANDIDATE INFORMATION PACKET**

H-2927 3/08;12/13;10/15 (d:\forms\hosp\ofm)

DATE

**PLEASE PRINT CLEARLY**

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PHONE:

Cell: \_\_\_\_\_  Home: \_\_\_\_\_  Work: \_\_\_\_\_

INDICATE PREFERRED CONTACT NUMBER BY CHECKING BOX.

PRIMARY CARE PROVIDER: \_\_\_\_\_

Phone number of provider: \_\_\_\_\_

Address: \_\_\_\_\_

MENTAL HEALTH PROVIDER: \_\_\_\_\_

Phone number of provider: \_\_\_\_\_

Address: \_\_\_\_\_

**INSURANCE INFORMATION**

NAME OF COMPANY: \_\_\_\_\_

INSURANCE ID #: \_\_\_\_\_

**For Office Use Only**

NPO: \_\_\_\_\_ Initial appointment: \_\_\_\_\_

PHQ-9: \_\_\_\_\_ Provider: \_\_\_\_\_

Moorehead Score: \_\_\_\_\_ Epworth Score: \_\_\_\_\_

Smoker: \_\_\_\_\_

PATIENT SELF HISTORY

MR #

DOB



**BASSETT MEDICAL CENTER**  
Cooperstown, NY 13326-1394

NAME

**BARIATRIC SURGERY  
CANDIDATE INFORMATION PACKET  
NEW PATIENT HISTORY FORM**

H-2927-A 3/08;6/13;10/15;10/18 (d:\forms\hosp\ofm)

DATE

**PLEASE PRINT CLEARLY**

**You must answer all sections**

Name of person completing form: \_\_\_\_\_

Name of person seeking evaluation: \_\_\_\_\_

Highest Level of Education: \_\_\_\_\_

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

Weight at puberty: *(check one)*

- skinny       normal       chubby

Current Height & Weight: \_\_\_\_\_ BMI **(from table included in packet)**: \_\_\_\_\_

Do you consider yourself a "Binge Eater" *(eat to the point of severe discomfort followed by severe guilt 2 or more times a week)*

- Yes       No

Describe typical episode: \_\_\_\_\_  
\_\_\_\_\_

**Pregnancies:** Have you ever gained weight during pregnancy that you did not loose after giving birth?  Yes     No

What eating behavior best describe you? *(check one)*

- I eat to relieve stress
- I eat to comfort myself
- I eat to reward myself
- I come from a culture of eating
- Other *(please describe)* \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have you ever used the following methods for weight loss?

*(check all that apply and provide dates - describe)*

- Vomiting \_\_\_\_\_       Water Pills \_\_\_\_\_       Ipecac \_\_\_\_\_
- Laxatives \_\_\_\_\_       Excessive Exercising \_\_\_\_\_

**Date of birth** \_\_\_\_\_

### **Most Recent 5 year Diet History**

We will need a detailed history from you if you expect this surgery will be covered by your insurance company.

**At least a five-year history of dieting is required by most insurances.**

**YOU MUST COMPLETE THIS FORM WITH SPECIFIC DETAILS REQUESTED**

**For the last 5 years, counting back from the current year, please list what you have done to lose weight.** Please include: Type of Diet, Dates and Amount of weight loss, and if regained pounds, number of pounds regained and how long after stopping the diet.

*Example: Year 2017: I joined Weight Watchers for 3 months and lost 12 pounds but regained 10 when I went off the program.*

*Example: Year 2016: Joined a gym for 6 months, lost 12 pounds but put it back on when I stopped going to the gym.*

*Example: Year 2015: I took over the counter diet pills for 6 months and lost about 18 pounds. When I stopped the pills, I gained all of it back.*

*Example: Year 2014: I stopped drinking soda & I ate smaller portions. Lost 18 pounds but I gained back 15 pounds since I started drinking soda again.*

**Year** \_\_\_\_\_

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**Year** \_\_\_\_\_

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**Year** \_\_\_\_\_

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**Year** \_\_\_\_\_

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**Year** \_\_\_\_\_

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**EPWORTH SLEEPINESS SCALE**

What is the chance you will doze off in the following situations? *(Check one that best describes you)*

**Sitting and reading**

- 0 No chance of dozing       1 Slight chance of dozing       2 Moderate chance of dozing  
 3 High chance of dozing

**Watching TV**

- 0 No chance of dozing       1 Slight chance of dozing       2 Moderate chance of dozing  
 3 High chance of dozing

**Sitting inactive in a public place, such as a theater or meeting**

- 0 No chance of dozing       1 Slight chance of dozing       2 Moderate chance of dozing  
 3 High chance of dozing

**As a passenger in a car for an hour without a break**

- 0 No chance of dozing       1 Slight chance of dozing       2 Moderate chance of dozing  
 3 High chance of dozing

**Lying down to rest in the afternoon when circumstances permit**

- 0 No chance of dozing       1 Slight chance of dozing       2 Moderate chance of dozing  
 3 High chance of dozing

**Sitting and talking to someone**

- 0 No chance of dozing       1 Slight chance of dozing       2 Moderate chance of dozing  
 3 High chance of dozing

**Sitting quietly after lunch without alcohol**

- 0 No chance of dozing       1 Slight chance of dozing       2 Moderate chance of dozing  
 3 High chance of dozing

**In a car, while stopped for a few minutes in traffic**

- 0 No chance of dozing       1 Slight chance of dozing       2 Moderate chance of dozing  
 3 High chance of dozing

Sum: \_\_\_\_\_

**MEDICAL HISTORY**

Please indicate whether you have any of the following health problems: *(please check yes or no)*

- |  |  |                             |  |                      |  |
|--|--|-----------------------------|--|----------------------|--|
| Stroke                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Seizure Disorder                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gastroesophageal            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gallbladder Disease  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Unconsciousness                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Reflux Disease              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anxiety                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heartburn                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Depression                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other Mental Illness                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sleep Apnea                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Disorder       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Deep vein thrombosis                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Stones        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pulmonary Embolism<br>(blood clot)       | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pneumonia                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diverticulitis              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis/ Gout      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Enlarged Heart              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Infertility          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Congestive<br>Heart Failure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Abnormal Menses      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chronic obstructive<br>pulmonary disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Urinary Incontinence | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|  |  | Heart Valve Disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No |                      |  |

**CURRENT LIST OF MEDICATIONS** (use separate sheet of paper if needed)

Name	Dose	Frequency

**ALLERGIES**

Name	Reaction

**PREVIOUS SURGERIES**

Date	Name of Surgery

**SOCIAL HISTORY**

Marital Status:  Single  Married  Separated  Divorced  Widowed

Current Living Arrangements:  Alone  Spouse/Significant other  Friend  Parent/Other Family member  
 School aged children

What is your occupation? \_\_\_\_\_

Do you enjoy your work? \_\_\_\_\_

Recreational activities/hobbies? \_\_\_\_\_

Have you ever been physically or sexually abused? \_\_\_\_\_

Do you exercise?  Yes  No If so, what type: \_\_\_\_\_

Number of times per week: \_\_\_\_\_ How long: \_\_\_\_\_

Do you use tobacco?  Yes  No  Never type: \_\_\_\_\_ amt/years: \_\_\_\_\_ Quit/when: \_\_\_\_\_

Do you use alcohol?  Yes  No  Never type: \_\_\_\_\_ amt/years: \_\_\_\_\_ Quit/when: \_\_\_\_\_

Do you use drugs?  Yes  No  Never type: \_\_\_\_\_ amt/years: \_\_\_\_\_ Quit/when: \_\_\_\_\_

Do you use caffeine?

Coffee/Tea  Yes  No  Never type: \_\_\_\_\_ amt/years: \_\_\_\_\_ Quit/when: \_\_\_\_\_

Soda  Yes  No  Never type: \_\_\_\_\_ amt/years: \_\_\_\_\_ Quit/when: \_\_\_\_\_

Chocolate  Yes  No  Never type: \_\_\_\_\_ amt/years: \_\_\_\_\_ Quit/when: \_\_\_\_\_

PATIENT SELF HISTORY

**FAMILY HISTORY SHEET**

Place a check in the boxes that apply to your family history.

	Mother	Father	Siblings # _____	Children # _____	Maternal Grand- mother	Maternal Grand- father	Paternal Grand- mother	Paternal Grand- father	Spouse
Height									
Maximum Weight									
Minimum Weight									
State of health if living/age									
Cause of death/age									

Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elevated BP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DVT/PE (blood clot)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical/ Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any questions or issues you would like to discuss with the health care provider regarding family history?

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**BARIATRIC SURGERY  
CANDIDATE INFORMATION PACKET  
PATIENT HEALTH QUESTIONNAIRE – 9**

H-2927-D 3/08;12/13 (d:\forms\hosp\).doc

DATE

**Over the last two weeks, how often have you been bothered by any of the following problems?**  
(Use ✓ to indicate your answer.)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3

For Office Coding      0 + \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_  
= Total Score \_\_\_\_\_

**If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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**BASSETT MEDICAL CENTER**  
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**BARIATRIC SURGERY**  
**CANDIDATE INFORMATION PACKET**

DATE

**QUALITY OF LIFE QUESTIONNAIRE**  
**SELF ESTEEM AND ACTIVITY LEVELS**

H-2927-E 4/08 (d:\forms\hosp\l.doc)

*Please make a check in the box provided to show your answer.*

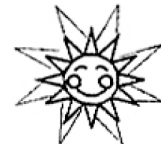
1. Usually I Feel . . .



Very Bad About  
Myself

Very Good About  
Myself

2. I Enjoy Physical Activities . . .



Not At All

Very Much

3. I Have Satisfactory Social Contacts . . .



None

Very Many

4. I Am Able To Work . . .



Not At All

Very Much

5. The Pleasure I Get Out Of Sex Is . . .



Not At All

Very Much

6. The Way I Approach Food Is . . .



I Live to Eat

I Eat to Live

PATIENT SELF HISTORY