Patient Information Profile

Lawrence Hospital Center

An affiliate of Columbia University College of Physicians and Surgeons

55 Palmer Avenue
Bronxville, New York 10708
914-787-4000

Please fill this profile out as carefully and accurately as possible. The information you provide us with will be used to determine your appropriateness for surgery. Some of this information may be used by your insurance company when making their determination of approval.

PATIENT INFORMATION

Date: _______________ Patient Name: ____

Address: ____ Apt. #: ________

City: ____ State: _________ Zip Code: ____________

Date of Birth: _________________ Age: _______ Social Security #: ________________________

Sex: M □ F □ Marital Status: □ Single □ Married □ Divorced □ Widowed

Home Phone #: (_______)_________________________ Cell #: (______)_____________________

E-Mail Address: ____

Occupation: ___________________________________ Bus. #:(______)_____________________

Employer: ____

Employer's Address: ____

Primary Physician: __________________________________ Phone #: (_____)________________

Address: ____

Primary Insurance: ______________________________ Phone #: (_____)__________________

ID #: ____ Group #: __________________________

Secondary Insurance: ___________________________ Phone #: (_____)__________________

ID #: ____ Group #: __________________________

CONTACT PERSONS:
This information is often vital to us if we need to contact you urgently.
Occasionally people move or have new phone numbers and do not let us know.

NEXT OF KIN
Name: _______________________________________ Relationship: _____________________

Address: ____

Home Phone #: ______________________________ Office #: __________________________

ADDITIONAL CONTACT
Name: _______________________________________ Relationship: ____________________

Address: ____

Home Phone #: _____________________________ Office #: __________________________

REFERRAL INFORMATION

Referring Doctor: ___________________________________ Date of Referral: _____________

Address: ____

____

Telephone #: ________________________________ Fax #: _____________________________

Specialist Physician: _________________________ Type of Specialist: ___________________

Address: ____

____

Telephone #: _______________________________ Fax #: ______________________________

Specialist Physician: _________________________ Type of Specialist: ___________________

Address: ____

____

Telephone #: _______________________________ Fax #: ______________________________

EMPLOYMENT

Current Employment:

Are you currently employed? ____

Are you full-time or part-time? ____

If you are unemployed, what is the reason? ____________________________________

Are you actively looking for work? ____

Has your weight made it difficult to find employment? ____________________________

If employed, please state what level of activity your job involves:

Little (sedentary job) ☐ Moderately active ☐ Very active (Labouring, etc.) ☐

SOCIAL PROFILE

FAMILY STRUCTURE:

Married:	☐	Single:	☐
Divorced:	☐	Partner/Relationship:	☐

Children/Ages: ____

____

____

Support persons/friends: ____

____

____

SMOKING HISTORY

☐ Never smoked

☐ Current → Age started regularly:_____
Average packs/day:_______

☐ Former → Age started regularly:_____
Age quit:_____
Average packs/day:_______

Do you have a history of drug or alcohol abuse? Yes ☐ No ☐
If yes, when was the last time? ______________________________________

ALCOHOL CONSUMPTION

Do you drink any alcohol? Yes ☐ No ☐

How often do you have a drink containing alcohol?

Every Day ☐ Most days ☐ Most weeks ☐ Most months ☐ Rarely (once or twice a year) ☐

What is the main type of beverage you drink? Please **check one only**.

Beer ☐ Wine ☐ Liquor ☐

From the list below please **check** the **main** alcoholic beverage you drink and **circle** any other you would drink at times.

Beer ☐ Light Beer ☐ Red Wine ☐ White Wine ☐

Liquor (specify) ____

When do you usually drink? Please **check** the **main** one. **Circle** any others that are relevant.

Social occasions ☐ Parties ☐ With meals ☐ Before / after meals ☐ Weekend session/s ☐

If you indicated above that you drank everyday, most days or most weeks, please **check** how many standard drinks you would have in a typical week.

(1 standard drink = 1 small glass of wine, 1 glass of full strength beer or a 1 oz of liquor)

1-2 ☐ 3-10 ☐ 11-20 ☐ 21-40 ☐ 40+ ☐

ACTIVITY LEVEL

Do you exercise on a regular basis? Yes ☐ No ☐

How many times per week: 0-2 ☐ 3-5 ☐ 5 or more ☐

How many minutes each session ____

What type of exercise? ____

____

WEIGHT HISTORY

Please indicate your weight at the following times and whether you consider your weight was **below average, average, above average or very heavy** in the relevant boxes.

	Weight	Below Average	Average Weight	Above Average	Very Heavy
Birth Weight					
Weight at starting school (5-6 yrs)					
Weight at beginning of high school (10-12 yrs)					
Weight at end of high school (15-18 yrs)					
Weight at time of commencing work (21 yrs)					
Weight at time of marriage (if applicable)					

THE FOLLOWING MUST BE COMPLETED.
PLEASE FILL IN YOUR WEIGHT FOR THE PAST FIVE YEARS.

What was your weight? 1 year ago?	
2 years ago?	
3 years ago?	
4 years ago?	
5 years ago?	

List any particular events that led to significant weight gain (e.g. pregnancy, quit smoking):

____

____

DIETARY HABITS

Please check the appropriate boxes below:	Always	Sometimes	Never
Do you skip meals?			
Do you have sweet cravings?			
Do you eat large portion sizes?			
Do you eat out at restaurants or get take out?			
Do you snack?			
Do you eat foods too high in fat?			
Do you tend to eat more when you are stressed, angry, depressed, bored, etc.?			
Do you eat large amounts of food until you are uncomfortably full?			
Do you ever vomit after eating too much?			
Do you eat alone out of embarrassment?			
Do you have feelings of disgust, depression or guilt after over eating?			

How many meals do you generally eat each day?____________________________________

How many times per day do you generally eat sweets? ______________________________

How many caffeinated beverages do you drink per day?______________________________

How many sweetened beverages do you drink per day? ______________________________

WEIGHT LOSS HISTORY

	Program	Date Started	Weight At Start	Months On Diet	Weight at End	Lbs. Lost	Time Until Regained
	South Beach Diet						
	Weight Watchers						
	Jenny Craig						
	LA Weight Loss						
	Nutri-System						
	Cambridge Diet						
	Atkins Diet						
	Very Low Calorie Diet						
	Liquid Diet ☐ Optifast ☐ Medifast ☐ Slimfast						
	Other Diet ☐ ___________________ ☐ ___________________ ☐ ___________________						
	Hypnosis						
	MD Supervised Program						
	Overeaters Anon						
	Weight Loss Clinic						
	Structured Exercise Program						
	Nutritional Counseling						
	Appetite Suppressants ☐ Phen/fen ☐ Redux ☐ Meridia ☐ Xenical ☐ Phentermine ☐ Amphetamines ☐ Fastin ☐ Attenuate ☐ Over-the-counter pills ☐ Herbal supplements						
	Surgery ☐ Liposuction ☐ Breast reduction ☐ Tummy tuck ☐ Lipectomy						

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following and if so, please indicate:

	PARENT	SIBLING/ CHILD	OTHER RELATIVES (cousins, aunts, grandparents etc)	NO FAMILY HISTORY	DON'T KNOW
Diabetes					
Heart Disease					
Hypertension					
Gout					
Gallstones					
Obesity					
Snoring / Sleep Apnea					
Asthma					
Allergies					
Hayfever					
Dermatitis / Eczema					
High Cholesterol					
Osteoporosis					
Hip fractures					

ALLERGIES (including foods, medications): Yes ☐ No ☐

If yes, please give details: ____

____

____

SURGICAL HISTORY

Please give details of any past operations:

Surgery	**Date**	**Reason**

PERSONAL MEDICAL HISTORY

Have you ever suffered with any of the following health problems:

Condition	Yes	No	Details
Diabetes	Yes ☐	No ☐	Details: ______________________
Hypoglycemia	Yes ☐	No ☐	Details: ______________________
High blood pressure	Yes ☐	No ☐	Details: ______________________
Heart attack	Yes ☐	No ☐	Details: ______________________
Angina	Yes ☐	No ☐	Details: ______________________
Congestive heart failure	Yes ☐	No ☐	Details: ______________________
Stroke	Yes ☐	No ☐	Details: ______________________
High cholesterol	Yes ☐	No ☐	Details: ______________________
Thyroid disease	Yes ☐	No ☐	Details: ______________________
Polycystic ovarian syndrome	Yes ☐	No ☐	Details: ______________________
Infertility	Yes ☐	No ☐	Details: ______________________
Asthma	Yes ☐	No ☐	Details: ______________________
Emphysema	Yes ☐	No ☐	Details: ______________________
Sleep apnea	Yes ☐	No ☐	Details: ______________________
Ulcer disease	Yes ☐	No ☐	Details: ______________________
Reflux disease	Yes ☐	No ☐	Details: ______________________
Hiatal hernia	Yes ☐	No ☐	Details: ______________________
Gallbladder disease	Yes ☐	No ☐	Details: ______________________
Hepatitis	Yes ☐	No ☐	Details: ______________________
HIV	Yes ☐	No ☐	Details: ______________________
Rheumatoid Arthritis	Yes ☐	No ☐	Details: ______________________
Osteoarthritis	Yes ☐	No ☐	Details: ______________________
Gout	Yes ☐	No ☐	Details: ______________________
Degenerative Disc Disease	Yes ☐	No ☐	Details: ______________________
Lupus	Yes ☐	No ☐	Details: ______________________
Cancer	Yes ☐	No ☐	Details: ______________________
Depression	Yes ☐	No ☐	Details: ______________________
Anxiety disorder	Yes ☐	No ☐	Details: ______________________
Bipolar disorder	Yes ☐	No ☐	Details: ______________________
Schizophrenia	Yes ☐	No ☐	Details: ______________________
Alcoholism	Yes ☐	No ☐	Details: ______________________
Venous insufficiency	Yes ☐	No ☐	Details: ______________________
Blood clot in leg or lungs	Yes ☐	No ☐	Details: ______________________

REVIEW OF SYSTEMS

Are you having any of the following symptoms?

Symptom	Yes	No	Details
Headaches	Yes ☐	No ☐	Details: ____________
Shortness of breath	Yes ☐	No ☐	Details: ____________
Cough	Yes ☐	No ☐	Details: ____________
Palpitations	Yes ☐	No ☐	Details: ____________
Chest pain	Yes ☐	No ☐	Details: ____________
Dizziness	Yes ☐	No ☐	Details: ____________
Fatigue	Yes ☐	No ☐	Details: ____________
Joint pain	Yes ☐	No ☐	Details: ____________
Muscle pain	Yes ☐	No ☐	Details: ____________
Anxiety	Yes ☐	No ☐	Details: ____________
Panic attacks	Yes ☐	No ☐	Details: ____________
Depression	Yes ☐	No ☐	Details: ____________
Difficulty sleeping	Yes ☐	No ☐	Details: ____________
Constipation	Yes ☐	No ☐	Details: ____________
Diarrhea	Yes ☐	No ☐	Details: ____________
Leakage of urine with cough/sneeze	Yes ☐	No ☐	Details: ____________
Indigestion	Yes ☐	No ☐	Details: ____________
Heartburn	Yes ☐	No ☐	Details: ____________
Vomiting	Yes ☐	No ☐	Details: ____________
Abdominal pain	Yes ☐	No ☐	Details: ____________
Blood in urine/stool	Yes ☐	No ☐	Details: ____________
Difficulty urinating	Yes ☐	No ☐	Details: ____________
Impotence	Yes ☐	No ☐	Details: ____________
Pain in legs	Yes ☐	No ☐	Details: ____________
Swelling in legs	Yes ☐	No ☐	Details: ____________
Varicose veins	Yes ☐	No ☐	Details: ____________
Snoring	Yes ☐	No ☐	Details: ____________
Excessive daytime sleepiness	Yes ☐	No ☐	Details: ____________
Falling asleep inappropriately	Yes ☐	No ☐	Details: ____________
Waking up at night because you cannot breathe	Yes ☐	No ☐	Details: ____________

MEDICATIONS

Please indicate whether you are now or have previously taken any of the following medications. If yes, please state the name of the medication and how long you have been or were taking it.

Medication for psychiatric disorder	Yes ☐	No ☐	Details: ___________________________
Migraine medication	Yes ☐	No ☐	Details: ___________________________
Medications for asthma or breathing	Yes ☐	No ☐	Details: ___________________________
Hormones	Yes ☐	No ☐	Details: ___________________________
"The Pill"	Yes ☐	No ☐	Details: ___________________________
Cortisone	Yes ☐	No ☐	Details: ___________________________
Estrogen Replacement	Yes ☐	No ☐	Details: ___________________________

Please list all medications that you are currently taking:

MEDICATION	***DOSAGE***	***FREQUENCY***

VITAMINS / SUPPLEMENTS

Do you take multivitamin tablets / or other herbal remedies dietary supplements?

Yes ☐ No ☐

Please name the multivitamin or other dietary supplements you usually take.

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

FOR WOMEN ONLY

Do you have regular periods (26-33 days) Yes ☐ No ☐
If not, please describe: ______________________________

____

Do you have problems with excessively heavy periods Yes ☐ No ☐
If Yes, please described ______________________________

____

Have you had difficulty in conceiving in the past? Yes ☐ No ☐

Do you currently have problems with infertility? Yes ☐ No ☐

Have you suffered from excess body hair or acne? Yes ☐ No ☐

Have you ever been told by a doctor that you have polycystic ovaries? Yes ☐ No ☐

Have you had problems with pregnancy and/or childbirth? Yes ☐ No ☐

If so, in what way ______________________________

____

Have you had a caesarean section? Yes ☐ No ☐
If so, why? ______________________________

When was your last PAP test? ______________________________

Was it normal Yes ☐ No ☐

Are you sexually active Yes ☐ No ☐

Do you use any form of birth control? Yes ☐ No ☐

If yes, which one(s) ______________________________

When was your last mammography ______________________________

Was it normal Yes ☐ No ☐

SLEEP HISTORY

Please place an **X** in the appropriate box.

	NEVER	**SOMETIMES**	**ALWAYS**
Do you snore?			
Do you wake during the night with a choking feeling?			
How often do you wake up more than once during the night?			
Do you have a headache when you wake up in the morning?			
Have you noticed a reduction in your sex drive?			
Do you feel sleepy during the day?			
Has anyone noticed that you momentarily stop breathing during the night?			
Do you wake up in the morning feeling confused?			
How often do you have a nap during the day?			
Do you feel sleepy in the evenings?			
Have you or anyone else noticed a change in your personality recently?			
How often do you doze off or fall asleep while driving?			

How likely are you to **doze off or fall asleep** in the following situation, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you.

Use the following table to choose the **most appropriate option** for each situation by placing an **X** the boxes below:

	(0) Never Doze	(1) Slight chance of dozing	(2) Moderate chance of dozing	(3) High chance of dozing
Sitting and reading				
Watching TV				
Sitting, inactive in a public place (e.g. a theatre or a meeting)				
As a passenger in 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 a lunch without alcohol				
In a car, while stopped for a few minutes in the traffic				

REFLUX / INDIGESTION

Do you have a history of heartburn or indigestion:

Yes ☐ No ☐ Details: ____

If yes, how often do you have reflux during the day?

Many times a day ☐ everyday ☐ most days ☐ most weeks ☐ occasionally ☐

Do you suffer from heartburn / indigestion during the night? If so how often?

Many times a day ☐ everyday ☐ most days ☐ most weeks ☐ occasionally ☐

What aggravates or causes your reflux? ____

Details: ____

Do you have difficulty swallowing?

Yes ☐ No ☐ Details: ____

Does food ever get stuck?

Yes ☐ No ☐ Details: ____

Does food or fluid reflux into the mouth?

Yes ☐ No ☐ Details: ____

Do you vomit with reflux?

Yes ☐ No ☐ Details: ____

Do you suffer from recurrent sore throats?

Yes ☐ No ☐ Details: ____

Do you suffer from a hoarse voice?

Yes ☐ No ☐ Details: ____

Do you suffer from a regular cough at night?

Yes ☐ No ☐ Details: ____

Please list any treatments you may use for reflux / heartburn or indigestion:

____

____

____

How did you learn about our program? (Check all that apply)

____ Newspaper advertisement

____ Televison/radio commercial

____ Talked with someone who had surgery Who? ________________________

____ Researched it through the internet.

____ Read books or articles about it

____ Discussed it with a health provider

____ Other ______________________________

Why do you want weight loss surgery?

____

____

____

____

Is your spouse / significant other supportive of your decision to have weight loss surgery?

Yes ☐ No ☐

Explain: ____

____

____

____

____

____