Geoffrey Wilcox, MD, FACS

HOPE BARIATRICS
Surgical treatment for weight loss

111 Hazel Lane Suite 100
Sewickley PA 15143
412.741.8862
fax 412.741.2553

HEALTH HISTORY QUESTIONNAIRE

Name _____ Insurance: _____

Date of birth _____ Age _____ Social Security #: _____

Today's date _____

Patient Address:

_____

Phone: home #: _____ work # _____

e-mail: _____

PRIMARY CARE or REFERRING PHYSICIAN:

Name: _____

Address: _____

Phone: _____ Fax: _____

WEIGHT LOSS HISTORY: Height _____ Current Weight _____ BMI _____
At what age did your weight become a problem? _____ What was your lowest adult weight? _____
What was your highest adult weight? _____ What is your desired or "goal" weight? _____

Please describe your age and situation (major life-stress, if any) at the onset of your weight problem:

_____

Approximate weight at:
20 yrs. ago: ____ 10 yrs. ago: ____ 5 yrs. ago: ____ 2 yrs. ago: ____ 1 yr. ago: ____ 6 months ago: ____

WEIGHT LOSS PROGRAMS and MEDICATIONS: Maximum weight lost on ANY program: _____ pounds
Check all programs you have participated in:

___ Weight Watchers	___ Jenny Craig	___ Atkins Diet	___ Bariatric Centers
___ Slim Fast	___ Nutri System	___ TOPS	___ Keto
___ Optifast	___ Medifast	___ Healthy Performance	___ Other
___ Metabolife	___ Diet Center	___ Meridia	

CHECK ALL DIET MEDICATION YOU'VE USED PAST & PRESENT:

___ Fen-Phen	___ Phentermine/Adipex	___ Qsymia	___ Belviq
___ Redux	___ Xenical	___ Other	

MEDICATIONS YOU ARE ALLERGIC TO AND /**REACTION:** (examples: rash, swelling, hives)

_____

_____

_____

Have you had any of the following obesity-related conditions?

YES	NO	
—	—	Blood clots (legs/lungs)
—	—	Bulimia/excessive vomiting
—	—	Daytime falling asleep
—	—	Depression
—	—	Diabetes Mellitus
—	—	GERD
—	—	Gout
—	—	Hernia
—	—	Heartburn/Esophagitis
—	—	Hiatal Hernia
—	—	High Blood Pressure
—	—	High Cholesterol
—	—	Pain/Arthritis in lower back
—	—	Pain/Arthritis in hips
—	—	Pain/Arthritis in knees
—	—	Pain/ Arthritis in ankles & feet
—	—	Shortness of breath
—	—	Rash/Dermatitis
—	—	Sleep Apnea Syndrome
—	—	Swollen Ankles/Feet

Please indicate if you had any of the following conditions at ANY time:

YES	NO	
—	—	Anemia
—	—	Angina
—	—	Asthma
—	—	Bladder/kidney infections
—	—	Blood transfusions
—	—	Cancer
—	—	Colitis/Irritable Bowel Syndrome
—	—	Easy bruising
—	—	Excessive/heavy breathing
—	—	Heart Attack
—	—	Heart Failure
—	—	Heart Murmur
—	—	Heavy drinking
—	—	Hepatitis
—	—	Kidney Stones
—	—	Liver disease
—	—	Lung disease/pneumonia
—	—	Rheumatic fever
—	—	Stroke
—	—	Thyroid trouble
—	—	Tumors
—	—	Ulcers

HEART& LUNGS

YES	NO	
—	—	Do you have chest pain with exercise?
—	—	Do you get short of breath often?
—	—	Do you get leg cramps when walking?
—	—	Do your feet get cold & numb?

HEAD & NECK

YES	NO	
—	—	Do you have migraine/severe headaches?
—	—	Do you have severe dizziness?

GI TRACT

YES	NO	
—	—	Are you troubled by frequent diarrhea?
—	—	Are you troubled by frequent constipation?

MEDICATIONS: Prescriptions and over the counter

Medication Name Dosage Time when taken

_____

_____

_____

_____

_____

_____

_____

VITAMINS / SUPPLEMENTS: _____

_____

SURGICAL HISTORY

Please list **all past surgeries** and hospitalizations:

PROCEDURE and DIAGNOSIS DATE HOSPITAL NAME / LOCATION

CONFIRMED MENTAL HEALTH DIAGNOSIS

__ None
__ Depression
__ Bipolar Disorder
__ Anxiety/panic disorder
__ Personality disorder
__ Eating disorder

ALCOHOL USE

__ None
__ Beer _____ 12 oz cans per week
__ Wine _____ 4 oz glasses per week
__ Liquor _____ 2 oz drinks per week

SUBSTANCE ABUSE (prescription or illegal drugs)

__ None
__ Rare
__ Occasional
__ Frequent

TOBACCO USE

__ None
__ Yes ___ packs per day How long? _____

CAFFEINE

__ Coffee ____ cups per day __ regular __ decaffeinated
__ Tea ___ cups per day __ regular __ decaffeinated
__ Soft drinks ____ cans per day

EATING HABITS

Are you on a special diet?
__ No __ Yes, please describe _____

Where do you eat most of your meals?
__ Home __ Restaurant __ Other, please describe _____

With whom do you usually eat? __ Alone __ With family __ Other, please describe _____

Who usually prepares the food you eat at home? _____

Please list any discomforts or allergies to food _____

What are some of your favorite foods? _____

Please explain your usual taste preference and eating habits: (examples: sweets, salty, binge eater, stress)

GENERAL INFORMATION

How does your family feel about you having this surgery?

How does your weight affect you socially?

How does your weight affect you physically?

Patient Signature Date

Geoffrey Wilcox, MD, FACS

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MEDICARE PATIENTS:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Hope Bariatrics for any services furnished to me by physician or supplier. I authorize any holder of medical information about me to release to the centers for Medicare Services and its agents any information needed to determine these benefits payable for related services.

FOR ALL OTHER INSURANCES:

I hereby authorize the release of any medical information necessary to process the claim and request payment of insurance carrier benefits to the party who accepts payment. I further authorize payment to the provider of services rendered to me.

SIGNATURE:_____

DATE:_____

ACCOUNT NUMBER:_____

PRE-REGISTRATION Date _____ Surgeon _____

Primary Care Physician _____ Phone No. _____

PATIENT INFORMATION

Name _____
Last First Middle Maiden

Address _____
Street City State Zip

Township/Boro _____ County _____

Age _____ Date of Birth _____
Month Day Year

Home Phone No. _____ Social Security No. _____

Sex ____ M ____ F Marital Status ____ Single ____ Married ____ Widowed ____ Divorced ____ Separated

Ethnicity/Race _____ Religion _____ Church _____

Employer _____ Phone No. _____

Address _____
Street City State Zip

Nearest Relative (spouse, parent, child, etc.) _____
Name Relationship

Address _____ Phone No. _____
Street City State Zip

Have you ever been a patient at Sewickley Valley Hospital? ____ Yes ____ No

If yes, please list date _____

If you remain overnight at the Hospital, do you wish clergy to visit? ____ Yes ____ No

PAYMENT INFORMATION

We will make copies of all insurance cards and information for your chart and hospital use

(Please provide additional information only if it differs from information already given)

Person providing your health insurance coverage _____

Relationship to patient _____ Self _____ Spouse _____ Parent _____ Other Date of Birth _____

Address _____

Phone No. _____ Social Security No. _____

Please list all types of health insurance coverage (Other) _____

Primary Insurance _____ Secondary Insurance _____

YOUR SURGICAL HISTORY (*Please list **all** past surgeries*)

Type of Surgery Year Hospital

_____

_____

_____

_____

_____

_____

(Examples: heart bypass, appendectomy, gallbladder removal, knee replacement)

Patient Name _____

Height _____ Weight _____

Phone Number _____
(where you can be reached 2 days prior to surgery)

Please fill out completely.

This information is used by your Anesthesia Physician and the staff at HVHS to ensure you receive the best possible care.

Please list all the medications you take including prescription, over the counter, herbals, supplements and diet aids.

_____

_____

_____

_____

Do you have a **latex allergy?** _____ **IF SO, NOTIFY SURGEON'S OFFICE STAFF IMMEDIATELY.**
List your **medicine allergies** _____
Please list any personal or family history of **problems with anesthesia** _____
_____
Which blood thinners do you take? (Coumadin, Plavix, Aspirin)? _____ For What? _____

Please ***circle*** any of the conditions listed below for which you have been diagnosed, treated, tested or take medication. If you had any testing, **please list when, where and doctor performing.**

HEART
☐ N/A
High Blood Pressure — Angina or Chest Pains
Heart Murmur — Irregular Heart Beat or Arrhythmia
Heart Attack — Pacemaker or Automatic Implantable Cardiac Defibrillator
Heart Catheterization _____
Stress Test _____
Echocardiogram/Ultrasound of Heart _____
Open Heart Surgery _____
EKG _____

LUNGS
☐ N/A
Asthma Wheezing COPD Emphysema Sleep Apnea
Do you smoke now? _____ Packs per day? _____ How many years? _____
When did you quit? _____ Packs per day? _____ How many years? _____

STOMACH
☐ N/A
Reflux / Hiatal Hernia / Heartburn on regular basis
Do you take over the counter antacids? _____ How often? _____

ENDOCRINE
☐ N/A
Diabetes or "Sugar" Pituitary Problems
Thyroid Cancer — Overactive / Underactive Thyroid
Other _____

KIDNEY
☐ N/A
Dialysis Kidney Stones
Other Problems _____

BRAIN AND NERVOUS SYSTEM
☐ N/A
Stroke Passing Out Multiple Sclerosis
Parkinsons Myasthenia Gravis Mini Stroke/Transient Ischemic Attack
Seizures Alzheimers Tumor
Other Problems _____

LIVER
☐ N/A
Hepatitis Jaundice
Other Liver Disease _____

CANCER
☐ N/A
Where? _____
How Treated? _____
When was last treatment? _____

GENERAL
☐ N/A
Anemia Bleeding Problems Motion Sickness
Claustrophobia Anxiety _____

Place Patient Label Here

145806 (7/12)

Uniquely Connected. For life.℠
HERITAGE VALLEY HEALTH SYSTEM

HEALTH HISTORY ASSESSMENT

Surgical Associates of Sewickley/ Hope Bariatrics
General, Advanced Laparoscopic and Bariatric Surgery
111 Hazel Lane Edgeworth Square Suite 100
Sewickley, Pennsylvania 15143-1136

PHONE: (412) 741-8862 **FAX: (412) 741-2553**

Geoffrey H Wilcox, MD, FACS

Patient Name _____
Birth Date _____
Phone _____

On July 6, 2001, the U.S. Government passed compliance regulations (HIPPA LAWS) that mandate all healthcare facilities protect health information and Inform consumers of the healthcare information practices of the facility. At This facility, we have always, and will continue to protect the privacy of your health information.

Your privacy is important to us. Please take a moment to provide us with the requested information. List person or persons to whom we may release your medical information to.

NAME	RELATIONSHIP	PHONE
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

PATIENT SIGNATURE _____ DATE _____

_____ YES IT IS OK TO LEAVE A MESSAGE ON MY MACHINE
_____ NO DO NOT LEAVE A MESSAGE ON MY MACHINE

FOR MEDICARE PATIENTS: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Surgical Associates of Sewickley/Hope Bariatrics for any services furnished to me by physician or supplier. I authorize any holder of medical information about me to release to the centers for Medicare Services and its agents any information needed to determine these benefits payable for related services.

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SIGNATURE_____

DATE_____

HOPE BARIATRICS

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PRE-SURGERY
SLEEP APNEA QUESTIONNAIRE

1) Have you ever fallen asleep at work?	YES	NO
2) Do you snore?	YES	NO
3) Has anyone told you that you stop breathing at night while you sleep?	YES	NO
4) Do you wake up at night?	YES	NO
a) if "yes", do you gasp for breath	YES	NO
b) if "yes', do you feel you are smothering or can't catch your breath?	YES	NO
5) Do you wake at night with chest discomfort or tightness?	YES	NO

Patient Name: _____ Date: _____

Surgeon: _____

Revised March, 2013

HOPE BARIATRICS

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Nutritional History

*Please complete **BOTH** sides of forms*
Bring to your appointment.

Name:_____ Date:_____
Have you attended a support group? _____ Location_____

Previous Attempts at Weight Loss:

	YES	NO	Please describe:
Atkins:			
Bariatric surgery:			
Behavior Therapy:			
Diet Medication:			
Jenny Craig:			
LA Weight Loss:			
Meal Replacement:			
Medically Supervised diet:			
Nutrition counseling:			
South Beach:			
Weight Watchers:			

Other:_____
Weight History: Adult Highest_____ Adult Lowest_____ Goal Weight_____

Most successful diet attempt was:_____
Amount of wt lost:_____
Kept off for: _____
Hours of sleep per night_____ restful____ restless____
Tobacco Use: type_____ ppd__ # of years___ Alcohol: Type _____how many___ per week
Caffeine: _____ cups per day
Occupation: _____

Diet Issues:

	YES	NO
Binge-Eater		
Emotional-Eater		
Grazer		
Night-Eater		
Voluntary Overeater		
Sedentary lifestyle		

Exercise: Yes_____NO_____ limitations_____
_____type
_____ duration
_____ times per week

(over)

HOPE

Name _____

Date _____

Behavior Evaluation Form

Please select the response which most closely matches your behavior at this time:

	Always	Most of the time	Sometimes	Seldom	Never
I eat three meals each day.					
I take a vitamin supplement daily.					
I drink milk daily.					
I exercise reguarly.					
I plan my meals in advance.					
I drink sugar-free or diet beverages.					
I avoid caffeine in foods and drinks.					
I eat slowly.					
I chew my foods very well.					
I drink water daily.					
I use sugar substitutes,					
I eat a protein food at each meal (milk, meat, eggs, cheese, soy).					
I eat while doing other things(watch TV, read, drive in the car, computer work)					
I snack between my meals.					
I eat during the night.					
I overeat for emotional reasons (sadness, stress, anger, lonliness, happiness).					
I smoke or chew tobacco.					
I drink beer, wine or alcohol.					
I skip at least one meal a day.					
I don't have time to cook or plan healthy meals.					
I drink sweetened beverages (juice, soda/pop, koolaid, sport drinks, sweet tea)					
I add sugar to foods or drinks.					
I eat sweets, chips and "junkfood".					
I eat out or order take out daily.					

Revised: ; 2012

HOPE BARIATRICS

Name_____ Date:_____

Food Frequency

Please check the item that best describes your habits. Check which foods you eat from each group.

Food	Consumption		Type		
Milk	_____frequently _____occasionally _____rarely	___whole ___ 2% ___1% ___skim	___whole chocolate ___diet chocolate ___regular yogurt ___lite yogurt		
Protein consumption:		___poultry ___beef ___ pork ___legumes ___eggs	___processed meats ___soy products ___ regular cheese ___low fat cheese ___egg substitute	___peanut butter ___fish ___seafood	
Vegetables		___ frequently ___ occasionally ___ rarely	___cooked ___raw ___juice		
Fruit		___frequently ___occasionally ___ rarely	___raw ___juice ___canned:___juice packed___syrup pack		

Fats

How many serving of deep fat fried foods do you eat weekly: _____

What do you cook with: __ Margarine __ butter
__ Oil __ non-stick spray
__ drippings

What do you use on the table: __ Margarine __Butter __ low fat spread
__ Sour cream __ low-fat sour cream
__mayonnaise __ low-calorie mayonnaise
__salad dressing __ low-calorie dressing
__ cream cheese __ low-calorie cream cheese

Sweets	___ frequently ___ occasionally ___ rarely	___chocolate ___cookies ___ice cream	__other candy __cake __pie
Salty Snacks	___ frequently ___occasionally ___ rarely	___ chips ___popcorn ___nuts	__ pretzels __cheese puffs __crackers with cheese or peanut butter
Beverages	___frequently ___occasionally ___rarely	___soda ___water ___KoolAid ___ coffee	___diet soda ___juice ___fruit drink ___tea	___Crystal Light ___carbonated water ___ flavored water ___ decaf
Sweetener	___sugar ___artificial sweetener ___honey	____ Sweet n Low	____ Equal	____Splenda	____ Stevia
Salt	___ add to cooking ___ add at the table ___ use salt substitute				

(over)

HOPE BARIATRICS

Name:_____ Date: _____

Typical 24 Hour Food Intake

Breakfast: time ( )
Items consumed:

Lunch: time ( )
Items consumed:

Snack:

Dinner: time ( )
Items consumed:

Evening snack:

Revised: 2012