PATIENT PROFILE

The following information is important to your health. Please take time to completely and accurately fill out this important information. We are counting on you.

QUALITY OF LIFE
Please describe below, how you feel that your excess weight is affecting the following aspects of your life.

Daily activities you cannot perform

Ability to exercise

Effect on pain

Effect on ability to perform job duties

Social activities you cannot participate in

Effect on your marriage/relationships

Effect on relationship with your children

Effect on self-esteem

SLEEP APNEA
Have you been tested for sleep apnea?□ Yes □ No
Do you snore?□ Yes □ No
Do you ever wake up in the middle of the night gasping for air?□ Yes □ No
Has anyone ever told you that you stop breathing while asleep?□ Yes □ No
Do you have restless sleep?□ Yes □ No
Do you have daytime sleepiness or dozing off at inappropriate times?□ Yes □ No
Do you find yourself driving on “auto-pilot” without recall of the trip?□ Yes □ No
Do you have a dry throat on awakening?□ Yes □ No
Do you dream during brief naps or before fully asleep?□ Yes □ No
Do you have headaches or muscle aches on awakening?□ Yes □ No
Do you wake up frequently throughout the night?□ Yes □ No

Note: 2 or more definite yes answers – send for sleep study.

GASTROESOPHAGEAL REFLUX DISEASE
Do you frequently suffer from heartburn or indigestion?□ Yes □ No
Do you frequently use antacids?□ Yes □ No
Have you ever had an upper GI or endoscopy?□ Yes □ No
Do you wake up at night with indigestion?□ Yes □ No
EXERCISE HISTORY
Do you exercise regularly? □ Yes □ No
   If yes, describe the type and frequency__________________________________________________________
   If no, why?_____________________________________________________________________________________

PSYCHOLOGICAL/SUPPORT
Have you ever been diagnosed with a psychiatric condition?.................................□ Yes □ No
Have you ever been hospitalized for a psychiatric condition?.................................□ Yes □ No
Have you ever been sexually abused?.................................................................□ Yes □ No
Do you or have you ever had a history of (check all that apply)
   □ Binge eating   □ Bulimia (binge eating followed by self-induced vomiting)   □ Self-induced vomiting
   □ Laxative use to control weight   □ Compulsive eating
   □ Binge eating (check all that apply)   □ Hunger   □ Boredom   □ Stress   □ Guilt   □ Anger   □ Control   □ Depression   □ Enjoy taste
Why do you eat? (check all that apply) □ Hunger □ Boredom □ Stress □ Guilt □ Anger □ Control □ Depression □ Enjoy taste
Which of the following are major stresses in your life? (check all that apply) □ Job □ Children □ Spouse □ Lack of available time
   □ Running a household □ Medical problems
Have you ever had psychological counseling for weight management?...................□ Yes □ No
How do you rate your self-esteem? □ High □ Fair □ Low
Binge eating (check all that apply)
   □ I have episodes of eating amounts of food definitely larger than most people would eat in a two-hour period
   □ I have a sense of lack of control over eating during the episode
During a binge eating episode, I: (check all that apply)
   □ Eat much more rapidly than normal □ I eat alone because of embarrassment
   □ I eat until I feel uncomfortably full □ I feel disgusted with myself, depressed, or very guilty afterwards
How many days per week do you binge eat?___________________________________________________________

GOALS
What are your goals in the following areas?
 Amount of weight loss               Fitness/Health goals
In 1 month _______________________________ _______________________________
3 months _______________________________ _______________________________
6 months _______________________________ _______________________________
1 year _______________________________ _______________________________
Target weight _______________________________ _______________________________

Do you feel you will be able to perform the work and have the dedication to achieve these goals? □ Yes □ No

Having gastric bypass surgery for weight loss is not considered a “magic bullet” to losing weight rapidly; it takes commitment and it
   takes realistic goals. You will be asked to follow specific instructions in order to make your surgery a success. If you feel that you
   do not have to be compliant with these instructions and follow the diet, vitamin regime, and an exercise program, then please discuss
these concerns with us before you decide to go ahead with having surgery. It is your responsibility to follow this plan as given and
to attend support groups and classes offered by our program.

The patient profile is correct to the best of my knowledge. ________________________________________________     ________________
Patient Signature                                             Date
Insurance Coverage in the Bariatric Program

We make every effort to try to keep up with insurance company changes; however, there are times when a patient starts in the bariatric program and either halfway through or when completed, the insurance carrier decides to decline or not cover this procedure any more.

We feel that it is just as much of the patient’s responsibility to try to keep up with the ongoing changes of their insurance plan.

We recommend that you contact your insurance carrier monthly to make sure that this is still a covered benefit and that their guidelines have not changed. If there are any changes, they need to be reported to us right away.

I understand that by completing all required steps for Gastric Bypass, Gastric Sleeve or Lap Band does not guarantee me of having the surgery done, by either insurance denial or at the physician’s discretion.

I understand that if insurance denial does occur, I do have the option of self-paying. Prices will be discussed at that time.

_________________________________________________
Patient Name

_________________________________________________                          ___________________________
Patient Signature                                                                                                                       Date