PennState Health

SURGICAL WEIGHT LOSS SCREENING FORM

INFO SESSION DATE _____ DATE OF BIRTH: _____ AGE: _____ BMI: _____

Have you ever applied to our program before? YES / NO - If **YES,** when? _____

Patient Name _____
Patient Address _____
_____
_____
Patient Telephone (___)_____
Patient Email _____

Insurance Company _____
Insured's Name _____
Relationship to Patient_____
ID#_____
Group#_____
Is this plan through PEBTF (PA state employees)? **YES / NO**

Family Doctor _____
Address _____
_____
Telephone (___)_____

Please list any other specialists who take care of you.

Specialist _____
Address _____
_____
Telephone (___)_____

Specialist _____
Address _____
_____
Telephone (___)_____

MUST HAVE AN OOS LABEL ON THE FRONT SIDE OF THIS FORM
(2-SIDED FORMS MUST HAVE AN OOS LABEL ON BOTH SIDES)

Weight History

Height_____
Weight _____

At what age (in years) did you first have a weight problem? (Circle one)
5-10 10-15 15-20 20-30 30-40 40-50 50-60

Highest adult weight _____
Lowest adult weight _____
Weight one year ago _____

Weight-Loss Medications You Have Tried in the Past

List all medications (including over-the-counter) used to lose weight.			
Diet Medication Name	Dates Used	Weight Lost	Weight Regained

Have you ever used Fen-Phen? _____

Weight-Loss Plans You Have Tried in the Past

List any programs/diets you have tried, including both commercial programs, such as Weight Watchers, and at home approaches, such as limiting portion sizes (list most recent first).			
Diet Program	Dates in Program	Weight Lost	Weight Regained

Please briefly explain some of the reasons you have gained weight (examples: emotional eating, meal skipping, little activity, large portion sizes, food choices, snacking, etc.)

Surgical Weight-Loss Programs

Have you ever attended another surgical weight-loss program? **YES / NO** If **YES**, please answer the following questions:

Which program(s) did you attend? _____

What years did you attend this/these program(s)? _____

Did you complete the program? **YES / NO** If **NO**, why? _____
_____

Nutritional History

Have you ever been told you have an eating disorder? **YES / NO** If **YES,** what is the name of the eating disorder? _____

How often do you eat out each week? _____

How many meals do you eat each day? _____

Exercise

Do you currently exercise? **YES / NO** If **YES**, what do you do? _____
How often? _____

Do you use an adaptive device to walk (cane, walker, scooter, wheelchair, etc.)? **YES / NO**
If **YES**, what type? _____ How often (at all times, on rough walkways, occasionally, etc.)? _____

Medical History (Please check all concerns that you currently have or had in the past.)

Cardiovascular (heart)
- ❑ High blood pressure (hypertension)
- ❑ Chest pain, angina or tightness
- ❑ Irregular or rapid heart rate
- ❑ Heart murmur
- ❑ High cholesterol
- ❑ Stroke

Respiratory (lungs)
- ❑ Asthma
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Shortness of breath with activity
- ❑ Sleep apnea

Have you ever had studies of your heart? **YES / NO** What types of studies?

_____

Have you ever had any breathing tests? **YES / NO** If **YES**, what types of tests?

_____

Endocrine (metabolic)
- ❑ Diabetes
- ❑ Thyroid problems
- ❑ Low blood sugars (hypoglycemia)

Gastrointestinal (stomach/intestines)
- ❑ GERD (heartburn)
- ❑ Ulcers
- ❑ Irritable bowel syndrome
- ❑ Crohn's or ulcerative colitis
- ❑ Gallstones
- ❑ Liver disease
- ❑ Hepatitis

Blood /Immune System
- ❑ Anemia
- ❑ Lupus
- ❑ Fibromyalgia
- ❑ Bleeding disorders
- ❑ Immune disorders
- ❑ Blood clots (deep vein or pulmonary)
- ❑ Cancer

  Type? _____ When? _____

Musculoskeletal
- ❑ Arthritis
- ❑ Joint pain/problems
- ❑ Back pain/problems

Genitourinary (kidney)
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Urinary stress incontinence/frequency

Reproductive
- ❑ Infertility
- ❑ Polycystic ovary disease

Neurological (Brain)
- ❑ Stroke
- ❑ Seizures
- ❑ Severe headaches

Other Medical History Not Listed Above:

_____

_____

Surgical History

Procedure	Date	Disease	Surgeon/Hospital

Family Medical History (Please list medical illness, if known)

	Alive?	Diseases	Overweight?
Mother	**YES / NO**		**YES / NO**
Father	**YES / NO**		**YES / NO**
Sisters	**YES / NO**		**YES / NO**
Brothers	**YES / NO**		**YES / NO**

Current Prescription Medications

Medication	Amount (mg)	Frequency	Since (year)

Current <u>Nonprescription</u> Medications

(Including vitamins, nutritional supplements, herbal supplements, etc.)

Name	Amount	Frequency	Since (year)

Allergies (Please include your reaction to the allergen**)**

MUST HAVE AN OOS LABEL ON THE FRONT SIDE OF THIS FORM
(2-SIDED FORMS MUST HAVE AN OOS LABEL ON BOTH SIDES)

Psychological History

Are you **currently** being treated for any mental health concern?

❑ Depression ❑ Anxiety ❑ Bipolar disease

❑ Schizophrenia ❑ Other_____

Are you being followed by your PCP or a mental health provider? (List below) **YES / NO**

_____

Have you **ever been** treated for any mental health concern?

❑ Depression ❑ Anxiety ❑ Bipolar disease

❑ Schizophrenia ❑ Other_____

If **YES**: When? _____ Where? _____

Have you ever been hospitalized for a mental health reason? **YES / NO**

If **YES**: When? _____ Where? _____

Have you ever attempted suicide? Yes / No

If **YES**: When? _____ Where? _____

Psychologist/Psychiatrist or Therapist (Please list all providers. You may use the back if you have/had more than two.)
(If you see or **have ever seen** a mental health provider for any reason, please complete the release of records form at our office or at your mental health provider's office to release records to us.)

Name _____
Address _____
_____
Telephone (___)_____

Name _____
Address _____
_____
Telephone (___)_____

STOP—Bang Scoring Tool
Please answer the following questions:

1. Do you snore loudly? **YES / NO**
   (*louder than talking or loud enough to be heard through closed doors)*
2. Do you often feel tired, fatigued or sleepy during daytime? **YES / NO**
3. Has anyone observed you stop breathing during your sleep? **YES / NO**
4. Do you have, or are you being treated for, high blood pressure? **YES / NO**
5. Is your BMI more than 35? **YES / NO**
6. Are you over 50 years old? **YES / NO**
7. Is your neck circumference (measure around your whole neck) greater than (17 inches for males) or (16 inches for females)? **YES / NO**
8. Are you a male? **YES / NO**

Have you been diagnosed with sleep apnea in the past? **YES / NO**

When? _____ Where? _____

Are you currently using CPAP at night? **YES / NO**

Tobacco/Alcohol/Drugs (Please check or fill in.)

Have you smoked at least 100 cigarettes in your entire life? (*100 CIGARETTES = APPROXIMATELY 5 PACKS)* **YES / NO**

If **YES**, do you now smoke cigarettes?
❑ Every day ❑ Some days ❑ Not at all

If you now smoke cigarettes:
How many cigarettes per day do you usually smoke? _____
On days that you can smoke freely, how soon after you wake up do you smoke your first cigarette of the day? _____minutes
How many years have you smoked cigarettes? _____

If you don't smoke at all right now, how long ago did you quit smoking? _____

Do you currently use any other type of tobacco? **(***Tobacco includes cigars, pipes, snuff/dip, chew, hookah, dissolvables or electronic cigarettes)* **YES / NO**

If **YES**, what type of tobacco do you use? (Please mark all that apply.)

❑ Cigars ❑ Chew ❑ Dissolvable tobacco (lozenges, strips or sticks) ❑ Pipe

❑ Electronic cigarette ❑ Snus/snuff/dip ❑ Hookah/water pipe

Do you currently use any type of product that contains nicotine? **YES / NO**
If **YES**, what type of products do you use? (Please mark all that apply.)

❑ Patches ❑ Gum ❑ Juul ❑ Vape ❑ Other: _____

Do you drink alcoholic beverages? **YES / NO** If **YES**, how many drinks per week? _____

Have you ever been in therapy or rehab related to alcohol? **YES / NO**
If **YES,** when? _____ Where? _____

Do/did you use recreational drugs? **YES / NO** Which drug(s)?_____

If **YES**, have you quit? _____ When did you quit? _____

Have you ever been in therapy or rehab related to drugs? **YES / NO**
If **YES**, when? _____ Where?_____

Have you ever been in therapy or rehab related to prescription drug abuse? **YES / NO**
If **YES**, when? _____ Where? _____

Transportation

What form of transportation do you currently use? (Check all that apply.)

❑ CAT Share-A-Ride ❑Personal automobile ❑ Family member/friend

Do you need assistance with reading and writing? YES / NO
Please note that some testing will require you to read/write. You are welcome to bring along a support person to assist you in these sessions.

Preferred Language? _____

I have personally attended the information session or reviewed the session online and confirm that the information in this form is true and accurate to the best of my knowledge.
***Signature*_____ *Date/Time*_____**

Signature of person completing the form if not completed by the patient:
_____***Relationship to patient***_____

IMPORTANT: Failure to provide correct information can result in removal from the program.