Mount Sinai Section of Bariatric Surgery: Form BNP-1 Dr. Herron & Dr. Kini 5 East 98th Street, 14th Floor, New York, NY 10029	**Please Write Your Name Below:**

WELCOME TO THE MOUNT SINAI PROGRAM FOR SURGICAL WEIGHT LOSS!

We are pleased to welcome you to the Mount Sinai Program for Surgical Weight Loss! In order for us to better understand your medical history and to provide the best possible care, please complete the next few pages of this form. Please be sure to carefully and accurately fill in every section to the best of your ability. This will help your surgeon to have a better understanding of your weight loss issues and to counsel you appropriately regarding your weight loss surgery options.

SECTION 1. PRIMARY CARE DOCTOR INFORMATION

A. How did you hear about our program (doctor / friend / internet)?

_____

B. Who is your Primary Care Doctor ? What is their address and phone number?

Doctor's Name: _____

Doctor's Address: _____

_____

Doctor' s Phone:_____

Did you do any research on the internet? If so, which websites?

SECTION 2. PLEASE CHECK OFF ANY SYMPTOMS YOU HAVE (OR "NONE OF THE ABOVE"):

General
- □ Fever/chills/sweats
- □ Severe headaches
- □ Difficulty sleeping
- □ Weight gain
- □ Weight loss
- □ ***None of the above***

Muscles-Joints-Bones
- □ Back pain
- □ Shoulder pain
- □ Elbow or wrist pain
- □ Hip pain
- □ Knee pain
- □ Ankle or Foot pain
- □ Other:_____
- □ ***None of the above***

Urinary System
- □ Urinary incontinence
- □ Painful urination
- □ Blood in urine
- □ Other:_____
- □ ***None of the above***

Digestive System
- □ Belly pain
- □ Nausea
- □ Vomiting
- □ Constipation
- □ Diarrhea
- □ Blood in stool
- □ Pain around rectum
- □ ***None of the above***

Heart-Vascular
- □ Bleeding problems
- □ Chest pain
- □ Poor circulation in arms
- □ Poor circulation in legs
- □ Leg or ankle swelling
- □ Varicose veins
- □ ***None of the above***

Lungs
- □ Shortness of breath
- □ Wheezing
- □ Severe cough
- □ Bloody cough
- □ ***None of the above***

Skin
- □ Easy bruising
- □ Rashes
- □ Non-healing sores
- □ Changing moles
- □ Problem scars
- □ ***None of the above***

Men Only
- □ Lump in testicle
- □ Discharge from penis
- □ Skin problem on penis or scrotum
- □ Erection difficulty
- □ ***None of the above***

Women Only
- □ Irregular periods
- □ Breast lump
- □ Severe menstrual pain
- □ ***None of the above***

Other Systems
- □ Check if normal, otherwise please note on next page

SECTION 3: PAST MEDICAL HISTORY. PLEASE CHECK OFF ANY PROBLEMS, OR "NONE OF THE ABOVE":

Blood Vessels & Heart

- □ Bleeding problem 286.9
- □ Blood clots or DVT 453.40
- □ Chest pain (angina) 413.9
- □ Heart disease 414.00
- □ Heart attack (MI) 412
- □ High blood pressure 401.9
- □ High cholesterol level 272.0
- □ Stroke (CVA) 434.91
- □ Diseased leg arteries 440.9
- □ ***No heart problems***

Heart Procedures

- □ Cardiac catheterization (or angioplasty)
- □ ***No procedures***

Skin

- □ Skin infection (cellulitis) 682.9
- □ Lymphedema (swelling in legs) 457.1
- □ ***No skin problems***

Endocrine (Hormone) System

- □ Diabetes (on insulin) 250.02
- □ Diabetes (not on insulin) 250.02
- □ Diabetic nerve problems 250.6
- □ Diabetic retinopathy 362.0
- □ Polycystic ovary syndrome 256.4
- □ Low thyroid level 244.9
- □ Hyperthyroid 242.9
- □ ***No hormone problems***

Stomach & Intestines

- □ Gallstones 574.2
- □ Reflux or heartburn 530.19
- □ Crohn's disease 558.9
- □ Ulcerative colitis 558.9
- □ Colon cancer 153.9
- □ Fecal incontinence 787.6
- □ Hepatitis (Type:_____)
- □ Irritable bowel disorder 564.1
- □ ***No stomach or intestine problems***

Joints

- □ Pains in joints 716.99
  Which ones?_____
- □ ***No joint problems***

Lungs & Breathing

- □ Asthma 493.90
  Age of onset:_____
  Ever hospitalized?_____
  Last episode:_____
- □ Use home oxygen?
- □ Loud snoring 786.00
- □ Sleep apnea 780.57
  Do you use CPAP?_____
  CPAP setting:_____
  Last episode:_____
- □ Pulmonary embolus (clot) 415.19
- □ ***No lung problems***

Psychological

- □ Depression 311
  Age of onset?_____
- □ Bipolar disorder 296.7
- □ Schizophrenia 295.90
- □ Psychiatric hospitalization?
  Dates: _____
- □ ***No psychological problems***

Kidneys & Urinary System

- □ Frequent urinary infections
- □ Urinary incontinence 788.30
- □ Kidney stones 592.9
- □ Kidney failure 585
- □ ***No urinary or kidney problems***

All Other Systems

□ Check here if normal, otherwise, please describe any other major health issues:

_____

_____

_____

_____

_____

SECTION 4: FAMILY HISTORY:
(PLEASE CHECK PROBLEMS THAT RUN IN THE FAMILY)

- □ Obesity
- □ Bleeding problems
- □ Heart disease
- □ Cancer
- □ Diabetes
- □ High blood pressure
- □ Other: _____

_____

_____

Is your mother alive? □ Yes □ No

If deceased, from what cause:_____

Is your father alive? □ Yes □ No

If deceased, from what cause:_____

SECTION 5: SOCIAL HISTORY

Have you ever smoked? □Yes □ No

Started when:_____

Stopped when:_____

Packs per day:_____

How many alcoholic beverages do you drink?

_____ □ per day □ per week

What recreational drugs do you use, and how often:

_____

(Women only) How many pregnancies? _____

How many children? Ages?_____

Are you planning more pregnancies? □ Yes □ No

PLEASE CONTINUE ON TO PAGE 3...

SECTION 6: PLEASE LIST ALL YOUR MEDICATIONS:

Drug Dose How Often per Day?

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you have any drug or food allergies?

□ **Yes, I am allergic to:**

_____

_____

□ **No, I have no allergies**

Have you ever taken weight loss medications?
If yes, please give dates for each:

Phen-Fen? □ Yes □ No

Redux? □ Yes □ No

Pondimin? □ Yes □ No

Meridia? □ Yes □ No

Xenical? □ Yes □ No

Amphetamine? □ Yes □ No

Over the counter? □ Yes □ No

Which ones? _____

_____

_____

SECTION 7: PAST SURGICAL HISTORY

Have you had any of the following operations?

Operation		**Date**
Weight loss surgery?	□ Yes □ No	_____
Gallbladder removal?	□ Yes □ No	_____
If yes, was it:	□ Open □ Laparoscopic	
Appendectomy?	□ Yes □ No	_____
Hernia repair?	□ Yes □ No	_____
If yes, what type?		_____
Cancer surgery?	□ Yes □ No	_____
If yes, what type:		_____
C-Section?	□ Yes □ No	_____
Plastic surgery?	□ Yes □ No	_____
Heart surgery?	□ Yes □ No	_____

Have you had any other surgery? If so, please describe:

_____

_____

_____

SECTION 8: DIETARY RESTRICTIONS

Please check off any dietary restrictions that you have:

Vegetarian? □ Yes □ No _____

Vegan? □ Yes □ No _____

Kosher? □ Yes □ No _____

Lactose intolerant? □ Yes □ No _____

Food allergies? □ Yes □ No _____

Other restriction? □ Yes □ No _____

If yes, please describe:

_____

_____

PLEASE CONTINUE ON TO PAGE 4...

SECTION 9: YOUR WEIGHT LOSS HISTORY

Important: Your insurance company needs the information on this page to decide if they will cover the procedure. Please complete this page as fully as possible.

What is your height? Feet:_____ Inches:_____ What is your weight? Pounds:_____

Do you know what your Body Mass Index (BMI) is? □ Yes □ No If so, what is your BMI? _____

How long have you been overweight? _____

Do you consider yourself a "binge eater?" □ Yes □ No
Do you ever make yourself throw up? □ Yes □ No
Do you eat many sweet foods? □ Yes □ No
Do you eat many fried or fatty foods? □ Yes □ No

Please describe, in your own words, how obesity affects your life:

_____

_____

_____

_____

_____

_____

_____

_____

Please indicate which diets you have tried in the past:

Diet	Dates	Pounds Lost
□ Calorie counting (on own)		
□ Atkins diet (or low-carb)		
□ Jenny Craig		
□ Weight Watchers		
□ Optifast/Slimfast		
□ Overeaters Anonymous		
□ Scarsdale diet		
□ Nutrisystem		
□ Other		

_____

YOU'RE ALL SET! THANK YOU FOR COMPLETING THIS FORM!