JACOBI MEDICAL CENTER
DEPARTMENT OF BARIATRIC SURGERY

MEMO

THIS IS TO CONFIRM YOUR APPOINTMENT:

CLINIC: BARIATRIC SURGERY

DATE: _____

TIME: _____

PLACE: BUILDING # 8 – 2ND FLOOR – 2C

PLEASE COMPLETE ALL OF THE ENCLOSED PAPERWORK. BRING ALL THE ENCLOSED PAPERWORK ON YOUR SCHEDULED DATE.

VERY IMPORTANT: ALL OF THE APPOINTMENTS RELATED TO BARIATRIC SURGERY WILL BE GIVEN TO YOU BY OUR DEPARTMENT. PLEASE DO NOT ATTEMPT TO SCHEDULE THESE APPOINTMENTS WITHOUT OUR ASSISTANCE.

ANY QUESTIONS CALL US AT 718-918-5677 OR 718-918-6065

ALSO, YOU CAN EMAIL US AT

YOCASTA.HERRERA@NBHN.NET

BARIATRIC SURGERY
APPOINTMENT RECORD

PATIENT NAME		**MR NUMBER:**	
BARIATRIC INITIAL CLINIC APPT.	DATE:	**BLDG: # 8** 2ND FLOOR 2C	TEL. (718) 918-5677
CLINIC	PHONE #	LOCATION	APPT. TIME
BARIATRIC CLINIC	(718) 918-5677	**BUILDING 8** 2ND FLOOR 2C	**DATE:** **DATE:** **DATE:**
ENDOSCOPY ****Fasting after midnight** ****Bring someone with you**	(718) 918-7668	**BUILDING 1** 2ND FLOOR 2 SOUTH	**DATE:**
ULTRASOUND ****Fasting after midnight**	(718) 918-4957	**BLDG. #6** 3RD FLOOR – 3D	**DATE:**
NUTRITION	(718) 918-5677	**BLDG. #8** 2ND FLOOR 2C	**DATE:** **DATE:** **DATE:**
MEDICAL CLEARANCE	(718) 918-5677	**BLDG. #8** 4TH FLOOR 4C	**DATE:**
SLEEP STUDY ****If necessary**	**BETTER SLEEP NY** 3427 BRUCKNER BOULEVARD BRONX, NY 10461 ☐	**NY METRO SLEEP** 1250 WATERS PLACE SUITE 505 BRONX, NY 10461 ☐	*SLEEP CENTER WILL CONTACT YOU TO SCHEDULE AN APPOINTMENT.*
PULMONARY ***** If necessary**	(718) 918-5677	**BLDG. #8** 4TH FLOOR 4B	**DATE:**
PSYCHIATRIC EVAL	(718) 918-5677	**BLDG. #8** 2ND FLOOR 2C	**DATE:**
SUPPORT GROUP MEETINGS *(MANDATORY TO ATTEND 1 SUPPORT MEETINGS)*			
DATE:			
*****IMPORTANT: DO NOT ATTEMPT TO SCHEDULE THE ABOVE APPOINTMENTS. ALL**			
APPOINTMENTS HAVE TO BE GIVEN BY THE BARIATRIC DEPARTMENT.			

PLEASE BRING THIS PAPER TO EVERY APPOINTMENT. THIS WILL BE YOUR RECORD THAT YOU HAVE COMPLETED ALL THE NECESSARY REQUIREMENTS BEFORE YOUR SURGERY CAN BE SCHEDULED.

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QUESTIONS??? CALL US AT (718) 918-5677 OR (718) 918-6065
OR EMAIL US AT: YOCASTA.HERRERA@NBHN.NET

BARIATRIC SURGERY QUESTIONNAIRE

PLEASE PRINT CLEARLY – COMPLETE ALL INFO IN THE BOXES BELOW AND ANSWER ALL THE QUESTIONS.		
NAME:		MR NUMBER:
STREET ADDRESS:	APT. #	
CITY:	STATE:	ZIP CODE:
SEX: M ☐ F ☐	BIRTH DATE:	AGE:
HOME PHONE: ( )	CELL: ( )	
MARITAL STATUS:	NO. OF CHILDREN:	AGES:
BMI:	HEIGHT:	WEIGHT:
INSURANCE CARRIER:		**ID NUMBER:**

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____

Overweight: How many years have you been overweight? _____

DIET PROGRAMS AND SUPPLEMENTS: Indicate which of the following diets/plans you have attempted ⇩

PROGRAMS	DATES	DURATION	MD SUPERVISED	WEIGHT LOSS
Weight Watchers			YES ☐ NO ☐	
Jenny Craig			YES ☐ NO ☐	
Metabolife			YES ☐ NO ☐	
Medifast			YES ☐ NO ☐	
Nutri/System			YES ☐ NO ☐	
Atkins Diet			YES ☐ NO ☐	
Herbalife			YES ☐ NO ☐	
Slim Fast			YES ☐ NO ☐	
Grapefruit Diet			YES ☐ NO ☐	
Liquid Diet			YES ☐ NO ☐	

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Pritikin Diet			YES ☐ NO ☐	
Optifast			YES ☐ NO ☐	
TOPS			YES ☐ NO ☐	

LIST ANY OTHER PHYSICIAN-SUPERVISED WEIGHT LOSS ATTEMPTS: _____

WEIGHT-LOSS MEDICATION HISTORY: Please indicate if you have taken any of the following medications to lose weight ⇩

MEDICATION	DATES	DURATION	MD SUPERVISED	WEIGHT LOSS
Amphetamines			YES ☐ NO ☐	
Phentermine (Adipex, Fastin, Pondimen			YES ☐ NO ☐	
Phen-Fen			YES ☐ NO ☐	
Dexfenfluramine (Redux)			YES ☐ NO ☐	
Xenical (Orlistat)			YES ☐ NO ☐	
Meridia (Sibutramine)			YES ☐ NO ☐	
Other Diet Medications			YES ☐ NO ☐	

NON-DIETARY THERAPIES: Please indicate if you have tried any of the following weight loss therapies ⇩

THERAPY	DATES	DURATION	MD SUPERVISED	WEIGHT LOSS
Exercise			YES ☐ NO ☐	
Hypnosis			YES ☐ NO ☐	
Behavior Modification			YES ☐ NO ☐	
Acupuncture			YES ☐ NO ☐	
List any other weight loss methods you have tried			YES ☐ NO ☐	

HAVE YOU HAD PREVIOUS WEIGHT LOSS SURGERY? YES ☐ NO ☐
TYPE OF SURGERY_____

DATE: _____ SURGEON: _____WEIGHT LOSS: _____

OBESITY RELATED MEDICAL HISTORY: Do you, or have you had, any of the following illnesses or symptoms: ⇩

PLEASE CHECK OFF YES OR NO!!!

HEART DISEASE	YES ☐ NO ☐	**YEAR OF DIAGNOSIS:**		
Angina	YES ☐ NO ☐			
Heart Attack (M.I.)	YES ☐ NO ☐			
Coronary Bypass Surgery	YES ☐ NO ☐	**DATE:**		
Coronary Angioplasty	YES ☐ NO ☐	**DATE:**		
Palpitations (Abnormal Heartbeat)	YES ☐ NO ☐			
CONGESTIVE HEART FAILURE	YES ☐ NO ☐	**YEAR OF DIAGNOSIS:**		
HIGH BLOOD PRESSURE	YES ☐ NO ☐	**YEAR OF DIAGNOSIS:**		
DIABETES	YES ☐ NO ☐	**YEAR OF DIAGNOSIS:**		
Juvenile Onset	YES ☐ NO ☐			
Gestational (Pregnancy)	YES ☐ NO ☐			
Adult Onset	YES ☐ NO ☐			
Diet Controlled	YES ☐ NO ☐			
Oral Medications	YES ☐ NO ☐			
Insulin	YES ☐ NO ☐			
ELEVATED CHOLESTEROL	YES ☐ NO ☐	**YEAR OF DIAGNOSIS:**		
ELEVATED TRIGLYCERIDES	YES ☐ NO ☐			
ASTHMA	YES ☐ NO ☐	**YEAR OF DIAGNOSIS:**		
SHORTNESS OF BREATH	YES ☐ NO ☐	If Yes…Can Walk _____Blocks Can Climb _____Flights of Stairs		
SLEEP APNEA	YES ☐ NO ☐	If Yes, Do You Use a CPAP or BiPAP Machine **YES ☐ NO ☐**		
SLEEP DIFFICULTIES	YES ☐ NO ☐	Snoring Awakenings at Night Daytime Drowsiness Observed Apnea Spells Morning Headaches	**YES ☐** **YES ☐** **YES ☐** **YES ☐** **YES ☐**	**NO ☐** **NO ☐** **NO ☐** **NO ☐** **NO ☐**
REFLUX/HEARTBURN/ESOPHAGITIS/ HIATAL HERNIA	YES ☐ NO ☐	**YEAR OF DIAGNOSIS:**		
Prescription Medications	YES ☐ NO ☐			

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Over the Counter Medications	YES ☐ NO ☐	
Frequency of Use:		
Endoscopy	YES ☐ NO ☐	**DATE:**
VENOUS STASIS	YES ☐ NO ☐	
Leg or Ankle Swelling/Edema	YES ☐ NO ☐	
Leg Ulceration	YES ☐ NO ☐	
Leg Skin Color Change or Thickening	YES ☐ NO ☐	
PAIN OR ARTHRITIS OF ANKLES/ KNEES/HIPS	YES ☐ NO ☐	
Limits Ability to Walk or Exercise	YES ☐ NO ☐	
Prescription Medications	YES ☐ NO ☐	
Over the Counter Medications	YES ☐ NO ☐	
LOW BACK PAIN/SCIATICA	YES ☐ NO ☐	
Limits Ability to Walk or Exercise	YES ☐ NO ☐	
Prescription Medications	YES ☐ NO ☐	
Over the Counter Medications	YES ☐ NO ☐	
URINARY INCONTINENCE (Leakage of Urine)	YES ☐ NO ☐	
With Coughing/Sneezing/Straining	YES ☐ NO ☐	
Number of Times Per Week		
MIGRAINE HEADACHES	YES ☐ NO ☐	
Frequency		
Prescription Medications	YES ☐ NO ☐	
Over the Counter Medications	YES ☐ NO ☐	
DEEP VEIN THROMBOSIS(Blood Clots in Legs)	YES ☐ NO ☐	**YEAR OF DIAGNOSIS:**
Pulmonary Embolism	YES ☐ NO ☐	
Blood Thinning Medication	YES ☐ NO ☐	
ABDOMINAL WALL HERNIA	YES ☐ NO ☐	
Incisional (Previous Operation)	YES ☐ NO ☐	**DATE:**

Umbilical (Belly Button)	YES ☐ NO ☐	
Number of Hernia Repairs		**DATE:**
Hernia Currently Present	YES ☐ NO ☐	

PAST MEDICAL HISTORY: Please list all other medical conditions or illnesses not previously mentioned

_____

_____

_____

HOSPITALIZATIONS: Please list all non-surgical hospitalizations you have experienced as an adult ⇩

INDICATION	HOSPITAL	DATE

MEDICATIONS: Please list all medications you currently use ⇩

MEDICATION	DOSAGE	FREQUENCY	INDICATION

FAMILY HISTORY: Please indicate if family members have any of the following illnesses ⇩

Obesity	**YES ☐**	**NO ☐**	Breast Cancer	**YES ☐**	**NO ☐**
High Blood Pressure	**YES ☐**	**NO ☐**	Other Cancers	**YES ☐**	**NO ☐**
Diabetes	**YES ☐**	**NO ☐**	Kidney Disease	**YES ☐**	**NO ☐**
High Cholesterol	**YES ☐**	**NO ☐**	Lung Dx or Emphysema	**YES ☐**	**NO ☐**
Heart Disease	**YES ☐**	**NO ☐**	Blood Disorder	**YES ☐**	**NO ☐**
Stroke	**YES ☐**	**NO ☐**	Bleeding Tendency	**YES ☐**	**NO ☐**

PAST SURGICAL HISTORY: Please list all surgical procedures or operations ⇩

PROCEDURE	INDICATION	HOSPITAL	DATE

DO YOU HAVE ALLERGIES TO ANY MEDICATIONS: YES ☐ NO ☐ IF YES, PLEASE LIST MEDICATIONS AND REACTIONS (e.g., rash, breathing difficulty, shock, etc.)

_____

_____

_____

- **HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES ☐ NO ☐**
- **HAVE YOU EVER HAD HEPATITIS? YES ☐ NO ☐**
- **HAVE YOU EVER BEEN EXPOSED TO HIV/AIDS? YES ☐ NO ☐**
- **HAVE YOU EVER USED INTRAVENOUS DRUGS? YES ☐ NO ☐**

SOCIAL HISTORY ⇨ MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED

CHILDREN: ⇨ YES ☐ NO ☐ **HOW MANY?** _____ **AGES:** _____

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OCCUPATION: _____

DO YOU USE TOBACCO? YES ☐ NO ☐ **IF YES, NUMBER OF PACKS PER DAY** _____
YEARS OF USE: ____

DO YOU USE ALCOHOL? YES ☐ NO ☐ AMOUNT AND FREQUENCY _____

HAVE YOU EVER BEEN TREATED FOR DEPRESSION? YES ☐ NO ☐
ARE YOU CURRENTLY IN TREATMENT? YES ☐ NO ☐

IF YES, PLEASE INDICATE NAME OF YOUR PHYSICIAN OR THERAPIST_____

HAVE YOU EVER BEEN HOSPITALIZED FOR MENTAL ILLNESS? YES ☐ NO ☐
PHYSICIAN ATTESTATION: I HAVE REVIEWED AND VERIFIED THE ABOVE INFORMATION WITH

PATIENT: _____ PHYSICIAN: _____DATE: _____

Epworth Sleepiness Scale

Name: _____

Date: _____

Age: _____ Sex: ☐ Male ☐ Female

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just 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 scale to choose the most appropriate number for each situation:

0 = Would never doze
1 = Slight change of dosing
2 = Moderate chance of dosing
3 = High chance of dozing

Situation	**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 a 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……	
Total ……	

Score:	
0-10	Normal Range
10-12	Borderline
12-24	Abnormal

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