

Patient Name: _____ **Date:** _____

_____ Patient unable to attend DOH Information Session, but has received DOH Information Packet and has performed independent research on the procedure.

_____ Patient attended DOH Information Session (DATE: ____/____/____) and is ready to pursue LAP-BAND® procedure.

Please answer the following questions so that we can better meet your needs. Our goal is to help you lose weight to provide you with a healthier body and then support you in maintaining your new weight.

Are you interested in attending a LAP-BAND® Support Group after surgery? _____ YES _____ NO

DEMOGRAPHICS

Referring Physician: _____ **Phone #:** (____) ____ - ____

Practice Name: _____ **Address:** _____

Primary Care Physician: _____ **Phone #:** (____) ____ - ____

Practice Name: _____ **Address:** _____

Social Security #: ____ - ____ - ____ **Date of Birth (mm/dd/yyyy):** ____ / ____ / ____

What is your current: Height (ft' in"): ____ ' ____ " **Weight (lbs.):** ____ **BMI:** ____ (office use)

Duration of Obesity: ____ years **Maximum Weight:** ____ lbs. **Age:** ____ years

Have you had any prior Gastric Surgery (e.g., gastric bypass)? (check one) _____ YES _____ NO

If YES, 1) **What was the procedure?** _____

2) **When was the procedure performed?** _____

PERSONAL / SOCIAL HISTORY

Occupation: _____

Tobacco use: _____ YES _____ NO *If "yes", specify frequency* _____

Alcohol use: _____ YES _____ NO *If "yes", specify frequency* _____

Marital Status (married/single): _____ **Number of Children:** _____

Children Overweight: _____ YES _____ NO **Family Support for Weight Loss:** _____ YES _____ NO

EXERCISE HISTORY

MON TUES WED THUR FRI SAT SUN

Average total hours per week of exercise: _____ hour(s) _____

Exercises preferences (e.g., walking, running, tennis, swimming): _____

Barriers to exercise (e.g., time, pain, fatigue, lack of interest): _____

DIET HISTORY

Eating Habits (Please fill in your typical dietary intake (all foods/beverages) in a 24-hour period):

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____ Beverages: _____

Who buys the groceries? _____ How much do you spend a week on groceries? \$ _____

Do you read food ingredient and/or nutrition labels? _____ **YES** _____ **NO**

How many restaurant meals per week? _____

List specific food cravings: _____

Emotional Eating (eating in response to stress/anxiety, anger...please specify) _____

(Please check "Yes" or "No")

YES	NO
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Binge-Eating Disorder:

Eat more food than others in a 2-hour period.	<input type="checkbox"/>	<input type="checkbox"/>
Unable to stop eating or unable to control what or how much is eaten.	<input type="checkbox"/>	<input type="checkbox"/>
Eat rapidly	<input type="checkbox"/>	<input type="checkbox"/>
Eat until stuffed	<input type="checkbox"/>	<input type="checkbox"/>
Eat when NOT hungry	<input type="checkbox"/>	<input type="checkbox"/>
Eat alone because embarrassed to eat amount in front of others	<input type="checkbox"/>	<input type="checkbox"/>
Other (candy)	<input type="checkbox"/>	<input type="checkbox"/>
Frequency (___ days / week)		

Compensatory behavior

Purge	<input type="checkbox"/>	<input type="checkbox"/>
Fast	<input type="checkbox"/>	<input type="checkbox"/>
Laxatives	<input type="checkbox"/>	<input type="checkbox"/>
Excessive exercise	<input type="checkbox"/>	<input type="checkbox"/>
Other (lays down)	<input type="checkbox"/>	<input type="checkbox"/>

Prior Dieting Methods: Duration & total weight loss (*Please check off and fill in all the dieting methods you have tried.)

		Time on program (months)	Weight lost (pounds)	Weight loss maintained (months)
Self-directed				
<input type="checkbox"/>	Reducing portions			
<input type="checkbox"/>	Decrease snacks			
<input type="checkbox"/>	Decrease sweets			
<input type="checkbox"/>	Exercise			
Diets				
<input type="checkbox"/>	Atkins			
<input type="checkbox"/>	Carbohydrates Addict			
<input type="checkbox"/>	Cabbage Soup			
<input type="checkbox"/>	Other _____			
Group				
<input type="checkbox"/>	Weight Watchers			
<input type="checkbox"/>	Overeaters			
<input type="checkbox"/>	Jenny Craig			
<input type="checkbox"/>	Other: _____			
RX (Physician supervised medication)				
<input type="checkbox"/>	Meridia			
<input type="checkbox"/>	Xenical			
<input type="checkbox"/>	Phen-fen			
<input type="checkbox"/>	Other: _____			
Surgery				
<input type="checkbox"/>	Stapling			
<input type="checkbox"/>	VBG			
<input type="checkbox"/>	Roux-N-Y			
<input type="checkbox"/>	Other: _____			
Other				
<input type="checkbox"/>	SlimFast			
<input type="checkbox"/>	Other: _____			
<input type="checkbox"/>	Other: _____			

MEDICAL HISTORY

<i>Please check "Yes" or "No"</i>	YES	NO	Duration or Frequency of Disease
Obesity-Related Diseases			
Type II Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	
Joint Pains / Disability Level	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma (COPD)	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	
GERD (heartburn)	<input type="checkbox"/>	<input type="checkbox"/>	
Hypertriglyceridemia	<input type="checkbox"/>	<input type="checkbox"/>	
Hypercholesterolemia	<input type="checkbox"/>	<input type="checkbox"/>	
Menstrual Irregularity	<input type="checkbox"/>	<input type="checkbox"/>	

Past Medical History

Menopause	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	
Past Surgery: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Past Surgery #2: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	

Family History

Obesity	<input type="checkbox"/>	<input type="checkbox"/>	
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	
Type II Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	

Medications (please list all medications you are currently taking)

_____	_____	_____
_____	_____	_____
_____	_____	_____

Assessment & Recommendations:

Patient has tried multiple weight loss methods, but actual referral dependent upon surgical consult and all tests. If surgeon recommends LAP-BAND Adjustable Gastric Banding weight loss surgery then patient will be instructed nutritionally pre-op and post-op; encouraged to begin and continue activity (30 minutes/day) and given an opportunity to part of LAGB support group with a health psychologist and other LAGB patients.