FLORIDA FAWCETT
SURGICAL SPECIALISTS

FOR CLINIC USE ONLY
HT: ________ WT: _______
BMI: _________

Patient Intake Packet (PIP)

Patient Name ____ **Date of Birth:** ________________________

What is your height?_______**Ft** ______**in** **How much do you weigh?**__________**Lbs.** **BMI:**___________

NOTE: If you have had any type of surgical weight loss in the past other than the adjustable gastric banding, do not complete this packet. Please call the clinic for further assistance/instruction.

Are you able to read, write and communicate in the English Language? ❍ **YES** ❍ **NO**

If not, what is your primary language?____

Please list any other barriers to communication, education or any other special accommodations that you may require:

________________________ Preferred method of learning: ____

Patient Employment Information:

Employment status: ❍ Full Time ❍ Retired ❍ Disabled ❍ Student
❍ Part Time ❍ Unemployed ❍ Homemaker ❍ Leave of Absence

Patient's Current Employer:____ Years Employed:___________

Patient's Employer's address:____

Patient's Present or Former Occupation:____

Disabled? ❍ Yes ❍ No If Yes, specify the year and cause: Year:_______ Cause:_________________________

Can you walk unassisted? ❍ Yes ❍ No How far before needing rest?______________________(Approximate # of feet)

If you need assistance walking, what device(s) do you use? ❍ Cane ❍ Walker ❍ Crutches ❍ Other:____________

Are you wheelchair bound and unable to stand at all? ❍ Yes ❍ No How long in wheelchair?______________(Month/year)

Do you have a Medical Surrogate, Power of Attorney or anyone who makes your medical decisions?

❍ **YES** ❍ **NO** If yes, who?____Relationship to you?________________

Blood Consent:

***You must be willing to accept blood or blood products during, or after surgery if your condition is such that the physician deems it necessary. ☐ Yes, I agree ☐ No, I do not agree

Primary/Referring Physician:

First Name:______________________________ Last Name:____

Street Address:____

City:_____________________________ State:________ Zip Code:__________ Phone:_________________________

Have you discussed Weight Loss Surgery with your physician? ❍ Yes ❍ No Is your physician supportive? ❍ Yes ❍ No

Please list all Specialty Providers involved in your care: (cardiologist, pulmonologist, endocrinologist etc.)

Provider Name	Telephone Number	Specialty

Patient Signature:____ **Date**:_________________________

Weight Loss History:

How long have you been overweight?__________Years How long have you been 35 pounds overweight?_________Years

How long have you been 100 pounds or more overweight?__________Years When did you start dieting?__________Age

Have you ever had a “stomach stapling” or other gastric restriction procedure? ❍ Yes ❍ No

(If yes, please provide this information when entering in your previous surgical history.)

What is the most weight you have ever lost on a single diet?________lbs. How did you lose the weight?________________

How long did you sustain the weight loss?___________________________ ❍ No diet attempts of any kind

Check all that apply:

Unsupervised Diet Attempts: ❍ **NONE**

❍ Body for Life/Bill Phillips ❍ High Protein ❍ Low Fat ❍ Cabbage Soup
❍ Pritikin ❍ Stillman Diet ❍ Mayo Clinic ❍ Fasting
❍ Gloria Marshall ❍ Herbal Life ❍ Calorie Counting ❍ Scarsdale
❍ Richard Simmons ❍ Sugar Busters ❍ Atkin’s Diet ❍ Slim Fast
❍ Health Spa ❍ Low Carbohydrate ❍ South Beach ❍ Other:_____________

Supervised Diet Attempts: ❍ **NONE**

❍ Nutri-System ❍ Overeaters Anonymous ❍ Weight Watchers ❍ Jenny Craig
❍ TOPS ❍ Optifast ❍ HMR ❍ DASH
❍ LA Weight Loss ❍ Diet Center ❍ Other:____

Over-the-Counter or Prescribed Medications for Weight Loss: ❍ **NONE**

❍ Acutrim ❍ Dexatrim ❍ Ionamin/Adipex ❍ Phendiet ❍ Prozac
❍ Wellbutrin ❍ Amphetamines ❍ Didrex ❍ Tenuate ❍ Phentrol
❍ Redux ❍ Byetta ❍ Plegine ❍ Sanorex ❍ Meridia
❍ Xenical ❍ Diuretics (water pills) ❍ Pondimin ❍ Phenteramine
❍ Fen-Phen, # of months:_____________ ❍ Other:____

Behavioral Treatments for Weight Loss: ❍ **NONE**

❍ Hospitalization ❍ Hypnosis
❍ Physical Therapy ❍ Psychological Therapy
❍ Residential Programs ❍ Other:________________

Exercise: ❍ **NONE**

❍ Walking or Running ❍ Stationary cycle or treadmill
❍ Swimming ❍ Weight Training
❍ Team Sports ❍ Other:____________________

Eating Habits, Do you:

Snack between meals? ❍ Yes ❍ No
Eat a lot of sweets? ❍ Yes ❍ No
Drink caffeine-containing drinks? ❍ Yes ❍ No
•If yes, how many cups per day?_______________

Eat large meals? (gorge) ❍ Yes ❍ No
Drink carbonated beverages? ❍ Yes ❍ No
•If yes, how many cans/bottles per day?___________
Drink soda pop? ❍ Yes ❍ No ❍ Diet ❍ Regular

Have you used any of the following to control your weight? (Check all that apply)

❍ Binging and Purging ❍ Binging followed by food restriction ❍ Vomiting

❍ Excessive Exercise ❍ Excessive Calorie Restriction/Fasting

If so, when and how long was this period of behavior? ______________________________

Do you currently force yourself to vomit after eating? ❍ Yes ❍ No

Why do you feel you eat? ❍ Physical Hunger ❍ Loneliness ❍ Anxiousness ❍ Makes me happy ❍ Bored ❍ Other: ____________

What reasons do you feel contribute to your weight? ❍ Over Consumption ❍ Inactivity ❍ Emotional Wellbeing

What else contributes to your weight struggle, i.e. how do you account for why you have been unable to lose weight and/or maintain any weight lost?

____

____

Please tell us how your weight is interfering with your health and quality of life? ______________________________

____

____

Why are you seeking weight loss surgery? ______________________________

____

____

Please tell us why you feel you can be successful with weight loss surgery, despite the extreme lifestyle and dietary changes required?

____

____

If you use eating as an emotional outlet, what will you substitute when your eating is restricted?______________________

____

____

What is your greatest fear regarding surgery?______________________________

Medical History/Review of Symptoms: (Check all that apply)

General:	☐ **NONE**	
☐ Fevers	☐ Weight Gain	☐ Tired / No Energy
☐ Night Sweats	☐ Insomnia	☐ Hair Loss
☐ Appetite Change	☐ Other:______________________________	

Head and Neck:	☐ **NONE**	
☐ Wear contacts / glasses	☐ Vision Problems	☐ Hearing Problems
☐ Sinus Drainage	☐ Nose Bleeds	☐ Hoarseness
☐ Dentures, Partial / Full	☐ Allergies	☐ Glaucoma
☐ Regular Ear Infections	☐ Blurred / Double Vision	☐ Other:____________________

Cardiovascular: ☐ **NONE**

☐ Heart Attack
☐ Chest Pain w/ Activity
☐ Rhythm Changes
☐ Congestive Heart Failure
☐ **High Blood Pressure**
☐ Palpitations
☐ Varicose Veins
☐ Dyspnea on Exertion
☐ Ankle Swelling
☐ Ankle / Leg Ulcers
☐ **Elevated Triglycerides**
☐ Phlebitis / DVT (blood clot in leg)
☐ Clogged Heart Arteries
☐ Rheumatic Fever / Valve Damage / MVP
☐ Rapid Heart Beat
☐ Irregular Heart Beat
☐ Cramping in legs when walking
☐ Heart Murmur
☐ Atrial Fibrillation
☐ **Elevated Cholesterol**
☐ Other:______________________________

Respiratory: ☐ **NONE**

☐ Asthma
☐ Emphysema / COPD
☐ Bronchitis
☐ Pneumonia
☐ Chronic Cough
☐ Shortness of Breath at Rest
☐ **Use of Cpap / Bipap**
☐ Use of Oxygen
☐ Snoring
☐ Pulmonary Embolism (blood clot in lung)
☐ **Sleep Apnea / Epworth** _______
☐ Other:______________________________

Gastrointestinal: ☐ **NONE**

☐ Heartburn
☐ **Hiatal Hernia**
☐ Ulcers
☐ Diarrhea
☐ Blood in Stool
☐ History of Elevated Liver Enzymes
☐ Constipation
☐ IBS
☐ Umbilical Hernia
☐ Difficulty Swallowing
☐ Hemorrhoids
☐ Fissure / Polyps
☐ Rectal Bleeding
☐ Black, Tarry Stool
☐ Ventral Hernia
☐ Abdominal Pain
☐ Enlarged or fatty Liver
☐ Cirrhosis / Hepatitis
☐ Gallbladder Problems
☐ Jaundice
☐ Pancreatic Disease
☐ Nausea / Vomiting
☐ GERD (acid reflux)
☐ Incisional Hernia (abdomen)
☐ **Barrett's Esophagus**
☐ Other:____

Bladder/Kidney: ☐ **NONE**

☐ Kidney Stones
☐ Blood in Urine
☐ Prostate Problems
☐ Kidney Failure / Renal Insufficiency
☐ Leaking urine w/ cough/laugh/sneezing
☐ Men: PSA test in last year?
☐ Trouble starting urine
☐ Burning / Pain on urination
☐ Urinary Urgency/Frequency
☐ Overall Loss of Bladder Control
☐ Other:____

Gynecologic: (for women only) ☐ **NONE**

☐ Problems Conceiving / Infertility
☐ Currently Pregnant
☐ Uterine / Ovarian Cancer
☐ PCOS
☐ Menstrual Irregularity
☐ Menstrual Pain
☐ Excessively Heavy Periods
☐ Plan to have more children
☐ Post-Menopausal

How many pregnancies have you had:____________________________ Date of Last Pap Smear?________________________

How many miscarriages or abortions have you had:_________________ Date of last menstrual period?____________________

Breast: ☐ **NONE**

☐ Nipple Discharge
☐ Lumps / Fibrocystic Disease
☐ Other:______________________________
☐ Pain
☐ Cancer
Date of last Mammogram:_________________

Musculoskeletal: ☐ **NONE**

☐ Shoulder Pain ☐ Neck Pain ☐ Elbow Pain
☐ Hip Pain ☐ Wrist Pain ☐ Back Pain
☐ Foot Pain ☐ Knee Pain ☐ Ankle Pain
☐ Plantar Fasciitis ☐ Heel Pain ☐ Ball of Foot Pain
☐ Broken Bones ☐ Carpal Tunnel Syndrome ☐ Lupus
☐ Muscle Pain / Spasm ☐ Sciatica ☐ Rheumatoid Arthritis
☐ Fibromyalgia ☐ Other:____________________

Neurologic: ☐ **NONE**

☐ Balance Disturbance ☐ Dizziness ☐ Restless Leg Syndrome
☐ Stroke ☐ Seizures or convulsions ☐ Weakness
☐ Knocked Unconscious ☐ Numbness / Tingling ☐ Multiple Sclerosis
☐ Pseudo tumor Cerebri (loss of vision from high pressure in the brain) ☐ Other:____________________

Psychiatric: ☐ **NONE** **Are you currently under the care of a mental health provider?** ☐ **Yes** ☐ **No**

☐ Depression ☐ Anxiety
☐ Bipolar Disorder ("manic-depression") ☐ Alcoholism / Substance Abuse
☐ Been hospitalized for psychiatric problems ☐ Attended a chemical dependency program
☐ Attempted suicide ☐ Attention Deficit Disorder (ADD)
☐ Currently taking medications for psychiatric problems or for depression ☐ Victim of Mental/Emotional/Sexual/Physical Abuse
☐ Attention Deficit Disorder (ADD) ☐ Other:____________________

Endocrine: ☐ **NONE**

☐ Parathyroid ☐ Hypothyroid ☐ Goiter
☐ Low Blood Sugar ☐ Excessive Thirst ☐ Endocrine Gland Tumor
☐ "Pre-Diabetes" ☐ **Diabetes (Diet or Pill controlled)** ☐ **Diabetes (Insulin Shots)**
☐ Abnormal Facial Hair ☐ Excessive Urination ☐ Gout
☐ Other:____________________

Blood/Lymphatic: ☐ **NONE**

☐ Low Platelets (thrombocytopenia) ☐ Anemia ☐ HIV / AIDS
☐ Bruise Easily ☐ Lymphoma ☐ Swollen Lymph Nodes
☐ Bleeding/Clotting Disorder ☐ Blood thinning medicine use ☐ History of a blood clot
☐ Prior blood Transfusion ☐ Other:____________________

Skin: ☐ **NONE**

☐ Frequent Skin Infections ☐ Keloids (Excessively Raised Scars) ☐ Poor Wound Healing
☐ Psoriasis ☐ Rashes under Breasts / Skin Folds ☐ Rosacea
☐ Hair or Nail Changes ☐ Other:____________________

List Prescribed Medications:	**Taken for what condition:**	**Dosage/How Often:**
☐ **NONE**		
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

List any Over-the-Counter medications, herbal supplements or vitamins that you take on a regular basis:

Product:	**Taken for what purpose:**	**Dosage/How Often:**
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Pharmacy: ______________________ Location: ______________________________________

Allergies:

☐ Latex, Reaction:______________________________ ☐ Tape (adhesives), Reaction:__________________________

☐ Iodine, Shellfish Reaction:______________________ ☐ IV Contrast Dye, Reaction:__________________________

Medication Allergies: (List any medications that you are allergic to and your reaction):__________________________

____

____

Food Allergies (List foods and the reaction):____

Surgical History: ☐ **NONE**

		Year		Year
Gallbladder	(Open)	_______	Tonsillectomy	_______
Gallbladder	(Laparoscopic)	_______	D & C	_______
Appendectomy	(Open)	_______	Ear Surgery:______________________	_______
Appendectomy	(Laparoscopic)	_______	Mouth Surgery:____________________	_______
Hysterectomy	(Vaginal)	_______	Heart surgery: CABG/Stents	_______
Hysterectomy	(Abdominal)	_______	Valve Replacement	_______
Ovary Surgery:	❍ Ovaries Removed	_______	Pacemaker or Defibrillator	_______
Hernia Repair:	❍ **Hiatal** ❍ Umbilical	_______	Back:___________________________	_______
Tubal Ligation		_______	Knee: ❍ Right ❍ Left	_______
Cesarean Section		_______	Breast Biopsy: ❍ Right ❍ Left	_______
Colonoscopy		_______	Anti-reflux procedure (Nissen)	_________
Colostomy		_______	Kidney Surgery	_______
Colon Resection		_______	Other:___________________________	_______
Endoscopy (EGD- scope through mouth)		_______	Other:___________________________	_______

Have you previously had any type of weight Loss Surgery? **[ ] YES** **[ ] NO**

Year of Surgery:___________________________ Surgeon: ____

List any complications of WLS: ____

Original weight prior to Surgery: _______________ Lowest Weight Achieved: __________

Anesthesia Problems: Please tell us about any problems that you have had with anesthesia: ❍ **NONE**

❍ Nausea ❍ Heart Stopped ❍ Woke up during procedure

❍ Vomiting ❍ Stopped Breathing ❍ Other:_________________________________

❍ Difficulty Waking Up ❍ Difficulty Urinating

Social History:

Do you smoke now? ❍ Yes ❍ No If yes, how many packs per day?_____________

Have you smoked in the past? ❍ Yes ❍ No If you have quit, how many years since?_______

For how many years did you use tobacco? ___________Years

Do you use snuff or chew? ❍ Yes ❍ No If yes, how frequently do you use?____________

If you are a tobacco user, as part of your weight loss journey, a referral to a Tobacco Cessation Program is required.

Do you consume alcohol now? ❍ Yes ❍ No

If yes, how many times per week? __________ If yes, how many drinks each time?___________

For how many years do/did you drink alcohol? __________Years

Is anyone concerned about the amount you drink? ❍ Yes ❍ No If you have quit, how many years since?_______

Do you use street drugs now? ❍ Yes ❍ No If yes, what drugs?________________________

If yes, how frequently do you use these drugs? ___________ If you have quit, how many years since?_______

How many hours a day do you watch TV? ❍ Never ❍ Rarely ❍ 3-5 hours ❍ 5+ hours

What hobbies do you have that are important to you? ______________________________

Could someone help care for you if you were seriously ill? ❍ Yes ❍ No Who?______________________________

Are there people for whom you are the primary care giver? ❍ Yes ❍ No Who?______________________________

On a scale of 1 to 5 (1 = least satisfied, 5 = very satisfied), rate the following situations in your life.

Married Life? ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5

Present job/activities? ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5

Overall satisfaction with yourself? ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5

Family Medical History: (Check all that apply)

Disease	Mother	Father	Siblings (specify brother or sister)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Morbid Obesity							
Diabetes- Age Occurred							
High Blood Pressure							
Stroke- Age Occurred							
Heart Attack- Age Occurred							
Cardiovascular Disease							
Bleeding/Clotting Disorders							
Sleep Apnea							
Cancer: Type & Age Occurred							
Death- Age & Cause							
If Still Living, what age							

Thank you for taking the time to fill out our Patient Intake Packet (PIP).

Please check to make sure that you have completed all the following before sending in your packet:

☐ Filled out this form as completely as possible or placed NA if not applicable to you.

☐ Made a copy of the front and back of your insurance card

☐ Signed the Blood Consent and any other place your signature was required.

Please bring the completed PIP packet with you to the seminar, or to your first office visit. We must have the packet or we will have to reschedule your first office visit.

Date the packet completed:______________________________

Insurance Information:

Payment Type: ❍ Insurance ❍ Self-pay if no insurance benefits for bariatric surgery

	If it is determined through insurance benefit verification that you have an exclusion in your policy, are you interested in self-paying for surgery? **If yes, we will proceed with your process.** **If no, your process will be stopped.**	☐ **Yes, please call me with additional information** ☐ **No, please stop my process**

Disclaimer:

- West Florida Physician Network, LLC is not responsible for any incorrect benefit coverage information received from your insurance company. We encourage you to call and verify benefit coverage by calling the customer service number on the back of your insurance card (Medicare, Medicaid and Tricare excluded).
- There is no guarantee of payment for services that may be rendered to you. Should the insurance company deny any services, you will be responsible for 100% of the charges.
- Completion of this form does not indicate that you are approved for weight loss surgery. A surgical pre-approval can only be obtained once the necessary documentation is sent to your insurance provider after all criteria has been met. You will receive a letter from your insurance once approval is given.

By signing below, I acknowledge the following:

- **I have read and understand the disclaimer which includes that I am not approved for surgery at this point.**
- **Weight loss surgery comes with no guarantee for weight loss.**
- **I understand that I must follow all instructions given to me by the bariatric team to have the best chance of weight loss success and weight loss maintenance. I understand this requires lifestyle changes lifelong to be successful.**
- **I understand major complications, including death can occur with any surgery, including bariatric surgery, both short and long term.**
- **I understand that smoking, 8 weeks prior to and following surgery (lifelong) can increase my risk of having major complications requiring additional surgery.**
- **I will review my patient guidebook once received and not advance my diet following surgery unless instructed to do so. I will call the clinic nurse and ask for assistance if not tolerating food or fluids.**
- **I agree to complete my follow-up appointments as outlined in my Owner's Manual for the best success at overall health and wellness. This may include vitamin surveillance.**
- **I understand the importance of a regular exercise program in helping with weight loss and maintenance of weight lost.**
- **I understand the importance of and agree to attend monthly support meetings at least 2 times per year.**
- **I understand that the best possible success with my surgical tool includes a regular exercise program to lose the most amount of weight and to keep it off long term.**

Patient Signature: ______________________________ **Date:** ________________

Patient Printed Name:______________________________

FLORIDA FAWCETT
SURGICAL SPECIALISTS

Epworth Sleepiness Scale

Date:	
Name:	Date of Birth:

Do you currently have a diagnosis of sleep apnea? ________ If yes, do you wear a C-Pap or Bi-Pap? ________________

How likely are you to doze off or fall asleep in the situations described below, in contrast to just feeling 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 chance of dozing

2 – Moderate chance of dozing

3 – High chance of dozing

Situation:

Situation	Score
Sitting and reading	
Watching television	
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	
Laying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL SCORE	

Score Interpretation:

0 – 10 Normal Range 10 – 12 Borderline 12 – 24 Abnormal

Staff Signature: ______________________________________

Action: ☐ None needed at this time ☐ Sleep study referral needed