North Shore-LIJ Surgical Specialists
310 East Shore Road-Suite 203, Great Neck, NY 11023
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Name: ___________________________________ Date: ____________________________

Internist:__________________________________

You must complete **all** of the following tests to have surgery. Call the office periodically to be sure we are receiving all of your test results. Whenever possible, obtain copies of your records and forward them directly to this office. The following test results **must be received to get a tentative surgery date:** 1. Psychiatric clearance. 2. Dietary clearance. 3. Final sleep apnea study. **In addition,** if your insurance requires the 6 month supervised weight loss plan, we must receive **at least 3 months of the proper documentation.**

- Letter of support from your primary care physician
- Medical clearance (one week prior to surgery)
- Upper GI series
- Abdominal Sonogram
- Echocardiogram and stress test
- Pulmonary function test (PFT)
- Sleep apnea study
- Endoscopy
- Colonoscopy
- Dietary evaluation and clearance
- Psychiatric evaluation and clearance
- Lab work
- Attendance to **at least** 1 pre-operative support group meeting
- 5 year weight history from your primary care physician
- 6 month supervised weight loss plan (if applicable)
- Women age 40 and over
    - Mammogram (within 3 years)
    - Recent Pap smear (within 3 years)

Before you begin your medical tests, call your insurance company to be sure weight loss surgery is a covered benefit under your plan. The procedure codes are as follows:

Gastric Bypass-43846
Laparoscopic Gastric Banding-43770

Dietary Evaluation
- Lisa Gentile, RD 516-662-3801
- Nicolette Pace, RD 718-281-2500
- Lisa Lundy, RD 516-286-4223

Psychiatric Evaluation
- South Bay Counseling 631-563-4355
- Deborah Cosgrove 631-207-9270
- Eileen Rosendahl 516-869-8877

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BARIATRIC NEW PATIENT VISIT

Patient's Name: Date of visit:

DOB: Referring MD:

Laparoscopic Gastric Banding

Laparoscopic Gastric Bypass

Open Gastric Bypass

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Larry Gellman, M.D., F.A.C.S., F.A.S.M.B.S.
Marc L. Greenwald, M.D., F.A.C.S.
Paul Katz, M.D., F.A.C.S.
Lewis M. Kurtz, M.D., F.A.C.S.
Howard L. Nadjari, M.D., F.A.C.S.
Angelo J. Procaccino, M.D., F.A.C.S.

Dear Patient:

Congratulations on taking the first step towards a healthy life. So that we may best serve your personal needs, we ask that you take your time filling out the enclosed questionnaire. It is imperative that you answer ALL the questions to be best of your ability. Any gastric restrictive procedure is serious and we need as much information about you, the patient, in order to determine how we can best take care of you.

We understand that losing weight and maintaining weight loss over an extended period is difficult. There are different surgical options which can help morbidly obese individuals lose weight and maintain that weight loss. The patients understanding of these options along with a strong motivation to succeed after surgery are crucial. Altering lifetime habits requires education, emotional support and commitment. We are committed to helping you modify your eating behavior and assist you in making all the necessary lifestyle changes that will lead to a healthier life and long term weight loss.

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PERSONAL INFORMATION

Which surgery are you interested in? (Check all that apply):

________ Laparoscopic Gastric Banding

________ Laparoscopic Roux-en-Y Gastric Bypass

________ Open Roux-en-Y Gastric Bypass

Name: ______________________________ DOB:_________________ Date: _________

Address:____

Telephone:_________________ Work:____________________Cell: ________________

Email: ____

Contact Person:
This information is often vital to us if we need to contact you urgently. Occasionally people move or have new phone numbers and do not let us know.

1. NEXT OF KIN (Not spouse or live in partner)

Name: ___________________________________ Relationship:____________________________

Telephone: ____

2. ADDITIONAL CONTACTS

Name: ___________________________________ Relationship:____________________________

Telephone: ____

Name: ___________________________________ Relationship:____________________________

Telephone: ____

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SOCIAL PROFILE

____ Married ____ Single ____ Divorced ____ Partner

Children/Ages: ____

Friends: ____

___

Do you have a pet (s), if so, give details: ______________________________________

___

EMPLOYMENT

Are you currently employed? ____

Full time/ Part time: ____

If unemployed, what is the reason? ____

Are you actively looking for work? ____

Has your weight made it difficult to find employment? ___________________________

If employed, please state what level of activity your job involves:

Little (sedentary): ________ Moderately active: ________ Very Active: _________

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PHYSICIAN INFORMATION

Dr. Requesting Consultation: ______________________________

Address: ______________________________

Telephone: ______________________ Fax: ______________________

Primary Care Physician (Omit if same as above): ______________________

Address: ______________________________

Telephone: ______________________________

Other Physician (s) you see on a regular basis:

Name/Specialty/Address: ______________________________

Name/Specialty/Address: ______________________________

Name/Specialty/Address: ______________________________

WEIGHT HISTORY

Please indicate your weight at the following times:

	Below average	Average weight	Above average	Normal
Birth Weight				
Weight at age 5-6				
Weight at age 10-12				
Weight at age 21				

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WEIGHT LOSS HISTORY

	# Attempts	Mo/year	How long	Weight loss	Wt. Gain
Weight Watchers					
Nutri System					
Jenny Craig					
Diet Center					
Overeaters Anon.					
Slimfast					
Liquid protein					
Low calorie diet					
Atkins					
Scarsdale					
Richard Simmons					
Herbalife					
Cambridge					
Southbeach					
Physician supervised					
Other					

DIET PILLS

Fen-Phen: ____

Redux/Amphetamines: __________________________________

Other: ____

Was there any particular event that led to significant weight gain? If so, explain:
____

____

____

____

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PERSONAL MEDICAL HISTORY

Have you ever suffered with any of the following health problems:

Diabetes: Yes___ No____ Details ______________________________

Gestational Diabetes: Yes___ No____ Details ______________________________

Asthma: Yes___ No____ Details ______________________________

Respiratory/Breathing Problems: Yes___ No____ Details _____________________________

Arthritis or joint pain: Yes___ No____ Details ______________________________

Back pain: Yes___ No____ Details ______________________________

Kidney or urinary disorder: Yes___ No____ Details ______________________________

Neurological problems: Yes___ No____ Details ______________________________

Psychological disorder: Yes___ No____ Details ______________________________

Gallstones: Yes___ No____ Details ______________________________

Reflux or heartburn: Yes___ No____ Details ______________________________

Gastric or duodenal ulcer: Yes___ No____ Details ______________________________

Hepatitis or liver disease: Yes___ No____ Details ______________________________

High blood pressure: Yes___ No____ Details ______________________________

High cholesterol: Yes___ No____ Details ______________________________

Heart disease: Yes___ No____ Details ______________________________

Anemia or bleeding disorder: Yes___ No____ Details ______________________________

Thrombosis or clotting disorder: Yes___ No____ Details ______________________________

Varicose veins or leg Swelling: Yes___ No____ Details ______________________________

Eczema or skin conditions: Yes___ No____ Details ______________________________

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Please give details of any major illnesses: ____

____

____.

Please list all the medications you have taken in the past year and all the medications you are currently taking, along with the dosage.

Medications used in the past year: ____
____
____

Medications you are currently taking:____
____
____

ALLERGIES (Including foods, medications): ____________________________________
____
____

SLEEP HISTORY

How many hours of sleep do you get each night? ______________________

What is the quality of your sleep? Good _____ Fair _____ Poor _____

1. How often do you snore?

NEVER ____ALWAYS

2. Do you awake during the night with a choking feeling?

NEVER ____ALWAYS

3. How often do you wake up more than once during the night?

NEVER ____ALWAYS

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4. Do you have a headache when you wake up in the morning?

NEVER ____ ALWAYS

5. Have you noticed a reduction in your libido or sex drive?

NEVER ____ ALWAYS

6. Do you feel sleepy during the day?

NEVER ____ ALWAYS

7. Has anyone noticed that you momentarily stop breathing during your sleep?

NEVER ____ ALWAYS

8. Do you fall asleep while reading?

NEVER ____ ALWAYS

9. Do you wake up in the morning feeling confused?

NEVER ____ ALWAYS

10. How often do you take a nap during the day?

NEVER ____ ALWAYS

11. How often do you doze off or fall asleep while driving?

NEVER ____ ALWAYS

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BREATHING HISTORY

Does being active ever make your chest tight or make you wheeze?

Yes ______ No ______ If yes, please explain: ________________________________

____

ASTHMA

Have you ever had asthma?

Never ____ Currently ____ In the past ____

Have you ever had to spend a night in the hospital because of asthma or breathing problems? Yes______ No ______

If yes, was it in the past 12 months? Yes ______ No ______

In the past 12 months, have you taken a course of prednisone because of asthma or breathing problems? Yes ______ No ______

ACTIVITY

How many sessions of exercise, (walking, sports, etc.), do you do per week for 30 minutes or more at a time?
____

What type of activities? ____

____

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GASTROESOPHAGEAL REFLUX/DIGESTION PROBLEMS

Do you have a history of heartburn or any other digestion problems? Yes ____ No ____

Details: ____

If yes, how often do you have reflux during the day?

Multiple times per day ___ Every night ___ Most nights ___ Several times per week ___
Occasionally ___

Do you suffer from heartburn/indigestion during the night? If so, how often?

Several times per night ___ Every night ___ Most nights ___ Several times per week ___
Occasionally ___

What aggravates or causes your reflux? _____________________________________

____

Do you have difficulty swallowing? Yes ______ No ______

If yes, please explain: ____

Does food ever feel stuck? Yes ______ No ______ If yes, please explain: ____________

____

Do you vomit after reflux? Yes ______ No ______ If yes, please explain: ____________

____

Do you suffer from a regular cough at night? Yes ______ No ______ If yes, please
explain:____

WHY DO YOU WANT TO LOSE WEIGHT? ________________________________
____

____

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SURGICAL HISTORY

Please give details of any past surgeries: ____

____

____

Do you smoke? Yes ____ No ____ Never ____ If yes, how many per day? ___________

Have you smoked in the past? Yes ____ No ____ If yes, how many per day? __________

For how many years? _________________ When did you quit smoking? _____________

Do you drink alcohol? Yes ____ No ____ (If no, skip next question)

How often? _________________________ How much? ____________________________

Do you take multivitamin or dietary supplements? Yes ___ No ___ (If no, skip next question)

Rarely ____ Monthly ____ Weekly ____ Most days ____ Everyday ____

What type of vitamins do you take? ____

LADIES

Do you have regular periods? Yes ______ No ______

If not, please explain: ____

____

Have you had difficulty conceiving in the past? Yes ______ No ______

Do you currently have infertility problems? Yes ______ No ______

Do you suffer from excess body hair or acne? Yes ______ No ______

Have you ever been told by a doctor that you have cystic ovaries? Yes ______ No _____

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Do you experience urinary incontinence? Yes ______ No _____

Have you ever had problems with pregnancy and/or childbirth?

Yes ______ No _____

If so, in what way? ____

____

MALES

Do you have normal erections? Yes _____ No ______

FAMILY MEDICAL HISTORY

Please indicate family history of any of the following conditions:

	Parent	Sibling/child	Other relative	No family history	Don't know
Diabetes					
Heart Disease					
Hypertension					
Gallstones					
Sleep apnea/snoring					
Asthma					
High Cholesterol					
Allergies					
Osteoporosis					
Dermatitis					

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SPECIAL INFORMATION REGARDING YOUR PRESURGICAL EVALUATIONS AND DATE OF SURGERY

Medical Evaluations: Your physician has determined what medical testing is required for you depending on your past and current medical conditions. You must complete **all** of these tests before undergoing surgery.

Dietary Evaluation: This office, and your insurance company, requires that you see a nutritionist prior to undergoing bariatric surgery. It is mandatory that he or she specialize in bariatric surgery and is familiar with **this** surgical practice. This will ensure you have the correct dietary guidelines pertaining to the type of surgery you are having. **It is imperative you have a complete understanding of the post-operative diet.** If you see a dietician not known to this office, you must be sure to obtain the proper guidelines and present those guidelines to this office prior to your surgery.

Psychological screening and clearance: Part of your pre-surgical work-up requires a psychiatric evaluation and clearance. In addition, The American Society for Bariatric Surgery recommends this to ensure a successful outcome.

This evaluation enables your surgeon to identify any additional support you need both pre and post operatively. After your evaluation, the psychologist will provide you with feedback. Many patients find these recommendations helpful in preparing themselves for surgery. At times, we may require more extensive pre-surgical counseling so our patients are emotionally prepared for the changes and commitment bariatric surgery requires. Long term weight loss success is directly correlated to how mentally prepared you are for the surgery. You may be required to complete a brief course of pre-surgical therapy with a professional who specializes in weight management.

There is a possibility your surgeon, after conferring with the psychologist, will decide surgery may not be appropriate for certain individuals. In these cases, we make every effort to assist individuals with pursuing other treatment options.

Please note: In most cases, insurance companies will not cover both the dietary and psychological evaluations. If you choose to see professionals who are not recommended or known to this practice, you may not be given the correct information. Please speak to a staff member before seeing a dietician or psychiatric professional not associated with the practice.

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Your surgery date: You must complete all of the required testing to get a surgery date. **All** of your medical reports, dietary and psychological evaluations must be in our office to submit to your insurance. We book surgery very far in advance, therefore, the surgery date you are given is **tentative.** Unforeseen circumstances may arise which may change your surgery date. **PLEASE NOTE:** We make every effort to accommodate our patients. Booking surgery so far in advance does not give us time to allow for illnesses, vacations and emergency surgery. We realize our patients make special arrangements around their surgery date. If your surgery date is changed, please be aware we understand this may be a burden, but we can not control these circumstances.

If you would like to discuss any of the above, please call our office to speak with a staff member.

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INFORMATION REGARDING PREOPERATIVE SUPPORT GROUP MEETINGS

It is mandatory you attend at least one meeting before surgery
Gastric Bypass support group meeting schedule for the year 2009 is as follows:

January 12th
February 23rd
April 6th
May 18th
June 29th
August 10th
September 21st
November 2nd
December 14th

****Laparoscopic Gastric Banding-4th Tuesday of every month**

The meetings begin at 6:00 p.m., in our office at 310 East Shore Road, Suite 203, Great Neck, NY 11023. If you have any questions, please feel free to call 516-482-8657.

We will be discussing, in detail, the key aspects of bariatric surgery. Weight loss surgery is a serious undertaking and it is critical the patient, as well as family and/or friends of the patient, be educated about surgery. Therefore, you are permitted to bring up to two people with you to the meeting. Please be aware the material discussed may be inappropriate for children.

Note- Meetings are subject to change due to inclement weather, holidays and other circumstances. Please call the office to confirm before you attend.