

NH Medical & Surgical

Weight Loss Center

Portsmouth Regional Hospital ♦ Parkland Medical Center

Program Application

Date attended Informational Seminar (date) _____

site [] Derry

[] Portsmouth

1. Demographics:

| | | |
|--|----------------|--------------|
| Name _____ | DOB _____ | Age _____ |
| SSN _____ | Gender _____ | |
| Address _____ | | |
| City/state _____ | zip code _____ | |
| Phone# (H) _____ | (W) _____ | (Cell) _____ |
| Place of employment _____ | | |
| Email _____ | | |
| Insurance Company/Plan _____ | | |
| Insurance Policy # _____ | Group # _____ | |
| Insurance Phone # _____ | | |
| Subscriber's name _____ | DOB _____ | |
| Subscriber's place of employment _____ | | |
| Secondary Insurance Co./Plan _____ | | |
| Insurance Policy # _____ | Group # _____ | |
| Insurance Phone # _____ | | |

2. Health Care Providers

Name & Address PCP _____

Please list the names and phone numbers of any specialists you see:

3. Weight History

Current Weight (lbs) _____ Current Height _____ BMI _____

Onset Obesity Childhood _____ Adult _____

Family Obesity _____

In your opinion what are the contributing factors to your excess weight? Check all that apply:

Portion size Too much fat or sugar Nervous eating Emotional eating

Compulsive eating Stress Lack of exercise

Lack of knowledge regarding healthy eating

Other contributing factors _____

History of Eating Disorders?

Binging _____ Purging _____ Vomiting _____ Fasting _____ Laxatives _____

Diuretics _____ Appetite Suppressants _____ Other _____

Lowest Weight _____ Highest Weight _____

Ideal Body Weight (by medical standards) _____ Personal Ideal Body Weight _____

How much do you expect to lose as a result of treatment?

less than 50 lbs 50-100 lbs 100-150 lbs more than 150 lbs

What do you expect to be able to do after weight loss that you are unable to do now?

Current Diet Habits:

Eating style: Your degree of hunger before a meal

none little moderate extreme

How long does it take you to eat a meal? _____

Do you feel full after you eat? _____

Do you feel out of control when you eat? _____

Do you eat alone? _____ Do you store food out of sight? _____

Typical Food Intake

Please indicate what you would normally eat in an average day and approximately what time of day you would eat – include portion sizes. Do not forget beverages. (including how much)

| Breakfast | Lunch | Supper | Snacks |
|-----------|-------|--------|---|
| Time: | Time: | Time: | Time: Time: Time: Time: Time: |

Current Activity Level and Exercise:

Can you reach your feet when bathing or dressing? _____

Do you sleep in a bed? _____ Can you get in and out by yourself? _____

How far can you walk? _____

Do you have limitations of exercise? _____

Do you use a cane, walker or wheelchair? _____

Can you climb stairs? _____

Do you need to use stairs to get into your home? _____

Do you need to use stairs once you are in your home? _____

Do you currently exercise or participate in sports? (type/frequency) _____

Weight Loss Efforts

(Please check any you have tried, and circle any you have tried in the past 12 months)

| Commercial Diet Programs | Duration | Results |
|--|----------|---------|
| <input type="checkbox"/> Weight Watchers | | |
| <input type="checkbox"/> Jenny Craig | | |
| <input type="checkbox"/> Nutrisystem | | |
| _____ | | |
| _____ | | |

| Liquid Diets | Duration | Results |
|-----------------------------------|----------|---------|
| <input type="checkbox"/> Slimfast | | |
| <input type="checkbox"/> Optifast | | |
| <input type="checkbox"/> HMR | | |
| _____ | | |

| Prescription Medications | Duration | Results |
|---|----------|---------|
| <input type="checkbox"/> Redux (dexfenfluramine) | | |
| <input type="checkbox"/> Pondimin (fenfluramine) | | |
| <input type="checkbox"/> Fen-Phen | | |
| <input type="checkbox"/> Phentermine (Fastin, Adipex) | | |
| <input type="checkbox"/> Amphetamines | | |
| <input type="checkbox"/> Meridia (sibutramine) | | |
| <input type="checkbox"/> Xenical (orlistat) | | |
| _____ | | |

| Non-Prescription Medications | Duration | Results |
|--|----------|---------|
| <input type="checkbox"/> Ephedra, ma huang | | |
| _____ | | |
| _____ | | |

| Therapy and Other Programs | Duration | Results |
|--|----------|---------|
| <input type="checkbox"/> Behavior Therapy | | |
| <input type="checkbox"/> Psychotherapy | | |
| <input type="checkbox"/> Exercise programs | | |
| <input type="checkbox"/> Lean Bodies | | |
| <input type="checkbox"/> Atkins | | |
| <input type="checkbox"/> South Beach Diet | | |
| <input type="checkbox"/> Mike Thurman | | |
| _____ | | |
| _____ | | |

| Medical/Surgical Treatments | Duration | Results |
|---|----------|---------|
| <input type="checkbox"/> Previous gastric surgery, stomach stapling | | |
| <input type="checkbox"/> Jaw wiring | | |
| <input type="checkbox"/> Other surgery _____ | | |
| <input type="checkbox"/> Acupuncture | | |
| <input type="checkbox"/> Hypnosis | | |
| <input type="checkbox"/> Other _____ | | |

4. Comorbidities

Cerebrovascular Disease

- Deep Venous Thrombosis
- Atherosclerosis
- Peripheral Vascular Disease
- Lipid Disorder
- Hypertension
- Coronary Artery Disease/Congestive Heart Failure
- CVA (stroke)
- Venous stasis disease
- Ankle swelling
- Pseudotumor cerebri

Pulmonary Disease

- Pulmonary Emboli
- Sleep Apnea
- Asthma
- Pulmonary Hypertension
- Hypoventilation (Pickwickian syndrome)

Endocrine Disease

- Insulin resistance
- Type 2 Diabetes
- Hyposecretion of growth hormone

Gastrointestinal Disease

- GERD
- Fatty Liver
- Cirrhosis
- Gallbladder Disease

Cancer

- Colon
- Breast
- Ovarian
- Endometrial
- Prostate
- Renal
- Pancreatic
- Gallbladder
- Liver

Genitourinary Disease

- Stress Incontinence
- Reduced Fertility
- Menstrual Irregularities

Skin Problems

- Skin and Soft Tissue Infections
- Intertriginous Dermatitis

Skeletal Problems

- Osteoarthritis
- Degenerative Joint Disease
- Back Pain
- Gout

Psychosocial Problems

- Depression
- Altered body image
- Societal discrimination
- Anxiety disorders
- Other

5. Other Medical Problems

Heart/Cardiovascular

Lungs

Endocrine (thyroid, adrenal, etc)

Gastrointestinal

Cancer

Genitourinary

Skin Problems

Musculoskeletal

Nervous System

Psychological/Psychiatric

Head and Neck _____

Other _____

6. Previous Surgeries

Please list all surgeries with approximate date and reason for procedure if not obvious.

7. Medications

Please include dosage and frequency. Also include any herbals/vitamins/supplements/over-the-counter products.

8. Allergies

Medications _____

Latex ? Y N Other _____

9. Family History

Obesity _____

Coronary Artery Disease _____

Stroke _____

Diabetes _____

High Blood Pressure _____

Lipid Disorder _____

Cancer _____

Other _____

10. Social History

Marital Status _____ Spouse/Significant Other Name _____

Members of your Household (include names, ages, and relationships):

Who will be your support through this process?

Caffeine/Sodas _____

Tobacco: Type _____

Past (amt/day) _____

Current (amt/day) _____

Alcohol: Type _____

Past (amt/day) _____

Current (amt/day) _____

Illicit Substances: _____

Level of Education _____

Occupation/Employer Location _____

In the past year or two, how many days of work have you missed due to obesity-related conditions? Please elaborate.

11. Review of Systems

Please check any symptoms you have experienced chronically (frequent recurrences over the years) as well as in the past 2-3 months.

Head and Neck:

- _____ headaches _____ fainting/blackouts _____ dizziness _____ facial weakness
- _____ vision changes _____ conjunctivitis _____ changes in hearing
- _____ ringing in ears _____ ear infections or drainage _____ nosebleeds
- _____ sinusitis _____ nose blockage _____ sores in mouth _____ sore throat
- _____ difficulty swallowing _____ snoring _____ hoarseness _____ loss of speech
- _____ difficulty sleeping

Cardiovascular:

- _____ chest pain _____ irregular or rapid heart rate (arrhythmia) _____ angina
- _____ difficulty breathing while lying flat _____ heaviness in chest _____ murmur
- _____ pain down arms or into jaw _____ ankle swelling _____ cramps in legs or buttock w/exercise

Lungs:

_____ shortness of breath at rest _____ shortness of breath walking on flat ground
_____ shortness of breath climbing stairs (#steps _____)
_____ Emphysema/COPD _____ Bronchitis _____ Pneumonia
_____ cough _____ sputum production _____ bloody sputum

Breast:

_____ pain/soreness _____ nipple drainage _____ redness _____ lumps
_____ cysts _____ abnormal mammogram _____ biopsy in past
Approximate date of last mammogram _____

Endocrine:

_____ abnormal thyroid function _____ excessive hot or cold sensation
_____ visual changes _____ change in voice
_____ recent increase in thirst or urination _____ abnormal hair growth
_____ abnormal menses _____ numbness or tingling in hands or feet
_____ Other _____

Gastrointestinal:

_____ frequent diarrhea _____ frequent constipation _____ gallbladder problems
_____ ulcers _____ heartburn _____ liver disorders or hepatitis _____ colitis
_____ polyps or tumors _____ hemorrhoids or anal fistulae _____ Crohn's disease
_____ blood in stools _____ vomiting _____ cramps _____ hepatitis
_____ black stools _____ change in stool color/quality _____ jaundice
_____ nausea _____ Other _____

Blood:

_____ Anemia _____ Iron deficiency _____ Previous transfusions
_____ Other _____

Psychiatric:

_____ Depression _____ Bipolar disease _____ Eating disorder
_____ Previous suicide attempt(s)
_____ Other _____

Urinary:

_____ Kidney stones _____ urine infections _____ pain with urination
_____ difficulty starting or stopping _____ frequent urination at night _____ blood in urine
_____ change in urine color

Extremities:

_____ Swelling _____ Pain _____ Numbness _____ Weakness _____ Injuries

Gynecologic:

Age at first menses _____ LMP _____ Regular menses? Y N
Children Y N Ages _____ Age at first pregnancy _____
Breastfeeding history _____ Abnormal bleeding Y N
Abnormal discharge Y N Birth Control Pills or Other Hormones _____
Approximate date of last pelvic exam and PAP smear _____

Please initial the statements below and sign the bottom of the page when you are finished.

_____ I have carefully read and answered this application in its entirety.

_____ I understand that failure to provide a complete and honest record may result in delay or cancellation of any planned surgical procedures.

_____ Please attach a copy of your insurance policy's statement with respect to Morbid Obesity. This will assist us in obtaining preapproval for your surgery.

Signature

Date

I heard about tonight's program from (please check):

PRH'S OneSource Magazine_____

Other_____

Newspaper advertisement:

PRH/PMS Web Site_____

Portsmouth Herald_____

ObesityHelp.com_____

Foster's Daily Democrat_____

Friend or Family Members_____

Hampton Union_____

Flyer_____

Exeter Newsletter_____

Radio_____

York County Coast Star_____

Newspaper Health/Calendar Listing

Union Leader_____

(please specify newspaper):_____

Newburyport News_____

Other (please specify):_____

| | |
|--------------------------|--|
| Mail your application to | Atlantic Surgical Associates 330 Borthwick Ave. Suite 308 Portsmouth, NH 03801 |
|--------------------------|--|

For questions call Nancy Seesman ARNP
Bariatric Coordinator
603-334-2006