

**WOMACK ARMY MEDICAL CENTER  
DEPARTMENT OF THE ARMY  
WAMC STOP A  
2817 REILLY ROAD  
MXCX-DOS-GS - BARIATRICS  
FORT BRAGG, NC 28310-7301**

**PHONE: (910)907-0787**

**SURGICAL WEIGHT LOSS PROGRAM**

DATE: \_\_\_/\_\_\_/\_\_\_\_\_

Name \_\_\_\_\_

SPONSOR'S SS# \_\_\_\_\_ PATIENT'S SS#: \_\_\_\_\_

Gender: \_\_ male \_\_ female                      Date of Birth \_\_\_/\_\_\_/\_\_\_\_\_

Race:  
\_\_ Caucasian \_\_ Hispanic \_\_ African American \_\_ Asian \_\_ Native American \_\_ Other

Address \_\_\_\_\_  
                    Street                      City                      State      Zip Code

TELEPHONE: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email address \_\_\_\_\_

Who Referred You? \_\_\_\_\_ Reason for Referral \_\_\_\_\_

Occupation: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Employment Status:  
\_\_ Full time \_\_ Part time \_\_ Self-Employed \_\_ Homemaker \_\_ Student \_\_ Retired  
\_\_ Disabled

**PEOPLE LIVING IN YOUR HOUSEHOLD**

<b>NAME</b>	<b>AGE</b>	<b>RELATIONSHIP</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**HEALTH CARE PROVIDERS/MEDICAL**

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address (if off-post): \_\_\_\_\_ Fax: \_\_\_\_\_

**HEALTH CARE PROVIDERS – MENTAL HEALTH**

Therapist or Mental health Counselor \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Please list all other medical health providers and specialist. If you need more space, list additional providers' names, specialties, addresses, telephone and fax numbers on the back of this page.

Provider name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Provider name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Provider name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Alcohol, Tobacco, and Non-prescription Drug History**

Current use: List all alcohol, tobacco, and non-prescription drugs and the amounts that you currently use. List any additional products on the back of this page.

	<u>Type of Product</u>	<u>Amount per day</u>	<u>Per Week</u>
Alcohol:	_____	_____	_____
	_____	_____	_____
Tobacco:	_____	_____	_____
	_____	_____	_____
Drugs:	_____	_____	_____
	_____	_____	_____

When did you stop or plan to stop using?

Alcohol: \_\_\_\_\_ Tobacco: \_\_\_\_\_ Drugs: \_\_\_\_\_

**Family History**

Please list any relatives that have a history of any the following conditions:

- |                    |                                  |
|--------------------|----------------------------------|
| <b>Mother- M</b>   | <b>Maternal Grandmother- MGM</b> |
| <b>Father- F</b>   | <b>Maternal Grandfather- MGF</b> |
| <b>Brother – B</b> | <b>Paternal Grandmother- PGM</b> |
| <b>Sister- S</b>   | <b>Paternal Grandfather- PGF</b> |

Obesity \_\_\_\_\_ Diabetes \_\_\_\_\_ Heart Disease \_\_\_\_\_

Stroke \_\_\_\_\_ High Cholesterol/Triglycerides \_\_\_\_\_

Cancer \_\_\_\_\_

**Prescription Medications, Supplements and Remedies**

Please list all your current medications, supplements and remedies. If you need additional space, please continue on the back of this page.

**Prescription drugs, dosages and purpose** (including psychiatric medication and birth control. Please use back of form for additional space. )

<u>Medication</u>	<u>Dosage/How Often</u>	<u>Purpose</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Over the counter drugs:**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Vitamins/supplements/herbal remedies:**

_____	_____
_____	_____
_____	_____

**Allergies to prescription medications:**

<b>Allergy</b>	<b>Reaction</b>

**HOSPITALIZATIONS**

Please list all inpatient hospitalizations, including psychiatric and substance abuse treatment. If you need additional room, please continue on the back of this page.

Approximate Date	Problem	Hospital/Treatment Facility
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**PREVIOUS NON-BARIATRIC SURGERIES**

**Procedure:**

- Anti-reflux procedure
- Breast Cancer, biopsy
- Removal of gallbladder
- Knee replacement
- Peripheral vascular Procedure
- C-section
- Bowel resection
- Breast cancer, radiation
- Hip replacement
- Laminectomy
- Tubal ligation
- Other \_\_\_\_\_
- Breast cancer, mastectomy
- CABG
- Hysterectomy
- Nissen Fundoplication
- Vasectomy

**PREVIOUS BARIATRIC SURGERIES**

- |   |   |
|---|---|
| <input type="checkbox"/> Bilopancreatic diversion (BPD)   | <input type="checkbox"/> Gastric banding, adjustable            |
| <input type="checkbox"/> Gastric band, non-adjustable     |   |
| <input type="checkbox"/> Gastric bypass, (Roux-en-Y) open | <input type="checkbox"/> Gastric bypass(Roux-en-Y) laparoscopic |
| <input type="checkbox"/> Sleeve gastrectomy               | <input type="checkbox"/> Gastric bypass, mini loop              |
| <input type="checkbox"/> Intestinal Bypass                | <input type="checkbox"/> Gastric bypass, banded                 |
| <input type="checkbox"/> Vertical banded Gastroplasty     | <input type="checkbox"/> BPD with duodenal switch               |
| <input type="checkbox"/> Other (Please list) _____        |   |

Year: \_\_\_\_\_

Original weight: \_\_\_\_\_ lbs Estimated? \_\_\_\_ Actual? \_\_\_\_

Lowest weight achieved \_\_\_\_\_ lbs \_\_ estimated \_\_ actual

Surgeon: \_\_\_\_\_

Have you ever had an adverse reaction to anesthesia/sedation? \_\_\_\_Y \_\_\_\_N  
 (If you answered yes, please comment) \_\_\_\_\_

Has any of your relative had an adverse reaction to anesthesia/sedation? \_\_Y\_\_N  
 (If you answered yes, please comment) \_\_\_\_\_

**Current Medical Conditions**

Please check box and add information.

**Heart and Circulation:**

**Comments**

- |  |       |
|--|-------|
| <input type="checkbox"/> Chest pain/coronary artery disease/angina   | _____ |
| <input type="checkbox"/> Congestive Heart Failure                    | _____ |
| <input type="checkbox"/> Irregular or rapid heart beat (arrhythmias) | _____ |
| <input type="checkbox"/> Peripheral vascular disease                 | _____ |
| <input type="checkbox"/> Leg swelling (edema)                        | _____ |
| <input type="checkbox"/> Hypertension/high blood pressure            | _____ |
| <input type="checkbox"/> Stroke                                      | _____ |
| <input type="checkbox"/> Blood Clots/Deep Vein Thrombosis (DVT)      | _____ |
| <input type="checkbox"/> Other: _____                                | _____ |

**Lungs:**

- Shortness of breath \_\_\_\_\_  
 at rest  walking on flat ground  on stairs/hills
- Asthma \_\_\_\_\_
- COPD (emphysema, chronic bronchitis) \_\_\_\_\_
- Pulmonary Embolism (Blood clot in the lungs) \_\_\_\_\_
- Sleep Apnea \_\_\_\_\_ CPAP settings \_\_\_\_\_
- Pulmonary Hypertension \_\_\_\_\_
- Other: \_\_\_\_\_

**Gastrointestinal/GI:**

- Gastro Esophageal Reflux (GERD) \_\_\_\_\_
- Heartburn \_\_\_\_\_
- Ulcers \_\_\_\_\_
- Crohn's Disease/Ulcerative Colitis \_\_\_\_\_
- Frequent Diarrhea \_\_\_\_\_
- Frequent constipation \_\_\_\_\_
- Gallbladder  stones  removed \_\_\_\_\_
- Fatty liver \_\_\_\_\_
- Colon  hemorrhoids  polyps \_\_\_\_\_
- Liver  hepatitis  Cirrhosis \_\_\_\_\_
- Other: \_\_\_\_\_

**Endocrine:**

- Diabetes \_\_\_\_\_
- High cholesterol, high triglycerides \_\_\_\_\_
- Infertility \_\_\_\_\_
- Menstrual irregularities \_\_\_\_\_
- Polycystic Ovarian Syndrome \_\_\_\_\_
- Thyroid  Hypothyroidism (Underactive) \_\_\_\_\_  
 Hyperthyroidism (Overactive) \_\_\_\_\_
- Excessive hot or cold feeling \_\_\_\_\_
- Visual Changes \_\_\_\_\_
- Changes in your voice \_\_\_\_\_
- Recent increase in thirst or urination \_\_\_\_\_
- Abnormal hair growth \_\_\_\_\_
- Numbness or tingling in your hands or feet \_\_\_\_\_
- Other: \_\_\_\_\_

**MEDICAL HISTORY**

**Blood:**

- Anemia \_\_\_\_\_
- Iron Deficiency \_\_\_\_\_
- Other: \_\_\_\_\_

**Comments**

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**Musculoskeletal:**

- Back pain \_\_\_\_\_
- Gout \_\_\_\_\_
- Arthritis type: \_\_\_\_\_
- Fibromyalgia \_\_\_\_\_
- Other: \_\_\_\_\_

**Psychiatric:**

- Depression \_\_\_\_\_
- Bi-polar Disorder \_\_\_\_\_
- Eating Disorder  Anorexia  Bulimia \_\_\_\_\_
- Anxiety \_\_\_\_\_
- Other: \_\_\_\_\_

**Other:**

- Urinary Stress Incontinence \_\_\_\_\_
- Pseudotumor Cerebi \_\_\_\_\_
- Abdominal Skin/Pannus irritation/infection \_\_\_\_\_
- Abdominal Wall Hernia \_\_\_\_\_
- Kidney Disease \_\_\_\_\_
- Kidney Stones \_\_\_\_\_
- Other: \_\_\_\_\_

**WEIGHT AND WEIGHT LOSS HISTORY**

Current weight or best estimate \_\_\_\_\_ Current Height \_\_\_\_\_

Weight 1 year ago \_\_\_\_\_

Are you at your highest weight ever? \_\_\_ Yes \_\_\_ No

If your answered no, what was your highest weight and when? \_\_\_\_\_

Please check all previous weight loss methods that you have tried. List any additional

Commercial diet programs

- \_\_\_ Weight Watchers
- \_\_\_ Diet Workshop
- \_\_\_ Jenny Craig
- \_\_\_ OA
- \_\_\_ TOPS
- \_\_\_ Nutrisystem
- \_\_\_ Other: \_\_\_\_\_
- \_\_\_ Other: \_\_\_\_\_

Prescription diet medications

- \_\_\_ Redu (dexfenfluramine)
- \_\_\_ Pondimin (fenfluramine)
- \_\_\_ Phen-Fen
- \_\_\_ Phentermine (Fastin, Adipex)
- \_\_\_ Amphetamines
- \_\_\_ Meridia (sibutramine)
- \_\_\_ Other: \_\_\_\_\_
- \_\_\_ Other: \_\_\_\_\_

Liquid Diets

- \_\_\_ Optifast
- \_\_\_ HMR
- \_\_\_ Slimfast
- \_\_\_ Other: \_\_\_\_\_

Herbal and non-prescription remedies

- \_\_\_ Epedra, ma huang
- \_\_\_ Other herbals: \_\_\_\_\_
- \_\_\_ Over the counter diet aids
- \_\_\_ Other: \_\_\_\_\_

**WEIGHT AND WEIGHT LOSS HISTORY**

Therapy and Other Programs

- \_\_\_ Behavior therapy
- \_\_\_ Psychotherapy
- \_\_\_ Exercise programs
- \_\_\_ Feeding Ourselves
- \_\_\_ Self initiated or fad diets. Please list: \_\_\_\_\_

Medical and health Care Treatments

- \_\_\_ Previous gastric surgery/stapling
- \_\_\_ Jaw wiring
- \_\_\_ Other surgery: \_\_\_\_\_
- \_\_\_ Acupuncture
- \_\_\_ Hypnosis
- \_\_\_ Other: \_\_\_\_\_

# Cardiac Questionnaire

**Gastric bypass is an intermediate risk surgery according to the American Heart Association. In order to best prepare you for surgery please fill out the following questions appropriately. (Circle all that applies)**

1. Have you had heart surgery within the last 3 years? **YES** **NO**
  
2. Have you been seen recently by your heart doctor? **YES** **NO**
  
3. Do you have a heart condition? If yes, please describe. **YES** **NO**
  
4. Do you get chest pain with exercise? **YES** **NO**
  
5. Have you ever had a heart attack? **YES** **NO**
  
6. Have you been treated for heart failure? **YES** **NO**
  
7. Do you have diabetes mellitus? **YES** **NO**
  
8. Can you carry groceries in from the car? **YES** **NO**
  
9. Can you vacuum the house? **YES** **NO**
  
10. Can you mow the lawn using a push mower? **YES** **NO**
  
11. Have you ever had a stroke? **YES** **NO**
  
12. Do you have high blood pressure? **YES** **NO**  
Is it treated? **YES** **NO** **N/A**
  
13. How fast can you walk a mile?
  
14. What is your age?

OBSTRUCTIVE SLEEP APNEA SCREENING  
QUESTIONNAIRE

1. Do you snore loud enough to be heard through closed doors?  
Yes \_\_\_\_\_ No \_\_\_\_\_
2. Do you often feel tired, fatigued, or sleepy upon waking?  
Yes \_\_\_\_\_ No \_\_\_\_\_
3. Has anyone observed you stop breathing during your sleep?  
Yes \_\_\_\_\_ No \_\_\_\_\_
4. Do you have high blood pressure?  
Yes \_\_\_\_\_ (if yes) Are you being treated for it? Yes \_\_\_\_\_ No \_\_\_\_\_  
No \_\_\_\_\_
5. Is your Body Mass Index more than 35?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
(BMI= Your weight in pounds X 703/your height in inches X your height in inches)
6. Are you over 50 years old?  
Yes \_\_\_\_\_ No \_\_\_\_\_
7. Is your neck circumference greater than 40 cm?  
Yes \_\_\_\_\_ No \_\_\_\_\_
8. Are you a male?  
Yes \_\_\_\_\_ No \_\_\_\_\_

Bariatric Surgery Contract  
Womack Army Medical Center  
Fort Bragg, North Carolina

I, \_\_\_\_\_, agree to the following statements. I will abide by this contract for Bariatric Surgery. I know that it is in my best interest to follow these instructions and is expected by the Bariatric Surgery Service that each will be adhered to explicitly.

**(Initial each line)**

\_\_\_\_ I will attend at least one pre-operative support group meeting. I will attend post-op meetings for at least one year after surgery. Studies show that patients who participate in a support group have a higher success rate in the long term.

\_\_\_\_ I will have an exercise regimen that I initiate prior to my operation and will resume post operatively. I will provide a copy of my plan for my chart.

\_\_\_\_ I will adhere strictly to the pre-operative diet (low carb/high protein). This will start prior to my pre-op interview with the surgeon. I understand that this diet allows for shrinking of a fatty liver and therefore facilitates a smoother operation.

\_\_\_\_ I will adhere to a clear liquid diet for two (2) consecutive days prior to surgery.

\_\_\_\_ I will adhere strictly to the post op diet given to me. I understand the importance of following the rules of post op eating.

\_\_\_\_ I will follow up with the Bariatric Clinic as directed. The Bariatric Surgeon does not become my PCM.

\_\_\_\_ I am aware that I must stay in the area for 12 months following surgery in order to receive the best post-operative care.

\_\_\_\_ I will notify the bariatric clinic if, during the pre-op process, I find out that I am PCS'ing/ETS'ing.

\_\_\_\_ I will notify the bariatric clinic if, during the pre-op process, I find out that I am going to lose Tricare coverage.

\_\_\_\_ I am aware that it is my responsibility to call and schedule all post-operative appointments with the nutrition clinic as well as the bariatric clinic.

\_\_\_\_ I will see nutrition prior to all my bariatric post-operative appointments.

\_\_\_\_ I will take a multivitamin daily for the rest of my life.

Bariatric Surgery Contract  
Womack Army Medical Center  
Fort Bragg, North Carolina

\_\_\_\_ I will abstain from alcohol for at least one year.

\_\_\_\_ I will not use nicotine products. This includes Nicorette Gum, lozenges, E-Cigarettes, patches, chew or cigarettes. Nicotine is shown to have a direct effect on the incidence of ulcers.

\_\_\_\_ I will not become pregnant for at least 18 months after surgery. I will adhere to this time frame, so I am medically optimized for the health of my child.

\_\_\_\_ I will maintain a journal. Journal will consist of entries for diet, exercise and mood. I will bring this to my post op appointments.

\_\_\_\_ I am aware that I must not gain weight from the date of my orientation or I will not be cleared for surgery.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## EXERCISE PLAN

NAME:

DATE:

SPONSERS LAST 4:

SUNDAY-

MONDAY-

TUESDAY-

WEDNESDAY-

THURSDAY-

FRIDAY-

SATURDAY-

Your exercise plan should consist of at least five days of workout and must not include house hold chores, walking the dog, etc.

## PATIENT PRE-OP CHECKLIST FOR YOUR RECORDS

	NEEDED Y/N	DATE COMPLETED	NOTES
SIGNED CONTRACT	Y		
NUTRITION CLASS	Y		
1:1 NUTRITION APPT(2 minimum)	Y		
FULL PHYSICAL EXAM/ WELL WOMAN EXAM	Y		
SUPPORT GROUP MEETING (1 minimum)	Y		
EXERCISE PLAN	Y		
COMPLETED LABS	Y		Contact us 1 week after you have completed all labs to go over results.
PSYCH EVALUATION	Y		
MAMMOGRAM (Women over 40)			
COLONOSCOPY (50 & up)			
PULMONARY FUNCTION TEST (Depending on medical history)			
CARDIAC CLEARANCE/ STRESS TEST(Depending on medical history)			
SLEEP STUDY (Depending on medical history)			
EGD/GI/SWALLOW STUDY (Depending on medical history)			
PRE OP QUIZ	Y		
MEMMORANDUM(WE WILL PROVIDE)	Y		
PRE OP CLASS	Y		
PRE OP W/SURGEON (After everything is completed on checklist)	Y		

CONTACT THE BARIATRIC CLINIC AFTER YOU COMPLETE EACH ITEM ON THE CHECKLIST SO THAT WE CAN UPDATE YOUR FILE. YOU CAN CALL 910-907-0787/910-907-9927.