PENNSTATE HERSHEY
Surgical Weight Loss

Department of Surgery
MIS/Bariatrics

Penn State Milton S. Hershey Medical Center
Penn State Hershey Surgical Weight Loss
4000 Vine St. M.C. HP20
Middletown, Pa 17057

Tel: 1-877-609-6848
Fax: (717) 531-0806
www.pennstatehershey.org/surgicalweightloss

Penn State Surgical Weight Loss Screening Form

SUBMIT THIS FORM AT THE SWL INFORMATION SESSION

INFO SESSION DATE: _____DATE OF BIRTH:_____AGE_____BMI_____

Have you ever applied to our program before - YES / NO - If yes when? _____

Ethnicity:

☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ Native American ☐ Other
☐ Native Hawaiian/Pacific Islander ☐ Two or More Races ☐ American Indian/Alaskan Native

Patient Name: _____
Patient Address: _____
_____
_____
Patient Telephone: (_____) _____
Patient Email: _____

Type of Insurance: _____
ID#_____
Group#_____

Family Doctor: _____
MD Address: _____
_____
MD Telephone: (_____) _____
MD Email: _____

Please list any other doctors who take care of you:

Specialist: _____
Address: _____
_____
MD Telephone: (_____) _____

Psychologist/psychiatrist or therapist:
(If you see or have ever seen a mental wellness provider for any reason, please complete the release of records form at our office or at your mental health provider's office to release records to us)

_____
Address: _____
_____
Telephone: (_____) _____

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Weight History:

Height: _____
Weight: _____lbs

At what age (in years) did you first have a weight problem (circle one)?
5-10 10-15 15-20 20-30 30-40 40-50 50-60

Highest adult weight _____lbs
Lowest adult weight _____lbs
Weight one year ago _____lbs

Diet /Exercise History:
Diet and Exercise Programs you have used for Weight Loss: (circle all that apply)

Fen-Phen	Redux	Xenical/Alli	Meridia
Medifast	Nutrisystem	Weight Watchers	Jenny Craig
Sugar Busters	Slim Fast	Hypnosis	Overeaters Anonymous
TOPS	Acupuncture	Wired Jaw	Richard Simmons
Low fat	South Beach	Mediterranean	Portion Control
Curves	Health Club	Water exercise	Home exercise program
Diabetic Diet	Atkins	Over the counter pills: type:_____	

Nutritionist/Dietitian:
Year seen:_____
Reason seen: _____

Physician Supervised Weight management program:
Type of
program:_____

Any other diets not listed above:_____

Were any of the above diets successful? If so, how long did you keep the weight off?
_____
_____

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Eating Habits (circle all that apply):

Skip meals Eat large portions Binge eat Eat out a lot Uncontrollable Eating

Eat sweets Grazing Eat late at night Eat more when stressed Snacking

<u>Please answer the following questions:</u>

1. During the past 6 months, did you often eat an unusually large amount of food within a 2 hour period (an amount that most people would agree is large)? YES / NO

2. During the times when you ate an unusually large amount of food, did you often feel you could not stop eating or control what or how much you were eating? YES / NO

3. During the past 6 months, how often did you have times when you ate unusually large amounts of food and felt that your eating was out of control? (circle one)
   a. Less than one day a week
   b. One day a week
   c. Two or three days a week
   d. Four or five days a week
   e. Nearly every day
   f. Never

4. Did you have any of the following experiences during these occasions? (If not applicable skip to #5)
   a. Eating more rapidly than usual? YES / NO
   b. Eating until you felt uncomfortably full? YES / NO
   c. Eating large amounts of food when you didn't feel physically hungry? YES / NO
   d. Eating alone because you were embarrassed by how much you were eating? YES / NO
   e. Feeling disgusted with yourself, depressed, or feeling guilty after overeating? YES / NO
   f. Eating large amounts of food throughout the day with no planned mealtimes? YES / NO

5. In general, during the last 6 months, how upset were you by feeling that you could not stop eating or could not control what or how you were eating?
   a. Not at all
   b. Slightly
   c. Moderately
   d. Greatly
   e. Extremely

Exercise Habits:
Do you exercise? YES NO
I am not able to exercise: (reason)_____

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Social History:

Who currently lives with you in your household?_____

Who does the grocery shopping and cooking?_____

Education: (please circle all that apply) High School College Post-graduate

Current Occupation:_____Employer:_____

Years at this position:_____

Psychological History:

Are you currently being treated for a psychological disorder? YES/NO

Have you EVER been treated for a psychological disorder? YES/NO

Have you ever seen a therapist/Psychologist/Psychiatrist for any reason? YES/NO

Have you ever attempted suicide? YES/NO

Please explain any "YES" answers:_____

_____

_____

Medical/Surgical History:

Medical Problems (circle all that you have):

High blood pressure	High Cholesterol	Heart Problems	Lung problems
Asthma	Sleep Apnea	Diabetes	Joint Pains
Back Pain	Thyroid problem	Heartburn	Leg swelling
Gout	Blood clots	Frequent urination	Skin irritation
Leakage of urine	Fertility problems	Menstrual changes	Loss of sexual desire

Other Medical History not listed above:

_____

_____

Have you ever had any breathing tests? (circle answer) YES NO

If yes, what types of tests?_____

Have you ever had studies of your heart? (circle answer) YES NO

What types of studies?_____

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Surgical History:

Procedure	Date	Disease	Surgeon/Hospital

Family Medical History (Please list medical illness if known):

	Alive?	Diseases	Overweight? Yes/No
Mother	Yes / No		
Father	Yes / No		
Sisters	Yes / No		
Brothers	Yes / No		

Current Prescription Medications:

Medication	Amount (mg)	Frequency	Since (year)

Current <u>Non-prescription</u> Medications:
(including vitamins, nutritional supplements, herbal supplements, etc.)?

Name	Amount	Frequency	Since (year)

Allergies: ☐ No known drug allergies

ALLERGY TO:_____
Reaction:_____

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Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not 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

_____Sitting and reading
_____Watching TV
_____Sitting inactive in a public place (ex: theatre/meeting)
_____As a passenger in a car for an hour without a break
_____Lying down to rest in the afternoon when circumstances permit
_____Sitting quietly after a lunch without alcohol
_____In a car, while stopped for a few minutes in traffic
_____TOTAL

Do you snore at night? _____YES_____NO_____NOT SURE
Do you have headaches in the morning when you wake up?_____YES_____NO
Have you been diagnosed with sleep apnea in the past?_____YES_____NO
Are you using CPAP at night? _____YES_____NO

Surgical Weight Loss Programs:

Have you ever attended another surgical weight loss program? YES / NO
If YES, please answer the following questions:

Which program(s) did you attend?_____

What years did you attend this/these program(s)?_____

Why didn't you complete this/these program(s)?_____

May we contact the program(s) listed above? YES / NO

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Tobacco/Alcohol/Drugs: (check or fill in)

Have you smoked at least 100 cigarettes in your entire life? (*100 CIGARETTES = APPROXIMATELY 5 PACKS)* ☐ Yes ☐ No

If yes, do you now smoke cigarettes every day, some days, or not at all?
☐ Every day ☐ Some days ☐ Not at all

If you now smoke cigarettes:

- **How many cigarettes per day do you usually smoke? _____**
- **On days that you can smoke freely, how soon after you wake up do you smoke your first cigarette of the day? _____minutes**
- **How many years have you smoked cigarettes? _____**

If you don't smoke at all right now, how long ago did you quit smoking? _____

Do you currently use any other type of tobacco? *Tobacco includes cigars, pipes, snuff/dip, chew, hookah, dissolvables, or electronic cigarettes?* ☐ Yes ☐ No

If yes, what type of tobacco do you use (Please mark all that apply)?

☐ Cigars ☐ Chew ☐ Dissolvable Tobacco (lozenge, strips, or Sticks) ☐ Pipes

☐ Electronic Cigarettes ☐ Snus/Snuff/Dip ☐ Hookah/Water Pipe

Do you drink alcoholic beverages? YES NO If Yes, how many drinks per week?_____

Do you use recreational drugs? YES NO Quit_____years ago

Which drug(s)?_____

Transportation:
What form of transportation do you currently use? (check all that apply)

☐ Cat Share A Ride ☐ Personal Automobile ☐ Transportation by a Family Member/Friend

Do you need assistance with reading and writing? ☐ Yes ☐ No

I have personally attended the information session and/or reviewed the session online and confirm that the information in this form is true and accurate to the best of my knowledge:
Signature:_____ Date:_____

Signature of person completing the form if not completed by the patient:
_____Relationship to patient:_____ *1/30/15*