

MEDICAL MENTAL PACKET

Thank you for choosing EMPOWER Surgical & Medical Weight Loss

We look forward to meeting you at the following appointment.

Date: _____ **Time:** _____

Your office visit is located at:

Blackfoot
326 Poplar St.
(208) 782-3993

Idaho Falls
1975 Martha Ave. Ste. A
(208) 782-3993

Chubbuck
4742 Yellowstone Ave.
(208) 782-3993

Your first visit to our clinic is our educational seminar and requires a minimum of 1.5 hours. Please arrive 15 minutes early.

You must submit your completed packet prior to scheduling your first individual appointment.

Enclosed in this packet is a personal medical history form and a bariatric questionnaire, which must be completed in **full**. Please mail, email or deliver in-person prior to your first consultation. It is very important that you arrive on time for your scheduled office visits. If you are late, it may be necessary to reschedule.

You are unable to keep your appointment, please call and notify us at least 24 hours in advance. This will allow us to reschedule with another patient.

Thank you again for choosing Empower Surgical & Medical Weight Loss as you take this step toward improving your health.

PATIENT HEALTH HISTORY QUESTIONNAIRE

The following information is very important to your health. Please take time to fully and completely fill out this questionnaire. If there is not room for a complete history, please use additional paper.

Name: _____ Preferred Name: _____ DOB: _____

Email: _____ Phone: _____

Address: _____

SSN: _____ Race: _____ Ethnicity: _____

Legal Gender: _____ Gender at Birth: _____ Language: _____ Religion: _____

Primary Care Physician (PCP): _____

What is the reason you are seeing the surgeon? _____

How long have you had this problem? _____

Please list any specialty physicians you have seen in the past or are currently seeing if it relates to the issue, along with their addresses and phone numbers.

Physician: _____

Physician: _____

Specialty: _____

Specialty: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

1. Allergies

List allergies and type of known reaction:

Allergies

Reaction

2. Medications

List your current medication including vitamins. All medications must be listed here.

Medication(s)

Dosage

Frequency

For what condition?

List any herbal or over-the-counter medications you may be taking:

Have you taken any weight loss medications? If so, list the name of medications and when you took it.

Medication(s)	Date Taken
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

Do you take ibuprofen/NSAIDs or other anti-inflammatory medications? Yes No

3. Past Medical History

List all operations and the year they were performed (including endoscopies):

Operation(s)	Year
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

List all hospitalizations, reason, and year:

Hospitalization(s) and reason(s)	Year
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

3a. Have you had the following?

Diabetes:

Yes No

High Blood Pressure:

Yes No

High Cholesterol:

Yes No

GERD (reflux/heart burn):

Yes No

Obstructive Sleep Apnea:

Yes No

Stress Incontinence:

Yes No

Lower Extremity Edema:

Yes No

Polycystic Ovarian Syndrome:

Yes No

Depression:

Yes No

Seizures, Stroke, Paralysis:

Yes No

Ulcers (stomach/intestinal):

Yes No

Kidney or Bladder Disease:

Yes No

Liver Disease:

Yes No

Asthma, Emphysema, Tuberculosis, etc.:

Yes No

Arthritis:

Yes No

Bleeding Problems:

Yes No

Cancer:

Yes No

Infectious Diseases:

Yes No

Dialysis:

Yes No

Eating Disorder:

Yes No

Heart Disease:

Yes No

Non Healing Wound:

Yes No

Venous Stasis:

Yes No

COPD:

Yes No

Autoimmune Disease:

Yes No

4. Weight History

Have you ever tried to "go on a diet" to lose weight? Yes No

How many attempts have been made to lose weight? 1-3 4-9 10-25 >25

Of these, how many were successful? Please describe the outcome briefly.

At what age did you first have weight problems?

5-10 11-15 16-20 21-30 31-40 41-50

Did life events trigger weight change (having children, job, surgery, etc.)

Highest adult weight: _____ lbs

Lowest adult weight: _____ lbs

Highest weight 1 year ago: _____ lbs

Highest weight 2 years ago: _____ lbs

Highest weight 3 years ago: _____ lbs

4a. Have you ever had weight loss surgery before? Yes No

If no, move to section 5.

4b. If yes, what type? _____

What was the date of your surgery? _____

If you had any complications, please describe them: _____

Where was it done (hospital/city/state)?: _____

Who was your surgeon?: _____

What was your highest weight prior to your weight loss surgery?: _____

What was the lowest weight you got to after surgery?: _____

What issue(s) are you having from that surgery leading you to come and see the team at Empower?

5. Family History

Have there been any of the following diseases in your family? Please indicate if any family members died from these diseases.

Bleeding Disorders:

No Yes Who? _____

Diabetes:

No Yes Who? _____

Family History of Obesity?

No Yes Who? _____

Stroke or Paralysis

No Yes Who? _____

High Blood Pressure

No Yes Who? _____

Family history of Anesthesia Complications?

No Yes Who? _____

Cancer

No Yes Who? _____

Lung Disease (Asthma, emphysema, TB)

No Yes Who? _____

Other? Please list: _____

6. For Female Patients only:

Age started menses: _____

Last period: _____

Date of last PAP/Pelvic Exam: _____ Normal? Yes No

Date of last breast exam: _____ Normal? Yes No

Number of pregnancies: _____

Number of children: _____

Have you ever had a miscarriage? Yes No

Do you plan to have more children? Yes No

7. Social History

Single Married Divorced Widowed Other

Do you have children? Yes No If yes, how many? _____

What is your current occupation?: _____

If retired, what was your occupation?: _____

If disabled, what is your disability?: _____

Have you ever smoked? Yes No If yes, how much and how long? _____

If you quit smoking, when did you quit? (month/year) _____

Other nicotine use? Vaping Chew Patches Pouches Hooka Pipe

Do you drink alcohol? Yes No If yes, how much? _____

Have you ever used recreational drugs? Yes No If yes, what drugs? When? _____

Hobbies / how do you spend your free time?: _____

What's your 'why'? _____

9. CPAP Use

Do you use a CPAP, BiPap, or supplemental oxygen? No Yes If no, please complete questions in 9a.

9a. Please complete the Stop-Bang Sleep Apnea Questionnaire to the best of your ability. We can assist you at your first appointment if necessary.

STOP-BANG SLEEP APNEA QUESTIONNAIRE

Chung Fetal Anesthesiology 2008 and BJA 2012

STOP

Do you **SNORE** loudly? (louder than talking or loud enough to be heard through closed doors?) Yes No

Do you often feel **TIRED**, fatigued, or sleepy during the daytime? Yes No

Has anyone **OBSERVED** you stop breathing during sleep? Yes No

Do you have or are you being treated for high blood **PRESSURE**? Yes No

SCORE

BANG

Is your BMI more than 35kg/m²? Yes No

Is your age over 50 years old? Yes No

Is your neck circumference > 16 inches (40cm)? Yes No

Is your gender male? Yes No

Total Score _____ (office use only)

BARIATRIC SURGERY PROGRAM PATIENT PLEDGE

Please read and check each item

- I agree to discuss with my provider any aspect of my surgery or treatment that I do not understand. I agree to ask any questions I may have to any member of the Empower team.
- I agree to read all information and directions given to me by members of the Empower team.
- I agree to follow all instructions and directions given to me by my provider or members of the Empower team. This includes taking all medications, including vitamins, as directed by my provider during my pre/postoperative care and for the rest of my life as required.
- I agree to follow the dietary instructions given to me by members of the Empower team, understanding that they are designed by Registered Dietitians to provide me with a healthy plan to allow for optimal healing and maximum weight loss
- Pre-surgery, I agree to avoid weight gain. My provider has advised me that if I gain weight, my surgery may be rescheduled.
- I understand that mental health is important to my success and will follow all recommendations given to me by the Bingham Healthcare psychologist, understanding that this is in my best interest and may include additional therapy or treatment.
- I agree to walk and exercise as directed by the Empower team, including while I am in the hospital, understanding it promotes safe healing and optimum weight loss.
- I agree to keep all suggested appointments with my provider and keep them informed of my progress. I agree to keep all postoperative appointments at 2 weeks, 30-60 days, 3-6 months, 1 year, and annually thereafter.
- I understand that missing appointments or nutrition classes may require me to repeat sessions, add additional appointments, or restart the program.
- I agree to be on time to my appointments, acknowledging that I should arrive 30 minutes prior to my initial consultations with the provider and 15 minutes prior to follow-up appointments. I understand that I could be discharged from the program for excessive no shows or cancellations.
- I agree to stop smoking or avoid using nicotine products for at least 3 months prior to my surgery. I also understand that smoking should never be started or resumed after bariatric surgery.
- I understand that it is against medical advice to become pregnant within 12 months of weight loss surgery. I understand that pregnancy within 12 months of weight loss surgery may increase the risks of pregnancy.
- I understand that Facebook groups and social media can be utilized for additional support but that they do not replace medical advice or instructions from the Empower team. I agree to bring all my medical and surgical questions to Empower. I also understand that Facebook and social media are not appropriate ways to contact the Empower providers and staff and that I should utilize the phone, email, or patient portal for medical questions instead.
- I understand that the preoperative bariatric program is an extensive evaluation process to see if I am an acceptable candidate for weight loss surgery. I understand that surgery will not be offered to me if I am not found to be a safe or acceptable candidate. I understand that this decision is made by my providers when all information is available and agree it is in the best interest of my health and well-being.

My signature indicates that I have read, understood, and agree to the statements listed above.

SIGNATURE _____ DATE _____

WITNESS _____ DATE _____