CalvertHealth Medical Center

Bariatric Surgery
New Patient Information

Welcome to the Metabolic and Bariatric Surgery program at CalvertHealth Medical Center

You are about to embark on a new life altering experience that will help you improve your overall health and well-being! The Metabolic and Bariatric Surgery program at CalvertHealth Medical Center is a multidisciplinary program launched in May 2021 that aims to offer the most comprehensive, thorough, and up to date treatments to treat obesity and its medical implications.

The word *"bariatric"* is a term that comes from two Greek words that mean "weight" and "treatment". Therefore, "bariatric surgery" can be defined as treating weight by surgery. The term "*metabolic*" was recently added to "bariatric surgery" because of the known and proven improvements seen in the metabolic profiles of patients undergoing bariatric surgery. You and your Primary Care Physician have decided bariatric surgery may be an option for you. The decision to recommend surgery for the treatment of obesity requires multidisciplinary input to evaluate the indications for operation and to define and manage co-morbidities properly. The Metabolic and Bariatric Surgery Program team will help you make the final decision as to whether surgery is the *best* option for you.

This path you have chosen is going to help alleviate a lot of your health issues and concerns, at the heart of which is obesity. Years of experience have shown us that, when it comes to bariatric surgery, the most successful patients are the most informed. As such, as you go through our program, the team of experts will stress the need to stay well informed and ensure that you have an excellent understanding of the steps and expectations you should encounter.

Again, by being here and reading this, you are considering what is likely going to be the best decision you have taken in terms of improving your health and life in general. On behalf of the entire multidisciplinary team here at CalvertHealth Medical, I would like to congratulate you on making this brave decision and look forward to helping you achieve your goals.

Ramzi Alami, MD FACS FASMBS

Medical Director of the Metabolic & Bariatric Surgery Unit

Gregory Dalencourt, MD

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I am interested in: ❑ **Non-Surgical Weight Management** ❑ **Gastric Bypass**

❑ **Gastric Band Revision/Removal** ❑ **Sleeve Gastrectomy**

How did you hear about our program? _____

Contact Information

Nutritionist: _____

Patient Name: _____ **Date of Birth:** _____
Patient Address: _____
_____
_____
Patient Telephone: (_____)_____
Patient Email: _____

Psychologist: _____
Address: _____
_____
_____
Telephone: (_____)_____

Preferred Pharmacy: _____ Ph: _____

Insurance Carrier: _____ **State:** _____

Have you called to verify that Bariatric Surgery is a covered benefit? _____
Please confirm this for the Gastric Sleeve (CPT 43775) and Gastric Bypass (CPT 43644) surgeries.

Does your insurance require a supervised diet? (*be sure to ask)* _____

Your Current Height: _____ **Highest Adult Weight:** _____

Your Current Weight: _____ **Lowest Adult Weight:** _____

BMI:_____

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Bariatric History:

How long have you been interested in having weight loss surgery? _____
Have you ever been evaluated for weight loss surgery before? Yes/ No _____
When did weight become a problem for you? ☐ Child ☐ Teen ☐ Adult ☐ With Pregnancy
What do you feel has caused you to be heavy? ☐ Major Illness ☐ Major Stressor
☐ Medication ☐ Marriage ☐ Travel ☐ Trauma ☐ Divorce
☐ Food Choices ☐ Inactivity ☐ Genetics Other_____

Eating Patterns:

Describe your eating habits: _____
Do you skip meals? Yes/ No If so, which? _____
What do you drink? _____
Do you eat big meals, or have difficulty feeling full? Yes/ No If so, which? _____
How often do you eat outside the home/ include fast food? _____x's a week

Exercise or Activity:

Describe your exercise habits: _____
How often do you exercise? ☐ I don't ☐ Daily ☐ 2x/week ☐ 3x/week ☐ 4x/week
Can you walk up a flight of stairs without stopping? Yes/ No
Do you get chest pain or shortness of breath on exertion? _____
How far can you walk without stopping? ☐ <10 mins ☐ 15 mins ☐ 30 mins ☐ >30mins

Psychological Eating/ Problems:

Do you have any mental health concerns? _____
Are you experiencing any major life stressors currently? _____
Do you ever have binges (eating a large amount of food in a short period of time)? _____

Sleep:

Describe your sleep habits: _____
Do you have any difficulty sleeping? _____

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Weight Loss Attempts:

Program	Describe/ Year	Months on Program	Pounds Lost	Comments	Cost ($)
Diet pills (any)					
Weight Watchers					
Liquid Diets (Optifast or Slim Fast, etc.)					
Low calorie diets					
Low carb diets or Atkins					
Jenny Craig or Nutri-System					
Fad diets					
Physician Monitored Diet "Diet Clinics"					
Hypnosis/ counseling					
Surgery					
Dietician Counseling					
OA					
Gym Memberships Exercise Plans					

What diet/ weight loss plan has worked the best?

What do you feel has been your biggest barrier to losing weight/Exercising?

Why do you want to have weight loss surgery now?

What surgery are you most interested in having and why?

Personal Health History:

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Medical Problems (Circle all that apply):

☐ Diabetes	☐ High Blood Pressure	☐ Sleep apnea	☐ Cancer
☐ Heart Disease	☐ Reflux/ Heartburn	☐ High Cholesterol	☐ Stroke
☐ Stress Incontinence	☐ Gallstones	☐ Arthritis	☐ COPD
☐ Chronic Pain	☐ Low Back Pain	☐ Changes in Period/ PCOS	☐ CHF
☐ Glaucoma	☐ Blood Clots	☐ Kidney or Liver Disease	☐ Insomnia
☐ Venous Stasis	☐ Heart Attack	☐ Unexplained Weight Loss	
☐ Asthma	☐ Depression	☐ Bipolar Disorder	
☐ Chronic Fatigue	☐ Trouble Swallowing	☐ Daytime Drowsiness	

Any other Medical History/ Hospitalizations:

_____

_____

Surgical History (YEAR):

Tonsillectomy _____ Gallbladder Removal _____ Appendectomy _____

C- Sections _____ Hernia Repair _____ Other _____

Any other Operations:

_____

Allergies (Drug/Food):

_____

_____

Current Medications & Vitamins, Herbs, or Supplements:

Medication	Amount (mg)	Frequency	Prescriber & Since (year)
Ex. Lexapro	20 mg	QD	Dr. Jones - 2017

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Social History:

Where are you from? _____

Where do you live now? _____

Education: _____

Describe your living arrangements? _____

Marital Status:

□ Single □ Married □ Divorced □ Widowed □ Other

Children: _____

Any desire for children in the future? Yes/ No

Current Occupation: _____ **Employer:** _____

Years at this position: _____ **Can you take time off to recover?** _____

Are you on disability? **If so, since when and for what reason?**

_____

Who will help take care of you, if needed, after surgery? _____

Do you (or did you) smoke? □ Yes □ No □ Quit _____ years ago

You must be nicotine free x 3 months before surgery

Average daily tobacco habit: _____ packs/day for _____years

Do you drink alcoholic beverages? □ Yes □ No □ Quit _____ years ago

How much? _____

Do you use recreational drugs? □ Yes □ No □ Quit _____ years ago

You must be drug and alcohol free x 6 weeks before surgery

Do you have, or have you had, a problem with drugs or alcohol? □ Yes □ No

Explain: _____

Caffeine use? ☐ Yes ☐ No

Family History/Including Obesity:

Biological Father (alive or deceased) Age: _____ Medical Hx: _____

Biological Mother (alive or deceased) Age: _____ Medical Hx: _____

Extended Family (Siblings, Grandparents, your children): (list anything of importance)

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Are you experiencing (currently):

- ☐ Recent unexplained weight loss or weight gain
- ☐ Fevers/ Chills
- ☐ Night Sweats
- ☐ Dizziness
- ☐ Headaches
- ☐ Weakness
- ☐ Fatigue
- ☐ Coughing
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Chest Pain
- ☐ Pressure in Chest
- ☐ Palpitations
- ☐ Heartburn
- ☐ Snoring (apnea)
- ☐ Daytime Drowsiness
- ☐ Insomnia
- ☐ Trouble swallowing
- ☐ Constipation
- ☐ Change in Bowels/ Bloody Stools
- ☐ Abdominal Pain
- ☐ Hernias
- ☐ Pain or difficulty Urinating
- ☐ Libido changes
- ☐ Skin changes

Health Maintenance:

Do you see a healthcare provider regularly? ❑ No ❑ Yes: _____

Do you see a dentist regularly? ❑ No ❑ Yes: _____

When was your last:

Mammogram _____ Pap smear _____

Prostate Exam _____ Eye Exam _____

Lab work _____ EGD _____

Sleep Study _____ Colonoscopy _____

Cardiology Tests _____ Other: _____

Will you, the patient, commit to careful follow-up with us for up to 5 years? ❑ No ❑ Yes

_____ _____

Signature of Patient ***Date***