

Welcome to Einstein Bariatrics!

We are excited that you have chosen our laparoscopic weight loss program. Deciding to undergo bariatric surgery is a very important step in regaining control of your health and quality of life. We certainly want your appointments to be informative and enjoyable.

We ask that you complete this registration packet in its entirety. Incomplete forms cannot be processed. If you need assistance filling out your packet, please call our office at 215-663-6422. This packet must be dropped off, faxed or mailed to us before we can schedule your initial consultation. It will help us determine what testing and laboratory studies are necessary to safely proceed to surgery and whether you qualify for bariatric surgery benefits, as determined by your insurance provider.

Your initial appointment will last about one hour. We strive to provide timely and quality services. To ensure that effort, we ask that:

1. If your insurance company requires a referral form make sure you obtain one from your primary care physician before your appointment, or your appointment will be cancelled.
2. If you are unable to make your scheduled initial appointment please call us before your appointment to let us know. No-shows will not be allowed to reschedule their appointment. If you are significantly late, your appointment may be cancelled or rescheduled in order not to inconvenience other patients.
3. Children are welcome to come with you but are not allowed in the consultation room during the initial visit.

Sincerely,



Ramsey Dallal, MD
Director of Einstein Bariatrics



Alfred Trang, MD
Bariatric Surgeon

How did you hear about Einstein Bariatrics? Please check all that apply.

Referred by a current or former patient

Referred by a friend

Referred by a family member

Physician referral (name): _____

Internet search engine

Google

Yahoo!

Other search engines: _____

Which web site do you get **most** of your information from? _____

Newspaper

Bucks County Courier Times

Colonial News

Doylestown Intelligencer

Glenside News

Globe News

Hatboro Public Spirit

Huntington Valley Globe

Other _____

Jenkintown Times Chronicle

Montgomery Life

Norristown Times Herald

North Penn Life

Northeast Times

Perkasie News-Herald

Plymouth Whitemarsh Colonial

Roxborough Review

Souderton Independent

Springfield Sun

Spring-Ford Reporter

Swenksville Valley Item

The Ambler Gazette

The Willow Grove Guide

Don't remember

Radio

WBEN: 95.7 FM

WOGL: 98.1 FM

WBEB: 101.1 FM

WDAS: 105.3 FM

KYW: 1060 AM

Other _____

Billboard

At Einstein Bariatrics, we believe that successful patient outcomes are not based solely on the quality of the surgery. Providing our patients pre-operative education along with long-term multispecialty support is equally important. Our registered dietitians, exercise physiologist and psychologist offer educational tools that will help you.

Without exception, all patients in the Einstein Bariatrics program must use our team of registered dietitians, exercise trainers and psychologist. We will conveniently schedule all of these consultations to take place in a single day. Please contact our office staff for further information.

Services include:***Support Groups***

Our psychologist, registered dietitians and exercise physiologist run our support groups. Contact our office at 215-663-6422 for the support group schedule.

Printed Educational Materials

- Surgery handbook
- Consent, examination and other handouts for psychology testing and nutritional education.

Nutritionist

The nutritionist is your resource to learn about healthy eating after gastric bypass surgery. Our nutritionists provide pre-operative educational consultations and give post-operative lectures that are very helpful to our patients. They are also available for one-on-one post-operative consultations.

Psychologist

Einstein Bariatrics has appointed a psychologist to assist patients in their transition to a healthier self. Our psychologist specializes in the field of bariatric psychology, and runs our support groups and closely follows our patients in the post-operative period. The role of the pre-operative evaluation is to learn more about you so that we are able to individualize your care and plan for your post-operative needs.

Exercise Physiologist

A personal session with the exercise physiologist is also included in the program. Structured programs are designed for the specialized needs of our bariatric patients. Also included are their post-operative services during support groups and other educational seminars.

PATIENT REGISTRATION FORM

Patient name: _____ Home phone no: (_____) _____

Street address: _____ Cell phone no: (_____) _____

City: _____ State: _____ ZIP: _____

Social Security: _____ Age: _____ Birth date: _____

Sex: M F

Marital status: S M W D

Patient employer: _____ Occupation: _____

Employer address: _____ Business phone no: (_____) _____

Spouse name: _____

Emergency contact: _____ Contact phone no: (_____) _____

E-mail address (optional): _____

INSURANCE INFORMATION

Primary insurance co: _____ Phone no: (_____) _____

Street address: _____ City: _____ State, ZIP: _____

Policy/ID/claim no: _____ Group no: _____

Policyholder name: _____ Relation to patient: _____

Policyholder SS#: _____ Birth date: _____

Secondary insurance co: _____ Phone no: (_____) _____

Street address: _____ City: _____ State, ZIP: _____

Policy/ID/claim no: _____ Group no: _____

Policyholder name: _____ Relation to patient: _____

Physician information

Please list all your physicians so that we can give them updated information regarding your medical care.

Primary care doctor:

Specialty:

Name: _____

Name: _____

Address: _____

Address: _____

City: _____ State, ZIP: _____

City: _____ State, ZIP: _____

Phone no: (_____) _____

Phone no: (_____) _____

Fax no: (_____) _____

Fax no: (_____) _____

Specialty:

Specialty:

Name: _____

Name: _____

Address: _____

Address: _____

City: _____ State, ZIP: _____

City: _____ State, ZIP: _____

Phone no: (_____) _____

Phone no: (_____) _____

Fax no: (_____) _____

Fax no: (_____) _____

Pharmacy information

Please provide the name of the pharmacy that you prefer

Name of pharmacy: _____

Address: _____ City: _____ State, ZIP: _____

Phone No: (_____) _____

COMPREHENSIVE HISTORY

Entire form must be completed

Today's date: _____

Name: _____ Age: _____ Date of birth: _____

Race (optional): Caucasian African-American Asian Multicultural Other

Estimated height: _____ feet _____ inches Current estimated weight: _____ pounds

Drug allergies: _____ Type of reaction: _____

Drug allergies: _____ Type of reaction: _____

Drug allergies: _____ Type of reaction: _____

Other allergies, environmental or food: _____

Which procedure most interests you? Gastric bypass Lap-Band® Other: _____

What is the most important goal you want to achieve through weight loss surgery? _____

What weight would ...

be your dream weight: _____ you be happy with: _____

be acceptable: _____

For how long have you considered bariatric surgery? _____

Where did you get most of your information about bariatric surgery? _____

PAST MEDICAL HISTORY

Please check the box next to your weight-related medical conditions.

- | | | |
|---|---|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Fatty liver disease | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Leg swelling (edema) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Male hair growth (for women) |
| <input type="checkbox"/> Knee <input type="checkbox"/> Hip <input type="checkbox"/> Other | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Persistent snoring |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Plantar fasciitis |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Severe headaches |
| <input type="checkbox"/> Cancer: list type _____ | <input type="checkbox"/> High blood pressure (hypertension) | <input type="checkbox"/> Shortness of breath |
| _____ | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Skin rashes |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> High triglycerides | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Decreased libido (men) | <input type="checkbox"/> Infertility | <input type="checkbox"/> Venous stasis disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Urinary incontinence |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Irritable Bowel Syndrome | |

List any other medical conditions that you have been diagnosed with: _____

SOCIAL HISTORY**Tobacco (includes chew, pipe, etc)**Current use of tobacco: Yes No If yes, amount/day: _____Previous use of tobacco: Yes No If yes, amount/day: _____

Last used tobacco: _____ How long have you used tobacco products (in years)? _____

NOTE: The immediate cessation of smoking is strongly recommended. Tobacco products are associated with ulcer formation in patients who have had bariatric surgery. Quit today! Ask about smoking cessation programs available through Albert Einstein Medical Center.**Alcohol consumption**

Frequency of use: _____

Have you ever had a problem with alcohol? Yes NoHave you ever received treatment for alcoholism? Yes No**Illicit drugs**Previous use of illicit drugs: Yes No If yes, type: _____Current use of illicit drugs: Yes No If yes, type: _____Family history of drug and/or alcohol abuse: Yes NoAre you a Jehovah's Witness? Yes No**Employment/Home/Income/Education**Employed? No Retired Full-time Part-time

Description of employment: _____

Are you: Married Single Divorced Widowed Number of children: _____Are you receiving any type of disability? Yes No

Current combined family income before taxes:

 <\$20,000 \$20-\$40,000 \$40-\$60,000 \$60-\$80,000 >\$80,000

Highest achieved educational level:

 Less than 8th grade Some high school Completed high school Some college Finished college Any post-graduate education

FAMILY MEDICAL HISTORY

	Age	Disease	If deceased, cause of death
Father			
Mother			
Siblings			

Check here if adopted

FAMILY WEIGHT HISTORY (check box)

- Mother** normal weight slightly overweight (by less than 30 pounds) moderately overweight markedly overweight (by more than 100 pounds)
- Father** normal weight slightly overweight (by less than 30 pounds) moderately overweight markedly overweight (by more than 100 pounds)
- Siblings** normal weight slightly overweight (by less than 30 pounds) moderately overweight markedly overweight (by more than 100 pounds)
- Children** normal weight slightly overweight (by less than 30 pounds) moderately overweight markedly overweight (by more than 100 pounds)
- Spouse** normal weight slightly overweight (by less than 30 pounds) moderately overweight markedly overweight (by more than 100 pounds)

DIET HISTORY

At what age did you begin your first diet? _____ years of age

At what age were you ever your perfect weight? _____ years of age

What was your greatest single weight loss? _____

How long did you sustain that weight loss? _____

How was this weight loss achieved? _____

How many times have you lost 10 pounds? _____ 25 pounds? _____ 50 pounds? _____

How long have you been at your current weight? _____

What is the highest weight that you have ever been? _____

Have you ever undergone a diet that was supervised by a physician? Yes No

Have you ever been prescribed (check any that apply):

- Meridia Amphetamines Adipex Redux
 Xenical Topomax Dexadrim Other _____
 Fen-phen Acutrim Phentermine

Have you ever undergone: MediFast Optifast

Did your physician monitor your weight? Yes No

How frequently? (Every week? Every month?) _____

For how long were you under the care of a physician? _____

When did you stop seeing the physician? _____

Have you ever consulted with a nutritionist or dietician? Yes No

As a rough guess, please estimate the number of calories you think you eat in a day. _____

Please fill in answer.

Type of diet	Number of times attempted	Last attempted date	Amount of weight lost
Weight Watchers			
Jenny Craig			
NutriSystem			
Pritikin			
TOPS			
OA			
Atkins			
Fasting			
South Beach Diet			
Richard Simmons			
Herbalife			
Magazine Diets			
LIST OTHERS:			

Other weight loss methods tried:

Psychotherapy Hypnosis Acupuncture Health Club memberships

1. Do you experience frequent episodes of eating what others would consider an abnormally large amount of food? Yes No

2. Do you frequently feel unable to control what or how much you are eating? Yes No

If you answered "yes" to either #1 or #2 above, please answer the following:

a) At such times do you eat much more rapidly than usual? Yes No

b) At such times do you eat until you are uncomfortably full? Yes No

c) Have you eaten large amounts of food even when you were not physically hungry? Yes No

d) Do you eat alone out of embarrassment at the quantity of food being eaten? Yes No

e) Do you feel disgust, depression or guilt after overeating? Yes No

MEDICAL CONDITIONS AND REVIEW OF SYSTEMS

Cardiovascular system

Have you ever had (check any that apply):

- Chest pains (angina)
- Coronary artery disease
- Heart attack
- Heart bypass surgery
- Heart failure
- Heart murmurs (problems with your heart valves)
- Heart palpitations
- Heart stent placed
- High blood pressure (hypertension)
- Pacemaker
- Other heart problems _____

If you checked any of the above, please list when your diagnosis occurred and how this problem is being treated: _____

Have you ever had any of these tests performed (check any that apply):

- stress test
- heart catheterization
- heart ultrasound (echocardiogram)

We will need the results of all of these tests sent to us as soon as possible.

If you have checked any of the tests above, please list the date of the test and the results.

Do you have a cardiologist? Yes No If so, please provide cardiologist's name: _____

If you have a cardiologist, we will need a letter stating that your heart is OK for surgery.

Pulmonary system

Have you ever had (check any that apply): pneumonia asthma emphysema chronic cough Hoarseness

Do you have shortness of breath: at rest climbing up stairs walking down the driveway

Do you snore? Yes No

Do you ever stop breathing while asleep? Yes No

Do you awaken frequently? Yes No

Do you have daytime drowsiness when working/driving? Yes No

Do you have morning headaches? Yes No

Have you been diagnosed with sleep apnea? Yes No

If so, do you use a CPAP machine? Yes No If yes, what are your CPAP settings? _____

Epworth Sleepiness Scale

Please indicate the likelihood that you would fall asleep in the following situations (scale of 0 to 3) referring to your USUAL way of life in recent times.

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

Situation	Chance of Dozing
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g. theater)	_____
As a passenger in a car, for an hour, without a break	_____
Lying down to rest in the afternoon, when able	_____
Sitting and talking to someone	_____
Sitting quietly after lunch, without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL	_____

Endocrine systemThyroid problems (check any that apply): Hypothyroid (low thyroid) Hyperthyroid (high thyroid)Ever had thyroid surgery? Yes NoDo you have Diabetes? Yes No If yes, how long ago were you diagnosed? _____Do you take insulin? Yes No If yes, how long have you taken insulin? _____Are your sugars well controlled? Yes No

Do you have (check any that apply):

 Neuropathy (numbness, pain and/or tingling in hands or feet) Retinopathy (Diabetic changes in your eyes) Nephropathy (Kidney trouble)If applicable, did you develop diabetes while you were pregnant? Yes No

Any other endocrine problems? _____

GI system

Do you have (check any that apply):

Heartburn? Yes No

If so, how often? _____

Do you take over-the-counter medication? Yes NoDo you have a chronic cough? Yes NoAre you often hoarse? Yes NoIrritable Bowel Syndrome Yes NoDiverticulitis Yes NoConstipation Yes NoStomach ulcers Yes NoHepatitis A B CAbnormal liver enzymes Yes No

Have you ever had a (check any that apply):

 Colonoscopy Date: _____ Result: _____ Barium Enema Date: _____ Result: _____ Sigmoidoscopy Date: _____ Result: _____ EGD Date: _____ Result: _____**Patients greater than 50 years of age should have a colonoscopy once every five to ten years.**

Other GI problems: _____

Kidney and urinary tract

Do you ever involuntarily lose your urine? Yes NoIf yes, what causes you to lose urine: coughing jumping sneezing walking bending forwardDo you wear pads for protection? Yes No

Do you have (check any that apply):

 Any history of bladder surgery? Any history of bladder infections? kidney disease kidney stones Other: _____

For males greater than 50 years old:

Last Prostate Exam: _____(month/year) Last PSA test: _____(year)

Central nervous system

Do you have (check any that apply):

 Seizure Disorder Stroke Migraine headaches Other: _____**Blood disorders:**

Do you have (check any that apply):

 Anemia Blood clots Leukemia Bleeding problems Blood transfusion Other: _____**Cancer history**

Have you ever had any type of cancer? Yes No If yes, what type? _____

Treatment: _____ Last follow-up: _____

Psychological history

Have you ever had professional psychiatric treatment? Yes No Hospitalization? Yes No

Do you, or have you had a history of (check those that apply):

 depression anxiety disorder suicide attempts bipolar disorder schizophrenia drug or alcohol rehabilitation other _____

Name of your behavioral health professional: _____

Bone or joint problems

Do you have any of the following (check any that apply):

- | | | | | |
|---------------|-----------------------------------|-------------------------------|------------------------------------|---|
| Ankles | <input type="checkbox"/> swelling | <input type="checkbox"/> pain | <input type="checkbox"/> stiffness | <input type="checkbox"/> previous surgery |
| Knees | <input type="checkbox"/> swelling | <input type="checkbox"/> pain | <input type="checkbox"/> stiffness | <input type="checkbox"/> previous surgery |
| Hips | <input type="checkbox"/> swelling | <input type="checkbox"/> pain | <input type="checkbox"/> stiffness | <input type="checkbox"/> previous surgery |
| Back | <input type="checkbox"/> swelling | <input type="checkbox"/> pain | <input type="checkbox"/> stiffness | <input type="checkbox"/> previous surgery |
| Neck | <input type="checkbox"/> swelling | <input type="checkbox"/> pain | <input type="checkbox"/> stiffness | <input type="checkbox"/> previous surgery |
| Other: | <input type="checkbox"/> swelling | <input type="checkbox"/> pain | <input type="checkbox"/> stiffness | <input type="checkbox"/> previous surgery |

Do you have any of the following (check any that apply): gout fibromyalgia rheumatoid arthritis

Miscellaneous

Any other medical conditions that you need to describe in more detail? _____

QUALITY OF LIFE ASSESSMENT

Below are five statements with which you may agree or disagree. Using the 1 to 7 scale below, indicate your agreement with each item by placing the appropriate number on the line before that item. Please be open and honest with your responses.

1 = Strongly Disagree, 2 = Disagree, 3 = Slightly Disagree, 4 = Neither agree or disagree, 5 = Slightly Agree, 6 = Agree, 7 = Strongly Agree

- _____ 1. In most ways, my life is close to my ideal.
- _____ 2. The conditions of my life are excellent.
- _____ 3. I am satisfied with my life.
- _____ 4. So far, I have gotten the important things I want in life.
- _____ 5. If I could live my life over, I would almost change nothing.

Satisfaction with Life Scale

Diener, E. et al. (1985) The Satisfaction with Life Scale. J. Personality Assessment, 49 (1), 71-75

MEASURE YOUR PERSONAL HEALTH BELIEFS

Instructions: Each item below is a belief statement about your health with which you may agree or disagree. Beside each statement is a scale which ranges from strongly disagree (1) to strongly agree (6). For each item we would like you to circle the number that represents the extent to which you agree or disagree with that statement. The more you agree with a statement, the higher will be the number you circle. The more you disagree with a statement, the lower will be the number you circle. Please make sure that you answer EVERY ITEM and that you circle ONLY ONE number per item. This is a measure of your personal beliefs; obviously, there are no right or wrong answers.

1 = Strongly Disagree (SD), 2 = Moderately Disagree (MD), 3 = Slightly Disagree (D)
4 = Slightly Agree (A), 5 = Moderately agree (MA), 6 = Strongly Agree (SA)

	SD	MD	D	A	MA	SA
1. If I get sick, it is my own behavior which determines how soon I get well again	1	2	3	4	5	6
2. No matter what I do, if I am going to get sick, I will get sick	1	2	3	4	5	6
3. Having regular contacts with my physician is the best way for me to avoid illness	1	2	3	4	5	6
4. Most things that affect my health happen to me by accident	1	2	3	4	5	6
5. Whenever I don't feel well, I should consult a medically trained professional	1	2	3	4	5	6
6. I am in control of my health	1	2	3	4	5	6
7. My family has a lot to do with my becoming sick or staying healthy	1	2	3	4	5	6
8. When I get sick, I am to blame	1	2	3	4	5	6
9. Luck plays a big part in determining how soon I will recover from an illness	1	2	3	4	5	6
10. Health professionals control my health	1	2	3	4	5	6
11. My good health is largely a matter of good fortune	1	2	3	4	5	6
12. The main thing which affects my health is what I myself do	1	2	3	4	5	6
13. If I take care of myself, I can avoid illness	1	2	3	4	5	6
14. Whenever I recover from an illness, it's usually because other people (for example doctors, nurses, family, friends) have been taking good care of me	1	2	3	4	5	6
15. No matter what I do, I'm likely to get sick	1	2	3	4	5	6
16. If it's meant to be, I will stay healthy	1	2	3	4	5	6
17. If I take the right actions, I can stay healthy	1	2	3	4	5	6
18. Regarding my health, I can only do what my doctor tells me to do	1	2	3	4	5	6

Physician signature: _____ Date: _____

The physician signature ratifies that the patient's history completed within this packet substantiates the medical and physical information requirement.

Name: _____

Food Journal

This journal must be returned with your registration packet so that an appointment may be scheduled.

How to fill in your three day food journal:

- Include two weekdays and one weekend day.
- Write down all foods and beverages consumed, and note if they were diet or sweetened.
- Include cooking method: baking, broiling, frying or grilling.
- Include any seasoning used: butter, sour cream, sauce, etc., and the amount used.
- Include portion sizes in either cups or ounces. Try to be as accurate as possible.
- Include what time the foods were consumed.
- Most importantly, BE HONEST. This will only help you.

Form received in office on: _____

Name: _____

Three Day Food Journal

Day One:

MEAL	FOOD EATEN	AMOUNT OF FOOD CONSUMED (Portion size)	COOKING METHOD	SWEETENERS, SEASONINGS, SAUCES (gravy, syrup, dressing, etc.)	TIME OF DAY
Breakfast					
Snack					
Lunch					
Snack					
Dinner					
Snack					
	Total Protein:	Total Calories:			

Name: _____

Three Day Food Journal

Day Two:

MEAL	FOOD EATEN	AMOUNT OF FOOD CONSUMED (Portion size)	COOKING METHOD	SWEETENERS, SEASONINGS, SAUCES (gravy, syrup, dressing, etc.)	TIME OF DAY
Breakfast					
Snack					
Lunch					
Snack					
Dinner					
Snack					
	Total Protein:	Total Calories:			

Name: _____

Three Day Food Journal
Day Three:

MEAL	FOOD EATEN	AMOUNT OF FOOD CONSUMED (Portion size)	COOKING METHOD	SWEETENERS, SEASONINGS, SAUCES (gravy, syrup, dressing, etc.)	TIME OF DAY
Breakfast					
Snack					
Lunch					
Snack					
Dinner					
Snack					
	Total Protein:	Total Calories:			