CONSULTATION PACKET

Dr. Aviv Ben-Meir
Lake Health Bariatric Surgery Center
36100 Euclid Avenue, Suite 170
Willoughby, OH 44094

P: 440-602-6737
F: 440-942-0316

CONSULTATION CHECKLIST

Please bring the following items to your consultation with Dr. Ben-Meir:

☐ This completed packet. To expedite your consultation, please email or fax this packet to us two weeks before your scheduled appointment. You can email it to Courtney.Holbrook@lakehealth.org or fax to 440-942-0316.

☐ Your insurance card(s) - Both primary and secondary, if applicable.

☐ Your driver's license.

☐ Any information or health records you have collected from your other doctors.

☐ Any documentation you may have regarding previous diet attempts.

On behalf of the entire team, welcome to the Lake Health Bariatric Surgery Center! We look forward to helping you achieve your weight loss goals. Please feel free to contact me with any questions, concerns or suggestions you may have.

Sincerely,

Courtney Holbrook, Ph.D.
Program Manager
Lake Health Bariatric Surgery Center
P: 440-602-6737
F: 440-942-0316

LAKE HEALTH BARIATRIC SURGERY CENTER

PHOTOGRAPH RELEASE

I, _____, do hereby give the staff of Lake Health Bariatric Surgery Center permission to take my pre-operative photograph for my office chart.

I understand that any use of my photograph other than described above requires an additional release.

I have read and fully understand the intent and purpose of this release and am signing below without reservation.

Patient Signature _____

Date _____

Witness Signature _____

Date _____

HEALTH EVALUATION

MEDICATIONS

Medication Name	Dosage (mg, units, etc.)	How often do you take it?

Please list all medications, including over-the-counter medications, vitamins and supplements.

ALLERGIES

Allergy	Reaction

HEALTH EVALUATION

Primary Care Physician Name and Phone: _____

Referring Physician and Phone: _____

Pharmacy Name and Phone: _____

Mail Order Pharmacy Name: _____

MEDICAL HISTORY

Please list all of your medical and psychological conditions (i.e. diabetes, high blood pressure, gout, acid reflux, etc.).

_____

_____

_____

_____

_____

_____

SURGICAL HISTORY

Type of Surgery	**Approach** (check one)	**Year**
Gallbladder	☐ Open ☐ Laparoscopic	
Appendix	☐ Open ☐ Laparoscopic	
Intestinal surgery	☐ Open ☐ Laparoscopic	
Hernia repair		
Please list all other surgeries below:		

If you had your gallbladder removed, did you have pancreatitis at that time?

☐ Yes ☐ No ☐ Don't Know

If you had your appendix removed, do you know if it was ruptured?

☐ Yes ☐ No ☐ Don't Know

FAMILY HISTORY

Please indicate if relative is alive or deceased and medical history.

	Father alive? ☐ Yes ☐ No	Mother alive? ☐ Yes ☐ No	Brother alive? ☐ Yes ☐ No	Sister alive? ☐ Yes ☐ No	Son alive? ☐ Yes ☐ No	Daughter alive? ☐ Yes ☐ No
Morbid Obesity						
Diabetes						
Stroke (age)						
Heart Attack (age)						
Cancer (type)						
Blood Clot						
High Blood Pressure						

SOCIAL HISTORY

Are you employed? ☐ Yes ☐ No

If yes, what type of work? _____

Do you use tobacco products? ☐ Currently ☐ Never ☐ Quit - When? _____

How many years have you or did you smoke? _____

If yes, how many packs per day? _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, how often do you drink? _____

When you drink, how many drinks do you have? _____

Do you or have you ever used illicit drugs? ☐ Yes ☐ No

If yes, explain. _____

Do you have any religious, spiritual or cultural beliefs that may affect the treatment we give you? ☐ Yes ☐ No

If yes, explain. _____

Have you fallen in the past year? ☐ Yes ☐ No

If yes, how many times did you fall and were you injured? _____

Any concerns about domestic abuse? ☐ Yes ☐ No

Any concerns about pain medications? ☐ Yes ☐ No

Do you have any conditions that make learning difficult? Yes No

If yes, explain. _____

How do you learn best?
Mark your answers below, you may choose more than one.

☐ Reading

☐ Listening

☐ Handouts

☐ Discussion

☐ Demonstration: ☐ Video ☐ Hands-on

HEALTH EVALUATION

Please indicate if you currently have or have a medical history of any of the following:

☐ Yes ☐ No Hepatitis A, B, or C?

☐ Yes ☐ No HIV/AIDS?

☐ Yes ☐ No Cancer? (Including skin cancer)

If yes, when and what type of treatment did you undergo?

_____

☐ Yes ☐ No Have you ever taken immunosuppressant medications?

☐ Yes ☐ No Frequent headaches or migraines?

Last cardiac stress test? _____

Last echocardiogram (ultrasound of the heart)? _____

☐ Yes ☐ No Chest pain?

☐ Yes ☐ No High blood pressure?

If yes, how long have you had it? _____ years

How many medications do you take for it? _____

☐ Yes ☐ No Irregular heart beat?

☐ Yes ☐ No Coronary Artery Disease?

☐ Yes ☐ No Pacemaker?

☐ Yes ☐ No Palpitations?

☐ Yes ☐ No High cholesterol?

If yes, how long have you had it? _____ years

How many medications do you take for it? _____

HEALTH EVALUATION

☐ Yes ☐ No Sleep Apnea?

Last sleep study? _____

If you have sleep apnea, do you use a CPAP or BiPAP and what are your settings?

CPAP _____ AutoPAP _____ BiPAP _____

☐ Yes ☐ No Do you snore?

☐ Yes ☐ No Do you wake up with a headache?

☐ Yes ☐ No Do you have daytime sleepiness?

☐ Yes ☐ No Asthma or COPD?

☐ Yes ☐ No Do you feel short of breath with activity?

☐ Yes ☐ No Have you ever had to go to the ER or been hospitalized for breathing problems?

If yes, when was the last time? _____

☐ Yes ☐ No Have you ever been prescribed oral or intravenous steroids? (prednisone, Medrol pack, cortisone)

If yes, why and when? _____

☐ Yes ☐ No Peptic ulcer (stomach ulcer)?

If yes, when? _____

Last upper GI (barium swallow)? _____

Last upper endoscopy (EGD)? _____

Last colonoscopy? _____

HEALTH EVALUATION

☐ Yes ☐ No Heartburn?

If yes, how frequently do you have it? _____

☐ Yes ☐ No Do you take a daily medication for prevention?

What medication do you take? _____

☐ Yes ☐ No Underactive thyroid?

☐ Yes ☐ No Overactive thyroid?

☐ Yes ☐ No Diabetes?

If yes, how long have you had it? _____ years

☐ Yes ☐ No Do you take insulin?

If yes, for how long? _____ years

☐ Yes ☐ No Varicose veins?

☐ Yes ☐ No Leg/foot ulcers?

☐ Yes ☐ No Lower leg/ankle swelling?

☐ Yes ☐ No Blood clot (DVT)?

☐ Yes ☐ No Pulmonary embolism (PE)?

☐ Yes ☐ No Did anyone in your family ever have a blood clot or pulmonary embolism?

If yes, explain. _____

☐ Yes ☐ No Known genetic bleeding or clotting disorder?

HEALTH EVALUATION

----------(women only) ----------

☐ Yes ☐ No Uterine fibroids?

☐ Yes ☐ No Ovarian cysts?

☐ Yes ☐ No Infertility?

☐ Yes ☐ No Do you get regular menstrual periods?

If no, explain. _____

Date of last menstrual period? _____

Menopause? ☐ Yes ☐ No

☐ Yes ☐ No Kidney stones? When? _____

☐ Yes ☐ No Kidney disease?

☐ Yes ☐ No Frequent urinary tract infections?

☐ Yes ☐ No Urinary incontinence with laughing or sneezing?

☐ Yes ☐ No Osteoporosis/Osteopenia?

☐ Yes ☐ No Arthritis? Osteoarthritis or Rheumatoid

☐ Yes ☐ No Joint/back pain?

If yes, where is the pain? _____

☐ Yes ☐ No Hidradenitis?

☐ Yes ☐ No Open skin wounds?

☐ Yes ☐ No Rosacea?

☐ Yes ☐ No Healing problems?

If yes, explain. _____

DIET/WEIGHT LOSS HISTORY

How many years have you been overweight? _____

What was your highest adult weight? _____

What was your lowest adult weight? _____

How many calories do you think you eat daily? _____

What diet changes have you been successful in keeping? _____

_____

What is the most weight you lost while dieting? _____

How did you achieve this weight loss? _____

Have you ever had any other weight loss procedures? ☐ Yes ☐ No

If yes, explain. _____

Which medically supervised weight loss techniques have you followed?

☐ Injections for weight loss	☐ Behavior modification
☐ Acupuncture	☐ Dietitian visits
☐ Hypnosis	☐ Physician counseling
☐ OPTIFAST	Other _____
☐ Calorie restriction	Other _____

Which commercial diets have you tried?

☐ Weight Watchers	☐ Jenny Craig
☐ Nutri-Systems	☐ South Beach
☐ Atkins	☐ Low-carbohydrate
☐ Low-fat	☐ Slim-Fast diet
Other _____	Other _____

Please list any over-the-counter diet pills you have tried.

_____

_____

_____

_____

Please list any prescription diet pills you have tried.

_____

_____

_____

_____

Name _____ Date _____

Do you eat distinct meals or do you snack throughout the day?

_____

_____

Where do you eat most of the time?

_____

_____

Who does your grocery shopping and cooking?

_____

_____

Do you cook for anyone else?

_____

_____

How would you rate your cooking ability? (Check one)

☐ Convenience food only

☐ Can cook simple meals

☐ Can cook a complex meal

☐ Very proficient cooking ability

Do you read food labels? _____

Do you have any difficulty chewing or swallowing? _____

How often do you eat out? _____

Where (fast food, sit down, buffets, etc.) _____

What type of beverages do you drink?

_____

_____

Does your work schedule interfere with your ability to eat healthy? ☐ Yes ☐ No

If yes, explain. _____

Please write down everything you ate and drank yesterday.

Time	**Food/Drink**	**Amount**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been under the care of a mental health professional? ☐ Yes ☐ No

If yes, when and for what condition(s) _____

If yes, provider's name _____

Are you currently taking medications for your mental health? ☐ Yes ☐ No

If yes, please list the medications you are taking: _____

_____

If yes, please provide name and phone number of medical professional who prescribes these:

_____

Have you ever had an eating disorder such as anorexia or bulimia? ☐ Yes ☐ No

If yes, when was the most recent time this has been an active part of your life?

Month/Year _____

Have you ever been hospitalized due to a mental health problem? ☐ Yes ☐ No

If yes, when?_____

Have you ever been diagnosed with any of the following? Check all that apply.

- ☐ Depression
- ☐ Anxiety
- ☐ Eating Disorder
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Borderline Personality Disorder

PSYCHOLOGICAL ASSESSMENT

Have you ever experienced suicidal thoughts? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No

If yes, when? _____

Do you have a history of alcohol/drug abuse or dependence? ☐ Yes ☐ No

If yes, explain _____

Do you have a history of treatment for alcohol/drug abuse or dependence?
☐ Yes ☐ No

If yes, explain: _____

CAGE SUBSTANCE ABUSE SCREENING TOOL

Please respond Yes or No to each of the four questions below:

Have you ever felt you should cut down on your drinking or drug use?	☐ Yes	☐ No
Have people annoyed you by criticizing your drinking or drug use?	☐ Yes	☐ No
Have you felt bad or guilty about your drinking or drug use?	☐ Yes	☐ No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?	☐ Yes	☐ No