

SIERRA BARIATRIC SURGERY

PATIENT INFORMATION SHEET

Patient Name \_\_\_\_\_ Phone \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Social Security Number \_\_\_\_\_ Spouse's SS# \_\_\_\_\_

Emergency/Other Phone Numbers  
\_\_\_\_\_

Referred By \_\_\_\_\_ Primary Physician  
\_\_\_\_\_

Medical Insurance \_\_\_\_\_ Secondary Insurance  
\_\_\_\_\_

Person(s) authorized to communicate patient information with the office (example; confirm appointments by phone, receive results of tests) other than patient \_\_\_\_\_  
Relationship to patient \_\_\_\_\_

I hereby recognize that my health information may be used and disclosed, by Sierra Foothill Surgical Specialists and/or Sierra Bariatric Surgery, for treatment, payment and health care operations. I understand that I have the right by law to place restrictions on how this information is used and disclosed for treatment, payment and health care operations and that I may revoke my consent for release of information at any time with written notice. I realize that revoking such consent may result in Sierra Foothill Surgical Specialists and/or Sierra Bariatric Surgery's inability of to provide my medical care. I also authorize transfer of relevant medical information from referring physicians or specialists, and from any hospital to Sierra Foothill Surgical Specialists and/or Sierra Bariatric Surgery, and transfer of relevant medical information from Sierra Foothill Surgical Specialists and/or Sierra Bariatric Surgery to consulting specialists as deemed necessary by my surgeon. I acknowledge receipt of the Sierra Foothill Surgical Specialists and/or Sierra Bariatric Surgery's privacy policy.

I give permission to Sierra Foothill Surgical Specialists and/or Sierra Bariatric Surgery to leave information such as appointment reminders, test results, and other healthcare related information at my home if I am not present.                      YES      NO

Signed \_\_\_\_\_ Date \_\_\_\_\_

# Bariatrics Flow Sheet

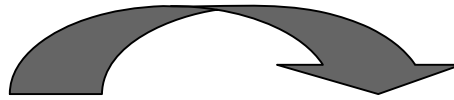
Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Patient screening:

1) Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

2) BMI \_\_\_\_\_

3) Referring MD: \_\_\_\_\_



Letter of Medical Necessity  
Date Mailed \_\_\_\_\_



Approval by insurance  
Date approved \_\_\_\_\_  
CPT approved \_\_\_\_\_



Schedule Surgery  
Date \_\_\_\_\_



Preop Physical Exam  
Date \_\_\_\_\_



Signed consent in chart  
Date \_\_\_\_\_

Photo in chart  
Date \_\_\_\_\_



**SURGERY!**  
Procedure:

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Schedule Appointment  
Date \_\_\_\_\_

Mail questionnaire

Bariatric Management Letter  
Date Mailed \_\_\_\_\_



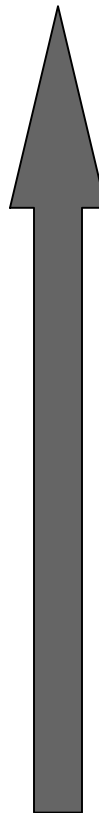
Office Consultation  
Date \_\_\_\_\_

Seminar  
Date \_\_\_\_\_

Mailed  
Date \_\_\_\_\_



Pre-op Workup:	<u>Appt. Date</u>	<u>Result</u>
1) Dietary <input type="checkbox"/>	_____	_____
2) Psychologist <input type="checkbox"/>	_____	_____
3) RUQ U/S <input type="checkbox"/>	_____	_____
4) Pulmonary? <input type="checkbox"/>	_____	_____
5) Cardiology? <input type="checkbox"/>	_____	_____
6) Other _____ <input type="checkbox"/>	_____	_____
7) Folder <input type="checkbox"/>	_____	_____
8) Other _____ <input type="checkbox"/>	_____	_____
9) Seminar date <input type="checkbox"/>	_____	_____



## Review of Systems

**Patient** \_\_\_\_\_

**Date** \_\_\_\_\_

Have you **ever** had any of the following? (Circle all that apply)

- |  |  |
|--|--|
| 1. Asthma                                | 24. Chronic Back Pain                          |
| 2. Emphysema/COPD                        | 25. Breast lumps/Nipple discharge              |
| 3. Tuberculosis                          | 26. Hernia                                     |
| 4. Pulmonary Embolus                     | 27. Bladder incontinence                       |
| 5. Sleep Apnea                           | 28. Stroke                                     |
| 6. Snoring                               | 29. Migraine headaches                         |
| 7. Chest pain/angina                     | 30. Seizure                                    |
| 8. Heart Attack (When? _____)            | 31. Weakness (Where? _____)                    |
| 9. High Blood Pressure                   | 32. Numbness (Where? _____)                    |
| 10. Congestive Heart Failure             | 33. Depression                                 |
| 11. Swelling in your ankles/legs         | 34. Anxiety disorder                           |
| 12. Irregular heart beat                 | 35. Anorexia/Bulimia                           |
| 13. Heartburn or acid reflux             | 36. Other Psychiatric Disorder                 |
| 14. Stomach ulcers or gastritis          | 37. Thyroid disorder                           |
| 15. Blood in your stool                  | 38. Diabetes                                   |
| 16. Irritable Bowel Syndrome             | 39. Blood clot in arm or leg (DVT)             |
| 17. Colitis                              | 40. Anemia                                     |
| 18. Polyps (Where? _____)                | 41. Easy bruising/won't stop bleeding when cut |
| 19. Pancreatitis                         | 42. Blood transfusion                          |
| 20. Jaundice (turned yellow)             | 43. HIV/AIDS                                   |
| 21. Hepatitis                            | 44. Cancer (Where? _____)                      |
| 22. Joint replacement (Which one? _____) | 45. Do you smoke?            YES    NO         |
| 23. Arthritis (Which joints? _____)      | 46. Do you drink alcohol?   YES    NO          |

List all surgeries you have had (include dates if possible):

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List all medications you currently take and their doses (include vitamins and herbs):

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Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_

Jeffrey R. Jenkins, MD, FACS  
Board Certified General Surgeon  
3257 Professional Dr., Suite E  
Auburn, CA 95602  
(530) 823-0701 / FAX (530) 823-0737

## Gastric Bypass Dietary History

(All of the answers to these questions will be strictly confidential)

Please bring this with you to your appointment with Dr. Jenkins

Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. What is your current weight? \_\_\_\_\_pounds
2. How tall are you? \_\_\_\_\_Feet \_\_\_\_\_inches
3. How much did you weigh:
  - a. When you were Ten years old \_\_\_\_\_
  - b. When you were 18 years old \_\_\_\_\_
  - c. Five years ago \_\_\_\_\_
4. Have you ever been on a diet? YES NO (if no, skip to #7)
5. How old were you when you were first put on a diet? \_\_\_\_\_
6. Which of the following diets have you used?

(check all that apply and list the length of time you were on the diet and total pounds lost)

<u>Diet</u>	<u>Length</u>	<u>Weight lost</u>	<u>Regained?</u>
Nutri-Systems	_____	_____	_____
Richard Simmons	_____	_____	_____
Jenny Craig	_____	_____	_____
Weight Watchers	_____	_____	_____
Atkins	_____	_____	_____
Slim Fast	_____	_____	_____
Metabolife	_____	_____	_____
Herballife	_____	_____	_____
Optifast	_____	_____	_____
Medifast	_____	_____	_____
Xenical	_____	_____	_____
Meridia	_____	_____	_____
Phen-Fen	_____	_____	_____
Other _____	_____	_____	_____
Other _____	_____	_____	_____

7. Have you ever purposefully vomited after eating to try to lose weight? YES NO
8. Do you exercise? YES NO
  - a. If yes, what do you do? \_\_\_\_\_
  - b. How often? \_\_\_\_\_
9. Do you consider yourself an overeater? YES NO
10. Do you eat for comfort (for reasons other than being hungry)? YES NO
11. Describe what you have for a typical:
  - a. Breakfast \_\_\_\_\_
  - b. Lunch \_\_\_\_\_
  - c. Dinner \_\_\_\_\_
  - d. Snack \_\_\_\_\_
12. Did you decide to consider surgery for weight loss or did someone else encourage you to be seen?  
SELF OTHER (If other, whom? \_\_\_\_\_)