The Crawford Clinic

General Surgery • Rheumatology

George Isaac Crawford, Jr. MD

LAP BAND

PATIENT INFORMATION PROFILE

Updated 03/19/2012

PERSONAL DETAILS

First Name:_____Last Name:_____

Address:_____

_____Zip code:_____

Telephone No: (Home)_____(Work)_____

Mobile No: _____ Date Of Birth:_____

Height:_____Weight:_____Age:_____Goal Weight:_____

Occupation:_____

Health Insurance:_____Membership No:_____

CONTACT PERSONS:

This information is often vital to us if we need to contact you urgently and helps with achieving good follow-up. Occasionally people move or have new phone numbers and do not let us know. Please select some contacts who can inform us if you have moved and forgotten to let us know your new address.

1. NEXT OF KIN

Name:_____Relationship:_____

Address:_____

_____

Telephone No: (Home)_____(Work)_____

2. ADDITIONAL CONTACT

Name:_____Relationship:_____

Address:_____

_____

Telephone No: (Home)_____(Work)_____

3. ADDITIONAL CONTACT:

Name:_____Relationship:_____

Address:_____

_____

Telephone No: (Home)_____(Work)_____

REFERRAL INFORMATION

Referring Doctor:_____Date of Referral:_____

Address:_____

Telephone Contact:_____

Local Doctor:_____

Address:_____

Telephone Contact:_____

Specialist Physician/Surgeon:_____

Other:_____

SOCIAL PROFILE

FAMILY STRUCTURE:

Married: ☐ Single: ☐

Divorced: ☐ Partner/Relationship: ☐

Children/Ages:_____

_____

_____

Support persons/friends:_____

_____

_____

PERSONAL MEDICAL HISTORY

Have you ever suffered with any of the following health problems:

Diabetes:		Yes ☐	No ☐	Details:_____		
Diabetes while pregnant:		Yes ☐	No ☐	Details:_____		
Asthma:		Yes ☐	No ☐	Details:_____		
Respiratory/Breathing problems:		Yes ☐	No ☐	Details:_____		
Sleep Apnea:		Yes ☐	No ☐	Details:_____		
Pains in the:	Hips	Yes ☐	No ☐	Details:_____		
	Feet	Yes ☐	No ☐	Details:_____		
	Knees	Yes ☐	No ☐	Details:_____		
	Back	Yes ☐	No ☐	Details:_____		
Kidney or urinary disorder:		Yes ☐	No ☐	Details:_____		
Incontinence of urine		Yes ☐	No ☐	Details:_____		
Stroke or nerve loss		Yes ☐	No ☐	Details:_____		
Gallstones:		Yes ☐	No ☐	Details: _____		
Heartburn or reflux:		Yes ☐	No ☐	Details:_____		
Peptic ulcer:		Yes ☐	No ☐	Details:_____		
Hepatitis or other liver disease:		Yes ☐	No ☐	Details:_____		
High blood pressure:		Yes ☐	No ☐	Details:_____		
Heart disease:		Yes ☐	No ☐	Details:_____		
High cholesterol or lipids:		Yes ☐	No ☐	Details:_____		
Infertility		Yes ☐	No ☐	Details:_____		

Anemia or bleeding disorder Yes ☐ No ☐ Details:_____

Thrombosis or clotting disorder: Yes ☐ No ☐ Details:_____

Varicose veins or leg swelling Yes ☐ No ☐ Details:_____

Skin conditions, especially under skin folds Yes ☐ No ☐ Details:_____

Ulcerative Colitis or Crohn's Yes ☐ No ☐ Details:_____

Lupus or Rheumatoid Arthritis Yes ☐ No ☐ Details:_____

Scleroderma Yes ☐ No ☐ Details:_____

Connective Tissue Disorders Yes ☐ No ☐ Details:_____

Barrett's Esophagitis Yes ☐ No ☐ Details:_____

Depression or other: Psychological/nervous disorder Yes ☐ No ☐ Details:_____

Please identify the major illnesses or health problems:_____

_____

_____

_____

_____

SURGICAL HISTORY

Please list any past operations**:**

_____

_____

_____

_____

_____

_____

PHYSICAL EFFECTS

Do you suffer any of the following physical limitations because of your weight?

Get short of breath easily	Yes ☐	No ☐
Always tired and lethargic	Yes ☐	No ☐
Cannot take part in family outdoor activities	Yes ☐	No ☐
Have difficulty buying clothes	Yes ☐	No ☐
Have difficulty with personal hygiene	Yes ☐	No ☐
Cannot cut your toenails	Yes ☐	No ☐
Travel, especially in planes, is difficult	Yes ☐	No ☐

What size clothes do you buy now? _____

List any other particular difficulties: _____

_____

_____

_____

_____

SOCIAL EFFECTS

Are you embarrassed about your appearance	Yes ☐	No ☐
Do you avoid social activities if possible	Yes ☐	No ☐

Looking in the mirror, would you describe your appearance as:

0	5	10
OK	Not too good	Revolting

Are you worried about the effect that your weight will have on your future health and your life expectancy? Yes ☐ No ☐

How important is your future health in causing you to consider surgery?

(Place a cross at the appropriate point along the line)

0		10
Not much	Quite a lot	The most important factor

WEIGHT HISTORY

Please indicate your weight at the following times.
Please indicate whether you consider your weight was below average, average, above average or very heavy in the relevant boxes..

	Below Average	Average Weight	Above Average	Very Heavy
Birth Weight				
Weight at starting school (5-6 years)				
Weight at beginning of high school (10-12 yrs)				
Weight at end of high school (15-18 years)				
Weight at time of commencing work (21 years)				
Weight at time of marriage (if applicable)				

WEIGHT LOSS HISTORY

For how long have you been seriously trying to lose weight? _____ years

Which of the following have you tried at some time?

Dieting - fad diets, something you have read about, etc ☐

Exercise - walking, swimming, sporting activities, etc ☐

Commercial weight loss groups:

- Jenny Craig ☐
- Weight Watchers ☐
- The Zone ☐
- Atkin's ☐
- Nutrisystem ☐
- Slimfast ☐
- Herbal Life ☐
- South Beach ☐
- Others - please list:_____

_____

Diet Pills:

- Meridia (sibtramine) ☐
- Tenuate (diethylpropion) ☐
- Adipex (phentermine) ☐
- Xenical (orlistat) ☐
- Adipost (phendimetrazine) ☐
- Others - _____

_____

Professional Advice:

- Local Doctor ☐
- Dietitian ☐
- Naturopath ☐
- Hypnotherapist ☐
- Psychologist ☐
- Acupuncturist ☐

Very low calorie diets:

- Modifast ☐
- Optifast ☐

Others:

- Injection therapy ☐
- Herbal remedies ☐
- Weight loss devices ☐

Surgical Treatments :

- Stomach stapling ☐
- Fixed gastric banding ☐
- Gastric Bypass ☐
- Small bowel bypass ☐
- Abdominoplasty ☐
- Liposuction ☐
- Other cosmetic procedures - List:

_____

_____

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following and if so, please indicate:

	PARENT	SIBLING / CHILD	OTHER RELATIVES (cousins, aunts, grandparents etc)	NO FAMILY HISTORY	DON'T KNOW
Diabetes					
Heart Disease					
Hypertension					
Gout					
Gallstones					
Obesity					
Snoring / sleep apnoea					
Asthma					
Osteoporosis					
Hip Fractures					
Dermatitis / Eczema					
High Cholesterol					
Lupus/Scleroderma					
Ulcerative Colitis/Crohn's Disease					

ALLERGIES (including foods, medications, dressings): Yes ☐ No ☐

If yes, please give details:_____

_____

ALCOHOL:

Do you drink alcohol: Never ☐ Rarely ☐ Regularly ☐

How many standard glasses do you drink per day _____

How many days do you drink per week _____

Do you drink Beer ☐ Wine ☐ Spirits ☐

SMOKING:

Do you smoke? ☐ Yes ☐ No ☐ Never If yes: how many per day?

_____

Have you smoked in the past? ☐ Yes ☐ No If so, how many per day? _____

For how many years _____ When did you stop smoking? _____

There is increasing evidence that alcohol consumption may help some of the risk factors that lead to heart disease and stroke. Indeed it may even decrease the mortality associated with these serious conditions.

We wish to look at these risk factors in people who are obese. To assist us we would like you to answer these few simple questions about your alcohol consumption and a few questions about any folate or multivitamins you may take.

Please tick your answers where appropriate.

Part A

Do you drink any alcohol? Yes ☐ No ☐ (go to part B)

How often do you have a drink containing alcohol?

Every Day ☐ Most days ☐ Most weeks ☐

Most months ☐ Rarely (once or twice a year) ☐

What is the main type of beverage you drink? Please check one only.

Beer ☐ Wine ☐ Spirits ☐

From the list below please **circle** the **main** alcoholic beverage you drink and **check** any others you would drink at times.

beer light beer red wine white wine

sparkling wine fortified wine spirits (specify)……

When do you usually drink? Please circle the main one. Check any others that are relevant.

Social occasions Parties With meals Before/after meals Weekend session/s

If you indicated above that you drank every day, most days or most weeks, please circle how many standard drinks you would have in a **typical week**. (1 standard drink = 1 small glass of wine, 1 glass of full strength beer or a nip of spirits).

1-2 3-10 11-20 21-40 40+

Part B- for non-drinkers only.

Is there a reason you don't drink any alcohol?

_____

_____

Part C

1. Do you take multi-vitamin tablets or other dietary supplements?

Yes ☐ No ☐ (go to 2)

If yes, how often do you take them?

Rarely ☐ Monthly ☐ Weekly ☐ Most days ☐ Every day ☐

Please name the multi-vitamin or other dietary supplements you usually take.

……

2. Do you take folate tablets? Yes ☐ No ☐

If yes, how often do you take them?

Rarely ☐ Monthly ☐ Weekly ☐ Most days ☐ Every day ☐

What dose do you take? 200mg ☐ 400mg ☐

ACTIVITY LEVEL ~ What exercise do you do on a regular basis?

How many sessions of exercise (walking, sports, etc.)
do you do per week for more than 30 minutes at a time. _____

What sort of activities: _____

How do you feel when exercising. Please mark level on scale:

0		10
Awful	Average	Excellent

LADIES

Do you have regular periods (26 - 33 days) Yes ☐ No ☐

If not, please describe _____

_____

Do have problems with excessively heavy periods Yes ☐ No ☐

If Yes, please described _____

_____

Have you had difficulty in conceiving in the past? Yes ☐ No ☐

Do you currently have problems with infertility? Yes ☐ No ☐

Have you suffered from excess body hair or acne? Yes ☐ No ☐

Have you every been told by a doctor that you have polycystic ovaries? Yes ☐ No ☐

Have you had problems with pregnancy and/or childbirth? Yes ☐ No ☐

If so, in what way _____

_____

Have you had a C-section? Yes ☐ No ☐

If so, why? _____

SLEEP HISTORY

How many hours sleep do you get a night?_____

Is there any thing else that keeps you awake at night? Yes ☐ No ☐

Details:_____

Would you consider the quality of your sleep is Good ☐ Fair ☐ Poor ☐

If your sleep is a major problem to you or your partner, would you be prepared to have a sleep study performed now and after you lose weight? Yes ☐ No ☐

SYMPTOMS OF SLEEP APNEA

To answer each question, circle the star in the position that best indicates your answer.

1. How often do you snore?

NEVER * * * * * ALWAYS

2. Do you wake during the night with a choking feeling?

NEVER * * * * * FREQUENTLY

3. How often would you sleep more than 8 hours in total in a 24 hour period?

NEVER * * * * * ALWAYS

4. How often do you wake up more than once during the night?

NEVER * * * * * ALWAYS

5. Do you have a headache when you wake up in the morning?

NEVER * * * * * ALWAYS

6. Have you noticed a reduction in your libido or sex drive?

NO * * * * * TOTAL

7. Do you feel sleepy during the day?

NEVER * * * * * ALWAYS

8. Has anyone noticed that you momentarily stop breathing during your sleep?

NO * * * * * FREQUENTLY

9. Do you fall asleep while reading?

NEVER * * * * * FREQUENTLY

10. Do you wake up in the morning feeling confused?

NEVER * * * * * ALWAYS

11. How often do you have a nap during the day?

NEVER * * * * * ALWAYS

12. Do you feel sleepy in the evenings?

NEVER * * * * * ALWAYS

13. Have you or anyone else noticed a change in your personality recently?

N0 * * * * * DEFINITELY

14. How often do you doze off or fall asleep while driving?

NEVER * * * * * FREQUENTLY

How likely are you to **doze off or fall asleep** in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you.

Use the following table to choose the **most appropriate option** for each situation by placing a tick in the boxes below:

Situation	**[0] Never doze**	**[1] Slight chance of dozing**	**[2] Moderate chance of dozing**	**[3] High chance of dozing**
Sitting and reading				
Watching TV				
Sitting, inactive in a public place (e.g. a theatre or a meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a lunch without alcohol				
In a car, while stopped for a few minutes in the traffic				

EMPLOYMENT

Current Employment:

Are you currently employed?_____

Are you full-time, part-time or casual?_____

What type of work are you doing?_____

If you are unemployed, what is the reason?_____

Are you actively looking for work?_____

Has your weight made it difficult to find employment? _____

If employed, please state what level of activity your job involves:

0	5	10
Little (sedentary job)	Moderately active	Very active (Labouring, etc.)

BREATHING HISTORY

Does being at work ever make your chest tight or wheezy?

Yes ☐ No ☐ details:_____

Have you ever had to change your job because it affected your breathing?

Yes ☐ No ☐ details:_____

Have you ever worked in a job, which exposed you to vapours, gas dust or fumes?

Yes ☐ No ☐ details:_____

ASTHMA

Have you ever had asthma? (tick one of the following)

Never ☐

Current ☐

In the past ☐

Don't know ☐

Have you ever had to spend a night in hospital because of asthma / breathing problems?

Yes ☐ No ☐

If yes was it in the last 12 months Yes ☐ No ☐

In the last 12 months, have you visited a hospital casualty department or seen a doctor urgently because you had asthma or breathing problems

Yes ☐ No ☐ Details:_____

In the last 12 months, have you taken a course or prednisolone because of asthma or breathing problems

Yes ☐ No ☐ Details:_____

In the last 12 months, have you missed work or school because of asthma or breathing problems?

Yes ☐ No ☐ Details:_____

COUGH AND SHORTNESS OF BREATH:

Do you usually have a cough? Yes ☐ No ☐

Do you usually bring up phlegm from your chest when you cough? Yes ☐ No ☐

Do you get short of breath on exertion? Yes ☐ No ☐

Do you get short of breath walking on the flat? Yes ☐ No ☐

Do you get short of breath walking uphill or doing housework? Yes ☐ No ☐

In the last 12 months, have you had an attack of shortness of breath that came on when you were not exercising and without obvious cause Yes ☐ No ☐

WHEEZE (a whistling noise that comes from the chest and may cause breathlessness or difficulty in breathing)

In the last 12 months, have you had wheezing in your chest? Yes ☐ No ☐

In the last 12 months, have you had an attack of wheezing that came on after you stopped exercising? Yes ☐ No ☐

In the last 12 months, have you had a feeling of tightness in your chest on waking in the morning? Yes ☐ No ☐

GASTROESOPHAGEAL REFLUX / INDIGESTION

Do you have a history of heartburn or indigestion

Yes ☐ No ☐ Details:_____

If yes, how often do you have reflux during the day?

Many times a day · everyday · most days · most weeks · occasionally ·

Do you suffer heart burn / indigestion during the night? If so how oftern

Many times a night · everynight · most nights · most weeks · occasionally ·

What aggrevates or causes your reflux?
Details:_____

Do you have difficulty swallowing?

Yes ☐ No ☐ Details: _____

Does food ever get stuck?

Yes ☐ No ☐ Details:_____

Does food or fluid reflux into the mouth?

Yes ☐ No ☐ Details:_____

Do you vomit with reflux?

Yes ☐ No ☐ Details:_____

Do you suffer from recurrent sore throats?

Yes ☐ No ☐ Details:_____

Do you suffer from a hoarse voice?

Yes ☐ No ☐ Details:_____

Do you suffer from a regular cough at night?

Yes ☐ No ☐ Details:_____

Please list any treatments you may use for reflux / heartburn or indigestion

_____

_____

_____

MEDICATIONS

Please indicate whether you are now or have previously taken any of the following medications.
If yes, please state the name of the medication and how long you have been or were taking it.

Medication for psychiatric disorder Yes ☐ No ☐ Details_____

Migraine medication Yes ☐ No ☐ Details_____

Medications to assist weight loss Yes ☐ No ☐ Details_____

Drugs for epilepsy Yes ☐ No ☐ Details_____

Drugs for asthma or breathing Yes ☐ No ☐ Details_____

Hormones, e.g.The Pill Yes ☐ No ☐ Details_____

Hormone Replacement Therapy Yes ☐ No ☐ Details_____

Cortisone Yes ☐ No ☐ Details_____

Please list all the tablets, drops, creams, etc that you are currently taking.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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