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LAP-BANDING
INITIAL PATIENT WORKSHEET

PATIENT DEMOGRAPHIC INFORMATION

Date: _____

First Name _____ **MI** _____ **Last Name** _____ **Maiden Name** _____ **Suffix** _____

Street Address _____ **Apt Number** _____

City _____ **State** _____ **Zip Code** _____

Date of Birth _____ **Age** _____ **Gender** _____ **Male** _____ **Female** _____

Social Security Number _____ **Email address** _____

Home Phone _____ **Work Phone** _____

Occupation _____ full time _____ part time _____ retired _____ disabled _____

What is your current marital status? _____ married _____ single _____ separated _____ divorced _____ widowed _____

Which of the following best describes your ethnic origin?

Black/African-American _____ White/Caucasian _____ Other _____
 Hispanic _____ Asian/Oriental or Pacific Islander _____

What category best describes your Highest Grade or Level of Education?

9 to 11 years _____ High School Graduate _____
 Vocational/Technical Training _____
 Attending College _____ College Graduate _____ Graduate Degree _____

What is your religion affiliation?

Atheist _____ Catholic _____ Jehovah Witness _____ Jewish _____
 Methodist _____ Presbyterian _____ Other _____

Weight/Diet History:

How tall are you? _____ ft _____ in _____ How much do you weigh? _____

What was your approximate weight at age.....

10 _____ lbs. 18 _____ lbs. 25 _____ lbs. 30 _____ lbs.
 35 _____ lbs. 40 _____ lbs. 45 _____ lbs. 50 and over _____ lbs.

PATIENT'S NAME _____

Please list the history of any food or liquid diets that you have tried in an attempt to lose weight.

Name of diet	Year	Length	Number of lbs. lost
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Please list the history of any medications that you have tried in an attempt to lose weight:

medication/dose	year	length	number of pounds lost
1			
2			
3			
4			
5			
6			

FAMILY HEALTH HISTORY:

This section pertains to immediate family members (ie. Mother, Father, Brothers, Sisters, Grandmothers, Grandfathers), please check any that apply and list which member of your family.

Arthritis	_____	High blood pressure	_____
Hepatitis	_____	Diabetes	_____
Cancer	_____	Heart Disease	_____
Stroke	_____	Respiratory disease	_____
Seizures	_____	Heart Attack	_____

MEDICATION INFORMATION:

Please list all prescribed and over the counter medication that you are currently using.

MEDICATION	DOSE	TIMES PER DAY	PURPOSE
1			
2			
3			
4			
5			
6			
7			
8			

PATIENT'S NAME _____

ALLERGY INFORMATION:

Please list any known Allergies: _____
What allergic reaction did you have? _____

PHARMACY INFORMATION:

Name of Pharmacy _____
Address _____
Phone number _____

EMERGENCY CONTACT INFORMATION:

Who could we contact in case of an emergency? _____
Phone number _____ Relationship to patient _____

HEALTH INFORMATION

Have any of the following conditions ever been significant problems for you? Please specify the physician who currently manages the problem. Please mark an **X** in the block.

CARDIAC	YES	NO	YEAR	PHYSICIAN
Coronary Artery Disease				
MI (Heart Attack)				
High Cholesterol/Triglycerides				
Chest Pain				
Valvular Heart Disease				
(e.g. Mitral Valve Prolapse, Mitral Valve Regurgitation etc.)				
Rheumatic Fever				
Heart Murmur				
Heart Arrhythmia				
(e.g. Irregular heart beat)				
Hypertension				
PULMONARY				
Asthma				
Pneumonia				
Bronchitis				
COPD (Emphysema)				
Tuberculosis				
Observed Sleep Apnea				
Loud Snoring				
Gasping for Breath at Night				
Family History of Sleep Apnea				
Diagnosed Sleep Apnea				
ENDOCRINE				
Diabetes Mellitus				
Hyperthyroid				
Hypothyroid				
Adrenal (Cushings)				
Other				

PATIENT'S NAME _____

GASTROINTESTINAL	YES	NO	YEAR	PHYSICIAN		
Reflux Disease (Heartburn)						
Peptic Ulcer Disease						
Gallbladder Disease						
Liver Disease						
Other						
CANCER						
Type/Organ (s) Affected						
PERIPHERAL VASCULAR DISEASE						
Arterial Vascular Disease						
Pulmonary Embolism						
DVT (Phlebitis)						
Peripheral Edema (e.g. Swelling legs, Ankles)						
Venous Stasis						
Varicose Veins						
RENAL						
Kidney Disease						
Urinary Stress Incontinence						
Kidney Stones						
CENTRAL NERVOUS SYSTEM						
Seizure Disorders						
CVA (stroke)						
Metabolic Disorders						
Migraine Headaches						
Other						
ORTHOPEDIC						
Lower Back Pain						
Diagnosed Osteoarthritis/DJD						
If yes, Joints involved	neck	shoulders	back	hips	hand/wrist	
	knees	ankles	feet	heels		
Painful joints (without Osteoarthritis/DJD)	neck	shoulders	back	hips	hand/wrist	
	knees	ankles	feet	heels		
Gout						

If yes, list joint involved: _____

Other Medical Disorders: _____

PSYCHIATRIC DISORDERS	YES	NO	YEAR	PHYSICIAN		
Depression						
Anxiety						
Schizophrenia						
Eating Disorder						
If yes, What type?						
Other						

PATIENT'S NAME _____

PATIENT'S PHYSICIAN INFORMATION

Name of Primary Care Physician _____
Address _____
Phone Number _____

Please list any other Physicians you see:

Name of Physician _____
Address _____
Phone Number _____

Name of Physician _____
Address _____
Phone Number _____

Name of Physician _____
Address _____
Phone Number _____

PREVIOUS SURGERY INFORMATION

If applicable, please indicate if your surgical procedure was done laparoscopic or an open procedure

Type of Surgery	Reason	Year
1		
2		
3		
4		
5		
6		

Have you ever had any trouble with Anesthesia? _____ yes _____ no
If yes, Please explain what occurred _____

PREVIOUS MEDICAL HISTORY

Do you have any problems with bleeding or clotting? _____ yes _____ no
Have you ever had any broken bones of the face? _____ yes _____ no
Have you ever had any broken bones of the back/neck? _____ yes _____ no

PATIENT'S NAME _____

OBSTETRICAL/GYNECOLOGICAL

Do you have a history of breast cancer? _____ yes _____ no
Have you ever had a hysterectomy? _____ yes _____ no
If yes, please indicate _____ vaginal _____ abdominal
Where the ovaries removed? _____ yes _____ no
Have you ever had a Cesarean Section? _____ yes _____ no
If yes, please indicate how many?
Have you ever had a Tubal Ligation? _____ yes _____ no
If yes, please indicate how the procedure was performed _____ laparoscopic _____ open
If applicable, please indicate the number of pregnancies to term
Please indicate whether you are: _____ pre-menopausal _____ post-menopausal

SMOKING/DRUG/ALCOHOL HISTORY

Do you currently use tobacco? _____ yes _____ no
Have you ever used tobacco? _____ yes _____ no
If you answered yes to the above questions:
What type of tobacco uses? _____ cigarettes _____ cigars _____ pipe _____ chew/snuff
What age did you start tobacco use? _____
How many years have you used tobacco? _____
How much do/did you usually smoke per day?
_____ less 1/2 pack _____ 1/2 to 1 _____ 1 1/2 to 2 _____ 2 1/2 or more
If Applicable, what age did you quit smoking? _____

Do you currently use alcohol? _____ yes _____ no
Have you ever had a problem with alcohol in the past? _____ yes _____ no
If yes, please indicate when and how long _____
If you answered yes, to the above questions:
what type(s) of alcohol did/are you drinking? _____ wine _____ beer _____ liquor _____ mixed drinks
Please indicate how many drinks you currently or have drunk each day?
_____ less than 2 _____ 2 to 5 _____ 6 to 10 _____ 11 or more

Please indicate other drugs that you currently use.
_____ marijuana _____ cocaine _____ heroin _____ amphetamines
_____ other

How long have you been using? _____ less 6 months _____ 6 months - 1 year
_____ more than 1 year

Have you ever used any drugs in the past? _____ yes _____ no
If so, which drugs _____
If so, how long? _____ less 6 months _____ 6 months - 1 year
_____ more than 1 year

PATIENT'S NAME

- Do you feel sleepy or have "sleep attacks" during the day? _____ yes _____ no
- Do you nap during the day? _____ yes _____ no
- Do you have trouble concentrating during the day? _____ yes _____ no
- Do you have trouble falling asleep when you first go to bed? _____ yes _____ no
- Do you awaken during the night? _____ yes _____ no
- Do you awaken more than once? _____ yes _____ no
- Do you awaken too early in the morning? _____ yes _____ no
- How long have you had trouble sleeping? _____
- What do you think precipitated the problem? _____

How would you describe your usual night's sleep(hours of sleep, quality of sleep, etc)

- Does your schedule for sleep and rising on the weekend differ from what it is during the week? _____ yes _____ no
- Do others live at home who interrupt your sleep? _____ yes _____ no
- Are you regularly awakened at night by pain or the need to use the bathroom? _____ yes _____ no
- Does your job require shift change or travel? _____ yes _____ no
- Do you drink caffeinated beverages (coffee, tea, or soft drinks) _____ yes _____ no
- What sleep medications, prescriptions or nonprescription, do you take? Please indicate the dose, how often you take it, and for how many months/years you have taken it

- Have you ever suffered from depression, anxiety, or similar problems? _____ yes _____ no
- Do you snore? _____ yes _____ no
- Does your sleep partner snore? _____ yes _____ no
- Does your sleep partner seem to stop breathing repeatedly during the night? _____ yes _____ no
- Does your sleep partner jerk his or her legs, or kick you while he or she is sleeping? _____ yes _____ no

PATIENT'S NAME _____

INSURANCE INFORMATION

Name of your Primary Medical Insurance Carrier _____
Group Number _____ ID Number _____
Agreement Number _____ Name of the Insured _____
Relationship to insured _____ self _____ spouse _____ child _____ other
Address _____
Telephone number _____ other _____

Name of your Secondary Medical Insurance Carrier _____
Group Number _____ ID Number _____
Agreement Number _____ Name of the Insured _____
Relationship to insured _____ self _____ spouse _____ child _____ other
Address _____
Telephone number _____ other _____

cardholder social security # _____
cardholder date of birth _____