CalvertHealth™
Medical Group

Bariatric Surgery
New Patient Information

Welcome to the Metabolic and Bariatric Surgery program at CalvertHealth Medical Center

You are about to embark on a new life altering experience that will help you improve your overall health and well-being! The Metabolic and Bariatric Surgery program at CalvertHealth Medical Center is a multidisciplinary program launched in May 2021 that aims to offer the most comprehensive, thorough, and up to date treatments to treat obesity and its medical implications.

The word *"bariatric"* is a term that comes from two Greek words that mean "weight" and "treatment". Therefore, "bariatric surgery" can be defined as treating weight by surgery. The term "*metabolic*" was recently added to "bariatric surgery" because of the known and proven improvements seen in the metabolic profiles of patients undergoing bariatric surgery. You and your Primary Care Physician have decided bariatric surgery may be an option for you. The decision to recommend surgery for the treatment of obesity requires multidisciplinary input to evaluate the indications for operation and to define and manage co-morbidities properly. The Metabolic and Bariatric Surgery Program team will help you make the final decision as to whether surgery is the *best* option for you.

This path you have chosen is going to help alleviate a lot of your health issues and concerns, at the heart of which is obesity. Years of experience have shown us that, when it comes to bariatric surgery, the most successful patients are the most informed. As such, as you go through our program, the team of experts will stress the need to stay well informed and ensure that you have an excellent understanding of the steps and expectations you should encounter.

Again, by being here and reading this, you are considering what is likely going to be the best decision you have taken in terms of improving your health and life in general. On behalf of the entire multidisciplinary team here at CalvertHealth Medical, I would like to congratulate you on making this brave decision and look forward to helping you achieve your goals.

Ramzi Alami, MD FACS FASMBS

Medical Director of the Metabolic & Bariatric Surgery Unit

CalvertHealth Medical Center

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I am interested in: Gastric Bypass Gastric Band Revision/ removal Sleeve Gastrectomy

How did you hear about our program? _____

Contact Information

Patient: _____
Patient Address: _____
_____
_____
Patient Telephone: (_____)_____
Patient Email: _____
Date of Birth: _____

Referring MD: _____
MD Address: _____
_____
_____
MD Telephone: (_____)_____
MD Email: _____

Primary MD: _____
MD Address: _____
_____
_____
MD Telephone: (_____)_____
MD Email: _____

Psychologist: _____
Address: _____
_____
_____
Telephone: (_____)_____

Insurance Carrier: _____ **State:** _____
Have you called to verify that Bariatric Surgery is a covered benefit? _____
Does your insurance require a supervised diet? (*be sure to ask)* _____

Your Current Height: _____
Your Current Weight: _____

BMI: _____

Please note: We Do Not Accept Charity Care

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Bariatric History:

How long have you been looking into having weight loss surgery? _____
Have you ever been evaluated for weight loss surgery before? Yes/ No _____
Have you ever had weight loss surgery, and are interested in a revision? _____
When did weight become a problem for you? Child Teen Adult With Pregnancy
At what age did you first begin dieting: _____ years old
Are your family members heavy? Yes/ No which ones? _____
What do you feel has caused you to be heavy? Major Illness Major Stressor
Medication Marriage Travel Trauma Divorce
Food Choices Inactivity Genetics Other_____
What was your highest adult weight? _____ Lbs. When? _____
What was your lowest adult weight? _____ Lbs. When? _____

Eating Patterns:

Describe your eating habits: _____
Do you skip meals? Yes/ No If so, which? _____
What do you drink? _____
How often do you drink sugar sweetened beverages? _____
Do you have any difficulty swallowing? _____
Are you allergic or intolerant to any foods? Yes/ No If so, which? _____
Do you eat big meals, or have difficulty feeling full? Yes/ No If so, which? _____
How often do you eat outside the home/ include fast food? _____x's a week

Exercise or Activity:

Describe your exercise habits: _____
How often do you exercise? I don't Daily 2x/week 3x/week 4x/week
What are your barriers to exercise? _____
Can you walk up a flight of stairs without stopping? Yes/ No
Do you get chest pain or shortness of breath on exertion? _____
How far can you walk without stopping? <10 mins 15 mins 30 mins >30mins

Psychological Eating/ Problems:

Do you have any mental health concerns? _____
Have you ever been hospitalized for mental health illness? _____
Are you experiencing any major life stressors currently? _____
Do you ever have binges (eating a large amount of food in a short period of time)? _____
Are you under the care of a psychologist/ psychiatrist/ counsellor? _____
Do you take any medications for mental health reasons? _____
If yes, who prescribes them for you? _____

Sleep:

Describe your sleep habits: _____
Do you have any difficulty sleeping? _____
Have you ever been tested for sleep apnea? _____Do you wear a CPAP?
Do you take sleep aides? _____

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Weight Loss Attempts

Program	Describe/ Year	Months on Program	Pounds Lost	Comments	Cost ($)
Diet pills (any)					
Weight Watchers					
Liquid Diets (Optifast or Slim Fast, etc.)					
Low calorie diets					
Low card diets or Atkins					
Jenny Craig or Nutri-System					
Fad diets					
Physician Monitored Diet "Diet Clinics"					
Hypnosis/ counseling					
Surgery					
Dietician Counseling					
OA					
Gym Memberships Exercise Plans					

What diet/ weight loss plan has worked the best?

What do you feel has been your biggest barrier to losing weight?

Why do you want to have weight loss surgery now?

What surgery are you most interested in having and why?

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Personal Health History:

Medical Problems (Circle all that apply)

Diabetes	High Blood Pressure	Sleep apnea	Cancer
Heart Disease	Reflux/ Heartburn	High Cholesterol	Stroke
Stress Incontinence	Gallstones	Arthritis	COPD
Chronic Pain	Low Back Pain	Changes in Period/ PCOS	
Glaucoma	Blood Clots	Kidney or Liver Disease	
Venous Stasis	Heart Attack	CHF	
Asthma	Depression	Bipolar Disorder	

Any other Medical History/ Hospitalizations:

_____
_____
_____
_____

Surgical History (YEAR):

Tonsillectomy _____ Gallbladder Removal _____ Appendectomy _____
C- Sections _____ Hernia Repair _____

Any other operations:

_____
_____

Allergies:

_____
_____

Current Medications:

Medication	Amount (mg)	Frequency	Since (year)

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Social History:

Where are you from? _____

Where do you live now? _____

Education: _____

Describe your living arrangements? _____

Marital Status:

□ Single □ Married □ Divorced □ Widowed □ Other

Children: _____

Any desire for children in the future? Yes/ No

Current Occupation: _____ **Employer:** _____

Years at this position: _____ **Can you take time off to recover?** _____

Are you on disability? _____ **If so, since when and for what reason?**

_____

Who will help take care of you, if needed, after surgery? _____

Habits:

Do you take any vitamins, herbs, supplements?

_____

_____

Do you (or did you) smoke? □ Yes □ No □ Quit _____ years ago

You must be nicotine free x 3 months before surgery

Average daily tobacco habit: _____ packs/day for _____years

Do you drink alcoholic beverages? □ Yes □ No □ Quit _____ years ago

How much? _____

Do you use recreational drugs? □ Yes □ No □ Quit _____ years ago

You must be drug and alcohol free x 6 weeks before surgery

Do you have, or have you had, a problem with drugs or alcohol? □ Yes □ No

Explain: _____

Family History:

Biological Father (alive or deceased) Age: _____ Medical Hx: _____

Biological Mother (alive or deceased) Age: _____ Medical Hx: _____

Extended Family (Siblings, Grandparents, your children): (list anything of importance)

_____

_____

_____

_____

_____

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Are you experiencing (currently):

Recent unexplained weight loss or weight gain		Fevers/ Chills	Night Sweats
Dizziness	Headaches	Weakness	Fatigue
Coughing	Wheezing	Shortness of Breath	Chest Pain
Pressure in Chest	Palpitations	Heartburn	Snoring (apnea)
Daytime Drowsiness	Insomnia	Trouble swallowing	Constipation
Change in Bowels/ Bloody Stools		Abdominal Pain	Hernias
Pain or difficulty Urinating		Libido changes	Skin changes

Health Maintenance:

Do you see a healthcare provider regularly?

Do you see a dentist regularly?

When was your last:

Mammogram _____ Pap smear _____ Colonoscopy _____

Prostate Exam _____ Eye Exam _____ Birth Control? _____

Have you had any routine diagnostic studies? (Please Attach Reports)

Lab work _____ Chest X- ray _____

EKG _____ Endoscopy _____

Cardiology Tests _____ Other: _____

Have you attended an information seminar by one of our doctors?

Will you, the patient, commit to careful follow-up with us for up to 5 years?

□ Yes □ No

_____

Signature of Patient ***Date***