Northwestern Medicine

Digestive Health Center Weight Loss Surgery Program Application

Northwestern Medicine Digestive Health Center
Lavin Family Pavilion, 259 East Erie Street, Sixteenth Floor, Chicago, Illinois 60611 | 312.695.5620

Date ____________________

Self

Name (last, first, MI, maiden) ____________________

Address ____________________

Date of birth ____________________ Age ____________________

Gender (please choose one): Male Female

Marital status (please choose one): Married Divorced Widowed Separated Never married

Can you be reached or can we leave you a message at your home phone during the day? Yes No Primary phone ____________________

Can you be reached or can we leave you a message at your work phone during the day? Yes No Secondary phone ____________________

Do you wish to receive communication via email? Yes No Email address ____________________

Employer ____________________ Occupation ____________________

Your primary care physician

Family physician ____________________ Date of last visit ____________________

How were you referred to us (please provide name)?

Physician ____________________ Family or friend ____________________

Other ____________________

Insurance information

Insurance company name ____________________ Policy number/Group number ____________________

Policy holder (name) ____________________ Customer service phone number ____________________

Continued >

Allergies

Are you allergic to any drug, food or substance? If yes, what happens when you take or are exposed to it (for example, Penicillin/Get a rash)

Allergen	Reaction

Tobacco

Do/Did you use any tobacco products? Yes No

If yes, what kind? ______________________________

How often do/did you use it? ______________________________

What year did you start? ______________________________

Quit date ______________________________

Weight history

Current weight ______________________________

Weight at age 18 ______________________________

Lowest weight ______________________________

Highest weight ______________________________

Height______________________________

Goal (desired) weight______________________________

Continued >

Weight Loss Surgery Program Application (continued)

Medical information

Do you have, or have you had, any of the following:

- Arthritis, joint pain
- Asthma
- Blood clot or clotting disorders
  - Where? ______________________________
  - When? ______________________________
- Bowel incontinence
- Cancer
  - What kind? __________________________
  - When? ______________________________
  - Treatment:
    - Surgery
    - Radiation
    - Chemotherapy
- Chest pain or angina
- Crohn's disease
- Colitis
- Frequent constipation or difficulty with evacuation
- Diabetes
- Fatty liver disease
- Frequent diarrhea or fecal incontinence
- Gallbladder trouble
- Headaches, how often? ________________
- Heart failure
- Heart attack, when? __________________
- Heart disease
- Heartburn, indigestion/GERD
- Hepatitis, what kind? B C
- Hernia, what kind? ___________________
- High blood pressure
- High cholesterol
- HIV
- Irritable bowel syndrome
- Lupus
- Sleep apnea
- Do you use: CPAP BiPAP
- Do you use oxygen? Yes No
  - How many liters? ____________________
  - How many hours/day do you use oxygen? ____________________________________
- Stomach ulcers
- Thyroid disease
- Polycystic ovarian syndrome (PCOS)
- Use wheelchair or scooter: Yes No
  - How many hours per day? ____________
- How far do you walk in a normal day? ____________________________________
- How many steps can you climb?
- How many steps do you climb daily?

Women

- Last menstrual cycle start date: ________
- Menopause: Yes No
- Other ______________________________

Blood transfusion

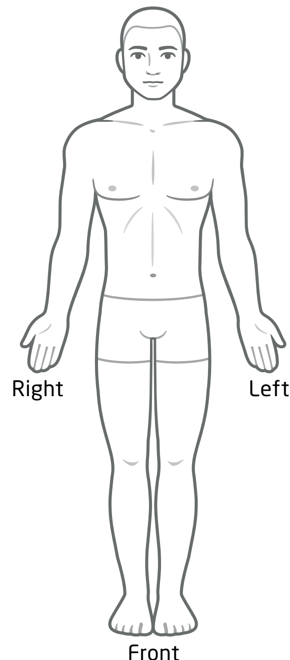
I agree to a blood transfusion, if needed. Yes No

Refusal of medically necessary blood products may affect your ability to have weight loss surgery.

Surgical information

Date	Surgery

On the diagram below, please indicate the location of any surgical incisions (scars from surgeries) that you have.



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Medication information

What medications do you take on a regular basis?

Medication name	Dosage (such as “mg”)	Frequency (times per day)	Why do you take it?

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