

# The Baricenter at the Laparoscopic Surgical Center of New York

A Surgical Weight Loss Program

Mark Reiner, MD  
L. Brian Katz, MD  
Anthony Vine, MD  
Brian Jacob, MD

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## Personal Information

Last Name \_\_\_\_\_  
First Name \_\_\_\_\_  
Address \_\_\_\_\_  
City / State / Zip \_\_\_\_\_  
Phone \_\_\_\_\_  
EMAIL \_\_\_\_\_  
Date of birth / age \_\_\_\_\_  
Weight / Height \_\_\_\_\_

## Primary Care Physician Information

How did you hear about our surgical weight loss program? \_\_\_\_\_

Primary Care Doctor:      Name \_\_\_\_\_  
   Address \_\_\_\_\_  
   Address \_\_\_\_\_  
   City/ State / Zip \_\_\_\_\_  
   Phone \_\_\_\_\_

Other Doctors:              Name \_\_\_\_\_  
   Address \_\_\_\_\_  
   Address \_\_\_\_\_  
   City/ State / Zip \_\_\_\_\_  
   Phone \_\_\_\_\_

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Address \_\_\_\_\_  
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## Review of Systems

	NONE	YES	IF YES, CIRCLE THOSE THAT APPLY
<b>Constitutional</b>	___	___	Fever / Sweating / Chills / Weight loss / Fatigue / Insomnia / Fainting Trauma or Accidents in the past? / Chronic Pain / Other _____
<b>Cardiovascular</b>	___	___	Heart Attack (date _____) / Chest pain / Heart burn / Mitral Valve Prolapse High Blood Pressure / Poor Circulation (arm, leg) / Leg Swelling / Varicose Veins / Leg or Ankle Ulcers / Other _____
<b>Respiratory</b>	___	___	Asthma / Bronchitis / Emphysema / Cough / Shortness of breath Wheezing / Tuberculosis (TB) in the past / Sleep Apnea / Other ___
<b>Gastrointestinal</b>	___	___	Abdominal pain / Nausea / Vomiting / Constipation / Diarrhea / Blood in Stool / Rectal Pain / Peptic Ulcer Disease / Heartburn / Reflux disease / Loss of Appetite / Jaundice / Dark Urine / Light-colored Stool / Difficulty Swallowing / Diverticulosis / Irritable Bowel Disease / Crohn's Disease / Ulcerative Colitis / Gall Bladder Disease or Gallstones / Hepatitis or Liver Cirrhosis / Hernia (Type _____) / Other _____
<b>Genitourinary</b>	___	___	Incontinence (type _____) / Painful or Burning Urination / Blood in urine / Renal Failure / Other _____
<b>Musculoskeletal</b>	___	___	Joint Pains (back, shoulder, elbow, wrist, hip, knee, ankle) Rheumatoid arthritis / Weakness / Chronic Back Pain / Other _____
<b>Neurologic</b>	___	___	Stroke / Other _____
<b>Psychiatric</b>	___	___	Depression / Anxiety / Bipolar / Other _____
<b>Endocrine/Metabolic</b>	___	___	Diabetes / Lupus / Thyroid disease / Connective Tissue Disorder / Other _
<b>Hematologic/Lymphatic</b>	___	___	High Cholesterol / Anemia / Bruising / Rashes / Nonhealing Sores or Ulcers / Changing Moles / Other _____
<b>Men Only</b>	___	___	Testicular Lump/ Penis Discharge / Erectile Dysfunction / Pelvic Skin Infections
<b>Women Only</b>	___	___	Irregular periods / Menstrual pain / Polycystic Ovaries / Breast Lump / Breast Cancer / Other _____

## Past Medical History (circle all that apply)

	NONE	YES	IF YES, CIRCLE THOSE THAT APPLY
<b>Cardiovascular</b>	___	___	Heart Attack 412.0 / Chest Pain (Angina) 413.9 / Coronary Artery Disease 414.0 CHF / High Blood Pressure 401.9 / Poor Circulation (arm, leg) (Claudication) 440.9 Leg Swelling (Lymphedema) 457.1 / Varicose Veins / Leg or Ankle Ulcers / Blood Clots (DVT) 453.4 / Syncope / Other _____
<b>Respiratory</b>	___	___	Asthma 493.9 / Bronchitis / Emphysema / Lung Cancer or Mass Pulmonary Embolus 415.19 / Tuberculosis (TB) in the past / Sleep Apnea 780.57 / Loud Snoring 786.0 / Home CPAP or BiPaP (settings _____) / Other _____
<b>Gastrointestinal</b>	___	___	Peptic ulcer disease / Heartburn = Reflux disease 530.19 / Hemorrhoids / Diverticulosis / Diverticulitis / Irritable bowel disease 564.1 / Crohn's disease 558.9 / Ulcerative colitis 558.9 / Gall bladder disease or Gallstones 574.2 / Hepatitis (Type _____) or Liver Cirrhosis / Pancreatitis / Hernia (Type _____) Colon Cancer 153.9 / Fecal Incontinence 787.6 / Other _____
<b>Genitourinary</b>	___	___	Incontinence 788.3 / Urinary Tract Infections / Bladder Cancer Prostate Cancer / Kidney Stones 592.9 / Renal Failure 585.0 / Other ___

1010 Fifth Avenue  
New York, New York 10028  
[www.laparoscopicsurgeons.com/baricenter](http://www.laparoscopicsurgeons.com/baricenter)  
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Fax: 212-650-9981

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	NONE	YES	IF YES, CIRCLE THOSE THAT APPLY
<b>Musculoskeletal</b>	___	___	Joint Pains (Arthritis) 716.99 / Gout / Rheumatoid Arthritis / Other
<b>Neurologic</b>	___	___	Stroke 434.91 / Carotid Artery Stenosis / Other _____
<b>Psychiatric</b>	___	___	Depression 311 / Anxiety / Bipolar 296.7/ Schizophrenia 295.9 / Other _____
<b>Endocrine/Metabolic</b>	___	___	Diabetes [on insulin] [on oral medicine] [no medicine] 250.02 / Hyperthyroid 242.9 / Hypothyroid 244.9 / Diabetic Retinopathy 362.0 / Hyperparathyroidism / Hypercalcemia / Adrenal Mass or Cancer / Pituitary Mass / Lupus / Connective Tissue Disorder / Other
<b>Hematologic/Lymphatic/Skin</b> ___	___	___	High Cholesterol 272.0 / Chronic Anemia / Cellulitis 682.9 Skin Cancer / Other _____
<b>Men Only</b>	___	___	Testicular Cancer / Prostate Cancer / Erectile Dysfunction
<b>Women Only</b>	___	___	Polycystic Ovaries 256.4 / Ovarian Cancer / Breast Cancer / Other

**Medication allergies:** \_\_\_\_\_

## Medications

Medical condition	Medication name	Dose	Frequency

## Prior Surgical History (if none, write "none")

Name of operation	Date

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## Social History (circle those that apply)

1) Smoking (if yes, packs per day _____) (number of years _____)
_____ I quit smoking _____ (date). _____ I have never smoked
2) Alcohol use? _____ drinks / day. _____ I do not drink alcohol.
3) Recreational drug use? _____ None

## Family History:

Number of children _____.	Date of last menstrual period:
Do you wish to become pregnant in the future? YES / NO	

## Circle conditions that apply to your family history

High Blood Pressure	Stroke
Heart disease	Cancer (type)
Diabetes	Ulcerative Colitis / Crohn's
Obesity	Other:

## Food / Dietary History:

- I have been trying to diet for \_\_\_\_\_ years. My height is \_\_\_\_\_.
- Max weight is \_\_\_\_\_, Lowest weight is \_\_\_\_\_, and today my weight is \_\_\_\_\_.  
Ideal Body Weight = \_\_\_\_\_. Excess weight = \_\_\_\_\_.  
Today my BMI (body mass index) is \_\_\_\_\_ kg/m<sup>2</sup>.
- Diets or pills I have tried:

	Yes	No	Dates		Yes	No	Dates
Phen-Fen				Redux			
Pondimin				Meridia			
Xenical				Amphetamine			
Weight Watchers				Atkins			
South Beach				Slim-Fast			
The Zone Diet				Optifast			
Nutrisystem				Jenny Craig			
Richard Simmons				Trim Spa			
Over the counter pills				Scarsdale Diet			
Other:							

## 4) Dietary Restrictions (circle all those that apply)

Vegetarian
Vegan
Kosher
Lactose intolerance
Food allergy?
Other?

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## **5) Food Frequency**

I **dine out** \_\_\_\_\_ times a week.

I eat **fast food** about \_\_\_\_\_ times a week.

I **cook** at home about \_\_\_\_\_ times a week.

I eat **fried food** about \_\_\_\_\_ times a week.

I eat **sweets** (cookies, candy, cake, icecream, chocolate) \_\_\_\_\_ times / week.

I crave to add butter, margarine, or mayonnaise to my food? Yes No.

I crave to have cheese frequently? Yes No

I crave to eat pasta? Yes No

I crave to eat Bread or Cereal? Yes No

I crave to eat Rice or potatoes? Yes No

My preference for protein is ? (circle all that apply)

Chicken, fish, beef, turkey, tofu, eggs, nuts

I like to drink (circle those that apply):

Juice, diet cola, regular cola, water, milk, iced tea, coffee, tea

ON THE LAST PAGE, PLEASE COMPLETE THE 2 WEEK FOOD DIARY.

## **6) Exercise History:**

Please list your weekly exercise routine:

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## 7) Two Week Diet History (remember to include all snacks)

Day	Breakfast	Est Calories	Lunch	Est. Calories	Dinner	Est. Calories
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						

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12			
13			
14			

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Call us for an appointment at 212-879-6677

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