(and Weight Loss Surgery Wellington)

PATIENT INFORMATION PROFILE

Roux-En-Y Gastric Bypass, One Anastomosis Gastric Bypass (Loop) & Sleeve Gastrectomy

2023

Personal details

Surname:_____
Given Name: _____ ☐ Male ☐ Female
Address: _____
Telephone (Home): _____
(Business): _____
(Mobile): _____
Date of Birth: _____ Birth Weight (if known):_____
Age:_____
Ethnic Group: _____
Occupation: _____
Email Address: _____
Best contact method e.g. Mobile, Email: _____
Insurer: _____ Membership Number: _____
Consult also attended by: _____
Preferred Pharmacy (name and address:_____
Current Height:_____ Current Weight:_____

Contact persons

This information is often vital to us if we need to contact you urgently and helps with achieving good follow up.

Next of Kin: _____
Relationship: _____
Address: _____
Telephone (Home): _____
(Business): _____

Additional Contact Name: _____
Relationship: _____
Address: _____
Telephone (Home): _____
(Business): _____

Medical Centre information

Tailor Clinics reserves the right to request your medical history from your health provider, and will not be responsible for any undisclosed information. We reserve the right to share any relevant information with your GP.

General Practitioner: _____
GP's Address: _____
Telephone contact: _____
Referred by: _____

Family structure:

- ○ Married
- ○ Divorced
- ○ Single
- ○ Partner/relationship

Children/ages: _____
Support persons/friends: _____

Surgical History

Please give details of past operations:

Procedure	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you or a family member had surgery with Tailor Clinics before?

_____

Do you have any adverse effect to a general anaesthetic? If yes, please describe:

_____

Do you have any Upper Abdominal Scarring? If yes, please describe

_____

Do you wear a hearing aid or have a pacemaker?

- ○ **YES**
- ○ **NO**

Medical history

Have you ever suffered from any of the following health problems?

Illness	Yes	No	Details
Diabetes	○	○	
Diabetes while pregnant	○	○	
Asthma	○	○	
Respiratory/breathing problems/fainting/dizziness	○	○	
Sleep apnoea / Snoring	○	○	
Pain in the: Hips	○	○	
Feet	○	○	
Knees	○	○	
Back	○	○	
Kidney or urinary disorder	○	○	
Incontinence(leakage of urine)	○	○	
Stroke or nerve loss	○	○	
Depression or other psychological disorder	○	○	
Anxiety	○	○	
Gallstones	○	○	
Heartburn/reflux/indigestion	○	○	
Stomach ulcer	○	○	
Hepatitis or other liver disease	○	○	
High blood pressure	○	○	
Heart Murmur	○	○	
Heart disease	○	○	
High cholesterol or lipids	○	○	
Infertility	○	○	
Anaemia	○	○	
Thrombosis or clotting disorder	○	○	
Menstrual problems	○	○	
Varicose veins or leg swelling	○	○	
Skin conditions, under skin folds	○	○	
Thyroid	○	○	
Epilepsy	○	○	
Bowel problems	○	○	
Gout	○	○	

Have you been in hospital for any other reason?

Medications

Please state all medications that you are on, the dose, and how long you have been taking them. Please include the contraceptive pill and any **herbal remedies.**

Medication	Dose	Duration

How often in a week, would you miss taking your regular medications?

_____

Are you allergic to any medications or foods? ◯ **YES** ◯ **NO**
If yes, please provide details below.

_____

Are you prepared to accept blood or blood products during surgery should excessive bleeding occur?

◯ **YES**
◯ **NO**

Family History

Do you have a family history of any of the following?

Please tick in the box if present

	Parent	Sibling/ child	Others-aunt, uncle, cousin, grandparent, etc	No family history	Don't know
Diabetes					
Heart disease					
High blood pressure					
Obesity					
Gallstones					

Alcohol intake

Do you drink alcohol? ☐ **YES** ☐ **NO**

If yes please complete the Alcohol Use questionnaire towards the end of this profile.

Smoking

Do you currently or have you ever smoked?

- ☐ Yes ___ cigarettes daily
- ☐ Yes, but have now stopped. When did you give up?_____
- ☐ Never

Are you currently using any nicotine products like patches/chewing gum or vaping liquid? If Yes, please state what this is: _____

Drugs of Dependence - medicinal or recreational

Do you currently take any of these substances, for either recreational or medicinal purposes? If yes, please tick appropriate box or boxes

- ☐ Marijuana
- ☐ Amphetamines
- ☐ Narcotics
- ☐ Other _____

Have you previously taken drugs of dependence? ☐ **YES** ☐ **NO**
If Yes, please state which substances.

_____

Weight loss history

I believe the primary cause of my weight issues are…

_____

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

Which of the following have you tried at some time? Please tick

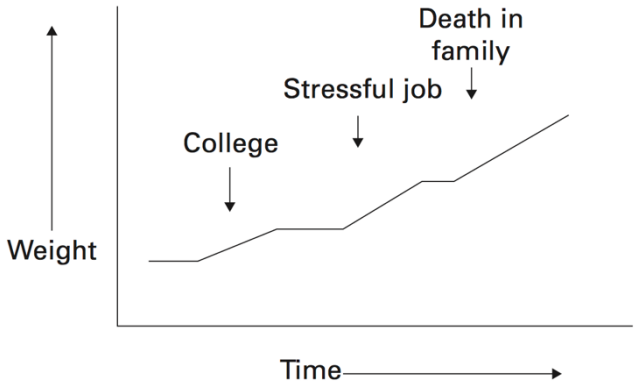
Dieting:	◯ Yes	◯ No
Diet Pills:	◯ Yes	◯ No
Professional Advice:	◯ Yes	◯ No

What is your greatest loss of weight and how did you achieve this?

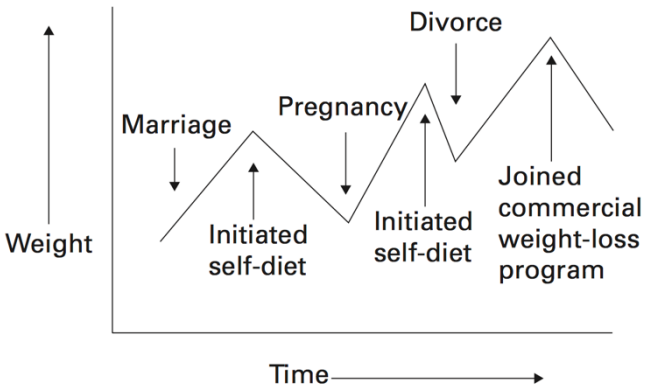
_____

Please see examples of two graphs below – one with progressive weight gain, and one with weight cycling weight gain. Please tick the graph that best shows your weight journey

☐ **Progressive Weight Gain**



☐ **Weight Cycling Weight Gain**



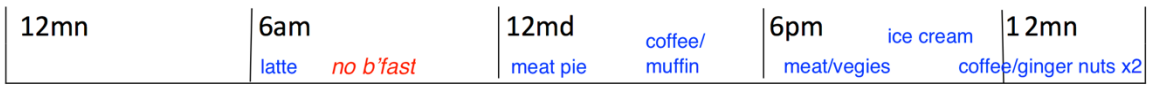
Please fill in the table below with your weight and life events:

Year	Weight in kg	Event

Habits with Eating

Meals ***please note if you skip meals w*** ***write down on the timeline below, what you eat/drink throughout the day.***

Example here:



Do you pick and/or graze? ◯ **YES** ◯ **NO**

When does this happen? _____

What are your danger times? _____

Employment

Are you currently employed?

... Select ...

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 for you to get employment?

_____

If you are employed, how much activity does your work involve?

◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯

0 1 2 3 4 5 6 7 8 9 10

Little (sedentary) — Moderately active — Very (Labouring)

Exercise

In the last 12 months how often have you participated in some kind of exercise?

- ◯ 1 – 2 times per week
- ◯ 1 – 2 times per month
- ◯ 3 – 4 times per week
- ◯ Not at all

What types of exercise do you enjoy?

_____

What type of exercise or sport do you not enjoy and why?

_____

How much time will you have to do exercise?

Minutes per day_____ Days per week_____

Write down & rate your goals for doing exercise:

...select... _____
...select... _____
...select... _____

Do you have any injuries/ pains/ medical conditions that will prevent you from doing exercise? *If yes, what are these:*

_____

What are your barriers to performing regular exercise?

_____

How would you describe your sleep?

◯ Good ◯ Medium (up and down) ◯ Poor/ Broken

Details: _____

How would you describe your energy levels? (High, Medium, Low)

_____

Rate in your view, the following benefits to exercise: (in importance 1-9) *1 being the least important, 9 being the most important*

...select... Improve your fitness
...select... Improve mood and stress levels
...select... Reshape body
...select... Enjoyment
...select... Improve flexibility
...select... Increase strength
...select... Increase energy levels

What are your hobbies and interests?

Anticipated benefits post bariatric surgery

Please answer these questions by writing a number from 0-100, using the following scale as a guide:

At this point, how important would you say it is for you to lose weight?

0	25	50	75	100
Not at all important	Less important as most other things I would like to achieve	About as important as most other things I would like to achieve	More important than most other things I would like to achieve	The most important thing I would like to achieve

Write your answer here: _____

At this point, how confident (without surgery) would you say that you could lose weight?

0	25	50	75	100
Not at all confident	A little confident	Moderately confident	Very confident	Totally confident

Write your answer here: _____

What three (3) benefits after bariatric surgery (other than achieving a number on the scales) will motivate you to maintain these lifestyle changes long-term?:

1. _____
2. _____
3. _____

AUDIT (Alcohol use tool)

Introduction

As part of our service we believe it is important to examine lifestyle issues likely to affect the health of our patients. This information will assist in giving you the best treatment and highest possible standard of care after bariatric surgery. Therefore, we ask that you complete this questionnaire that asks about your use of alcoholic beverages during the past year. Your answers will remain confidential, so please be as honest and accurate as possible.

By alcoholic beverages, we mean your use of wine, beer, vodka, sherry, etc. Try to answer the questions in terms of 'standard drinks'. One standard drink equals 10 g of pure alcohol.

Please refer to the guide below.

Thank you for your assistance.

Please select the relevant box which best fits your drinking. The total in the "Your Score" box will automatically calculate. Please see example below:

Questions	Scoring system					Your score
	0	1	2	3	4	

How often do you have a drink containing alcohol?

0	1	2	3	4	Your Score
Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
○	○	○	○	○	0

How many units of alcohol do you drink on a typical day when you are drinking?

0	1	2	3	4	Your Score
1 - 2	3 - 4	5 - 6	7 - 9	10+	
○	○	○	○	○	0

How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?

0	1	2	3	4	Your Score
Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
○	○	○	○	○	0

How often during the last year have you found that you were not able to stop drinking once you had started?

0	1	2	3	4	Your Score
Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
○	○	○	○	○	0

How often during the last year have you failed to do what was normally expected from you because of your drinking?

0	1	2	3	4	Your Score
Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
○	○	○	○	○	0

How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?

0	1	2	3	4	Your Score
Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
○	○	○	○	○	0

How often during the last year have you had a feeling of guilt or remorse after drinking?

0	1	2	3	4	Your Score
Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
○	○	○	○	○	0

How often during the last year have you been unable to remember what happened the night before because you had been drinking?

0	1	2	3	4	Your Score
Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
○	○	○	○	○	0

Have you or somebody else been injured as a result of your drinking?

0	1	2	3	4	Your Score
No		Yes but not in the last year		Yes during the last year	
○	○	○	○	○	0

Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?

0	1	2	3	4	Your Score
No		Yes but not in the last year		Yes during the last year	
○	○	○	○	○	0

Supplementary Questions:

Do you think you presently have a problem with drinking?

0	1	2	3	4	Your Score
No	Probably not	Unsure	Possibly	Definitely	
○	○	○	○	○	0

In the next 3 months, how difficult would you find it to cut down or stop drinking?

0	1	2	3	4	Your Score
Very easy	Fairly easy	Neither difficult nor easy	Fairly difficult	Very difficult	
○	○	○	○	○	0

To help us get more of an understanding of your psychological and behavioural health, we ask that you please complete the following questionnaires. The responses to these questionnaires will not be the determinant of your suitability for surgery, so please answer them as accurately as possible, without thinking too much about them. There are no right or wrong answers ☺

Below you will find a list of statements. ***Please rate the truth of each statement as it applies to you.*** Use the following scale to make your choice.

1	2	3	4	5	6	7
Never true	Very seldom true	Seldom true	Sometimes true	Frequently true	Almost always true	Always true

1. When I have negative feelings, I use food to make myself feel better

1	2	3	4	5	6	7
○	○	○	○	○	○	○

2. I am in control of how much physical activity I do

1	2	3	4	5	6	7
○	○	○	○	○	○	○

3. In order to eat well and do physical activity, I need to feel like it

1	2	3	4	5	6	7
○	○	○	○	○	○	○

4. I need to feel better about how I look in order to live the life I want

1	2	3	4	5	6	7
○	○	○	○	○	○	○

5. Other people make it hard for me to accept myself

1	2	3	4	5	6	7
○	○	○	○	○	○	○

6. If I'm overweight, I can't live the life I want to

1	2	3	4	5	6	7
○	○	○	○	○	○	○

7. If I gain weight, that means I have failed

1	2	3	4	5	6	7
○	○	○	○	○	○	○

8. I'm in control of my eating behaviour

1	2	3	4	5	6	7
○	○	○	○	○	○	○

9. My eating urges control me

1	2	3	4	5	6	7
○	○	○	○	○	○	○

10. If I eat something bad, the whole day is ruined

1	2	3	4	5	6	7
○	○	○	○	○	○	○

11. I am ashamed of my body

1	2	3	4	5	6	7
○	○	○	○	○	○	○

12. I avoid social situations where people might judge me

1	2	3	4	5	6	7
○	○	○	○	○	○	○

13. I feel self-conscious when I do physical activity

1	2	3	4	5	6	7
○	○	○	○	○	○	○

14. I have never liked exercise, so I just don’t do it

1	2	3	4	5	6	7
○	○	○	○	○	○	○

15. Worrying about my weight makes it difficult for me to live a life that I value

1	2	3	4	5	6	7
○	○	○	○	○	○	○

16. My thoughts and feelings about my body weight and shape must change before I can take important steps in my life

1	2	3	4	5	6	7
○	○	○	○	○	○	○

17. Before I can make any serious plans, I have to feel better about my weight

1	2	3	4	5	6	7
○	○	○	○	○	○	○

18. To control my life, I need to control my weight

1	2	3	4	5	6	7
○	○	○	○	○	○	○

19. Feeling fat causes problems in my life

1	2	3	4	5	6	7
○	○	○	○	○	○	○

20. My relationships would be better if my body weight and/or shape didn't bother me

1	2	3	4	5	6	7
○	○	○	○	○	○	○

21. If my life experiences had been different, I would not have a weight problem now

1	2	3	4	5	6	7
○	○	○	○	○	○	○

DASS21

Please read each statement and select a number 0, 1, 2 or 3 which indicates how much the statement applied to you ***over the past week***. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

Question	**0**	**1**	**2**	**3**
Questions 1 - 21	Did not apply to me at all	Applied to me to some degree, or some of the time	Applied to me to a considerable degree, or a good part of time	Applied to me very much, or most of the time

1.	I found it hard to wind down	0 ○	1 ○	2 ○	3 ○
2.	I was aware of dryness of my mouth	0 ○	1 ○	2 ○	3 ○
3.	I couldn't seem to experience any positive feeling at all	0 ○	1 ○	2 ○	3 ○
4.	I experienced breathing difficulty (e.g, excessively rapid breathing, breathlessness in the absence of physical exertion)	0 ○	1 ○	2 ○	3 ○
5.	I found it difficult to work up the initiative to do things	0 ○	1 ○	2 ○	3 ○
6.	I tended to over-react to situations	0 ○	1 ○	2 ○	3 ○
7.	I experienced trembling (e.g, in the hands)	0 ○	1 ○	2 ○	3 ○
8.	I felt that I was using a lot of nervous energy	0 ○	1 ○	2 ○	3 ○
9.	I was worried about situations in which I might panic and make a fool of myself	0 ○	1 ○	2 ○	3 ○

10.	I felt that I had nothing to look forward to	0	1	2	3
11.	I found myself getting agitated	0	1	2	3
12.	I found it difficult to relax	0	1	2	3
13.	I felt down-hearted and blue	0	1	2	3
14.	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15.	I felt I was close to panic	0	1	2	3
16.	I was unable to become enthusiastic about anything	0	1	2	3
17.	I felt I wasn't worth much as a person	0	1	2	3
18.	I felt that I was rather touchy	0	1	2	3
19.	I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	0	1	2	3
20.	I felt scared without any good reason	0	1	2	3
21.	I felt that life was meaningless	0	1	2	3

Submit

Please note: If the submit button does not produce an email with your completed form attached, please save your document and email your completed form to *reception@tailorclinics.co.nz*