Main Line HealthCare
Physician Network

PATIENT REGISTRATION FORM

Acct No: _____ Reg. By: _____ Entered Date: _____ Office Site: _____

Please complete this form in order to ensure proper billing of your services. **Please Print.** Today's Date:_____

Patient Name: _____
Last Name First Name MI
Other Name: _____
Sex: ☐ M ☐ F
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Other

Social Security Number: _____
Date of Birth: _____
Race: **(Response is not mandatory. Data is used for statistical reporting.)**
☐ African American ☐ Asian/Oriental ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other ☐ Unknown

Addr1:_____
Addr2: _____
City,St,ZIP:_____
_____

Home Phone: (_____) _____
Daytime Phone: (_____) _____
Cell Phone: (_____)_____

Email Address: _____

Employer: _____
Addr1: _____
Addr2: _____
City,St,ZIP: _____

Work Phone Number: _____

Primary Care Physician: _____ Referring Physician: _____

Pharmacy Name:_____City:_____Telephone#:_____

Please complete if guarantor is other than self. (The guarantor is the person financially responsible for this patient's bill.)

Guarantor: _____
Addr1: _____
Addr2: _____
City,St,ZIP: _____

Patient's Relationship to Guarantor: _____
Social Security Number: _____
Date of Birth: _____
Sex: _____
Home Phone: (____) _____
Work Phone: (____) _____

Employer: _____
Addr1: _____
Addr2: _____
City,St,ZIP: _____

_____

Emerg Cont: _____
Addr1: _____
Addr2: _____
City,St,ZIP: _____

Patient's Relationship to Emerg Cont: _____
Home Phone: (____) _____
Work Phone: (____) _____
Cell Phone: (____)_____

How did you hear of our practice? ☐ Billboard ☐ Brochure ☐ Health Fair ☐ Health Plan ☐ Internet ☐ JeFF NOW ☐ Mass Mailing ☐ Newspaper/Mag. ☐ Ongoing Care ☐ Other ☐ Patient ☐ Phone Bk ☐ Phys. Off./ER ☐ Relative ☐ Radio ☐ TV ☐ Word of Mouth

****

Insurance Information

A separate form is required for Worker's Compensation, Automobile Liability, or Legal services.

PRIMARY CARRIER: _____
Address :_____
Group/Plan #: _____
Subscriber's Name: _____
Relationship to Patient: _____

Telephone #: (____) _____
ID/Cert #: _____
Subscriber's DOB: _____
Effective Date: _____

SECONDARY CARRIER: _____
Address: _____
Group/Plan #: _____
Subscriber's Name: _____
Relationship to Patient: _____

Telephone #: (____) _____
ID/Cert #: _____
Subscriber's DOB: _____
Effective Date: _____

BRYN MAWR HOSPITAL BARIATRIC CENTER

PREOPERATIVE PATIENT HEALTH DATA

Physician Information:

Referring Physician Name	
Address	
City , State Zip	
Daytime Phone/Fax	**Email Address**

Primary Care Physician Name	
Address	
City , State Zip	
Daytime Phone	Fax number

Physician Name/Specialty	
Address	
City , State Zip	
Daytime Phone	**Fax Number**

Physician Name/Specialty	
Address	
City , State Zip	
Daytime Phone	**Fax number**

Pharmacy Information

Pharmacy Name	
Address City , State Zip	
Daytime Phone	**Fax Number**

BRYN MAWR HOSPITAL BARIATRIC CENTER

PREOPERATIVE PATIENT HEALTH DATA

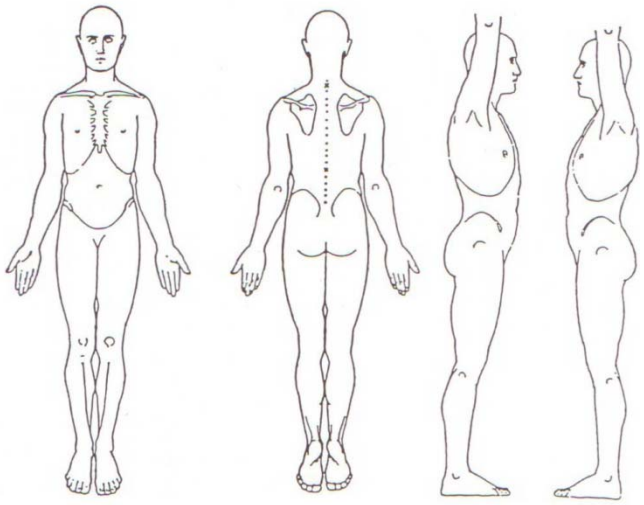
Past Medical History (Please check the box next to your medical condition)

☐ High blood pressure	☐ Angina	☐ Arthritis
☐ Diabetes	☐ Back pain	☐ Cancer:_____
☐ High cholesterol	☐ Crohn's disease	☐ Heart attack
☐ High triglycerides	☐ Blood clots	☐ Heart disease
☐ Fatty liver disease	☐ Depression	☐ Irregular menses
☐ Gallstones	☐ Diverticulosis	☐ Irritable bowel syndrome
☐ Severe headaches	☐ Shortness of breath	☐ Joint pain
☐ Persistent snoring	☐ Endometriosis	☐ Kidney disease
☐ Asthma	☐ Seizures	☐ Kidney stones
☐ Stroke	☐ Bleeding problems	☐ Leg swelling/ulcers
☐ Thyroid disease	☐ Gout	☐ Lung disease
☐ Male hair growth (women)	☐ Plantar fasciitis	☐ Hepatitis
☐ Infertility	☐ Urinary incontinence	☐ Decreased libido (men)
☐ Sleep apnea	☐ Skin rashes	☐ Heartburn
☐	☐ Gastric ulcers	☐

Prior Surgeries/Procedures/Cardiac Procedures

Date	Surgery/Procedure

Please indicate, on the diagram to the right, the location of any surgical incisions (scars from surgeries that you have.



Pregnancies

Date: Vaginal Delivery ☐ Cesarean Section ☐ Full Term ☐ Premature ☐	Date: Vaginal Delivery ☐ Cesarean Section ☐ Full Term ☐ Premature ☐
Date: Vaginal Delivery ☐ Cesarean Section ☐ Full Term ☐ Premature ☐	Date: Vaginal Delivery ☐ Cesarean Section ☐ Full Term ☐ Premature ☐
Date: Vaginal Delivery ☐ Cesarean Section ☐ Full Term ☐ Premature ☐	Date: Vaginal Delivery ☐ Cesarean Section ☐ Full Term ☐ Premature ☐

BRYN MAWR HOSPITAL BARIATRIC CENTER

PREOPERATIVE PATIENT HEALTH DATA

Allergies. Please list all medications, foods, substances you are allergic to and indicate what happens when you are exposed to it (ie penicillin… rash)

Medication/Food/Substance	Reaction when exposed

All Prescription Medications, Over the counter medications, vitamins/minerals (i.e. Calcium, One-a-day), herbals (ie St. Johns Wart), Tylenol, Advil, Ex-lax.

Prescription Name	**Dose (ie "mg")**	**Times per day you take**	**Why do you take?**

BRYN MAWR HOSPITAL BARIATRIC CENTER

PREOPERATIVE PATIENT HEALTH DATA

Tobacco Use

Current use of Tobacco ☐ Yes ☐No	If yes, amount/day
Previous use of Tobacco ☐ Yes ☐No	If yes, amount/day
Last used Tobacco:	How long have you used Tobacco? (in years)?

Alcohol Use

Frequency of Use:
Have you ever had a problem with alcohol? ☐ Yes ☐No
Have you ever received treatment for alcoholism? ☐ Yes ☐No

Illicit Drugs

Current use of illicit drugs ☐ Yes ☐No	If yes, type/amount
Previous use of illicit drugs ☐ Yes ☐No	If yes, type/amount
Family history of drug and/or alcohol abuse? ☐ Yes ☐No	

Social History

Family Members Name	Address/City/State	Relationship to you

1. Will other people support your efforts to lose weight? (circle one) YES NO

If yes, how many people will?_____ Who are these people?_____

How many of these people are actively helpful to you?_____

2. How many people do you talk with about your weight when you are upset about it?_____

How many of these people are helpful to you?_____

3. Will other people oppose or undermine your efforts to lose weight? (circle one) Yes NO

If yes, how many will? _____

Who are these people?_____

PREOPERATIVE PATIENT HEALTH DATA

4. Have you ever had any problems at any time with depression, anxiety, or other emotions that disrupted your normal functioning? (circle one) YES NO
5. Have you ever sought professional help for emotional problems? If yes, specify below:

Problem	**YEAR**	**Duration (wks)**	**Type of professional help**

6. How motivated are you to lose weight at this time? Pick a number between 1 and 10, in which 1=not motivated and 10=greatest motivation you have ever had. Your number _____
7. Why do you want to lose weight now, as compared to 1 year ago?_____
8. What is the single most important thing that you hope to achieve as a result of loosing weight?
9. Please indicate if you are currently experiencing any **greater than usual stress** in your life related to the following events. (Please complete each item by circling the appropriate box)
   a. Work Yes No
   b. Health Yes No
   c. Relationship with spouse/significant other Yes No
   d. Activities related to your children Yes No
   e. Activities related to your parents Yes No
   f. Legal/financial trouble Yes No
   g. School Yes No
   h. Moving Yes No
   i. Other_____

Please explain in a sentence any items to which you responded yes:_____

_____

_____

_____

_____

Family Medical History

Check if adopted ☐

	Age	Medical Conditions	If deceased, cause of death
Father			
Mother			
Sibling			
Sibling			
Sibling			
Sibling			
Sibling			

BRYN MAWR HOSPITAL BARIATRIC CENTER

PREOPERATIVE PATIENT HEALTH DATA

Family Weight History

Mother	☐ normal weight	☐ slightly overweight (by less than 30 pounds)	☐ moderately overweight	☐ markedly overweight (by more than 100 pounds)
Father	☐ normal weight	☐ slightly overweight (by less than 30 pounds)	☐ moderately overweight	☐ markedly overweight (by more than 100 pounds)
Siblings	☐ normal weight	☐ slightly overweight (by less than 30 pounds)	☐ moderately overweight	☐ markedly overweight (by more than 100 pounds)
Children	☐ normal weight	☐ slightly overweight (by less than 30 pounds)	☐ moderately overweight	☐ markedly overweight (by more than 100 pounds)
Spouse	☐ normal weight	☐ slightly overweight (by less than 30 pounds)	☐ moderately overweight	☐ markedly overweight (by more than 100 pounds)

Current weight		Length of time at current weight
Lowest weight	Highest weight	Weight at 18 years of age
Height		Goal (desired) weight
Greatest amount of weight lost How? When?		

Personal Weight Loss History

	Weight loss methods attempted	Weight lost	Supervised by physician	Sustained over six months	Attempted within last two years
	None				
Commerical Programs					
	Weight Watchers		☐	☐	☐
	Jenny Craig		☐	☐	☐
	Optifast		☐	☐	☐
	Nutrisystem		☐	☐	☐
	Atkins		☐	☐	☐
	TOPS		☐	☐	☐
	OA		☐	☐	☐
	South Beach Diet		☐	☐	☐
	Richard Simmons		☐	☐	☐
	Herballife		☐	☐	☐
	Pritikin		☐	☐	☐
Medications					
	Phen Fen		☐	☐	☐
	Meridia		☐	☐	☐
	Xenical		☐	☐	☐
	Amphetamines		☐	☐	☐
	Phentermine		☐	☐	☐
	Acutrim		☐	☐	☐
	Topamax		☐	☐	☐
	Dexatrim		☐	☐	☐
	Redux		☐	☐	☐
	Medifast		☐	☐	☐
	Laxatives		☐	☐	☐
Health Club Membership			☐	☐	☐

BRYN MAWR HOSPITAL BARIATRIC CENTER

PREOPERATIVE PATIENT HEALTH DATA

Behavior Modification					
	Psychotherapy		☐	☐	☐
	Hypnosis		☐	☐	☐
	Acupuncture		☐	☐	☐
	Consulted with nurtitionist				

Food Intake:

Do you eat breakfast every day? Y____ N____

How many meals do you eat per day?_____

How many snacks do you eat per day?_____

Please describe the meals and snacks you consumed yesterday:

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

How many servings of fluids do you consume per day:

Water_____ Coffee/tea_____

Non-fat or reduced fat milk_____ Whole Milk_____

Diet soda_____ Regular soda_____

Fruit juice_____ Sport drinks_____

Alcoholic beverages_____

Do you have any food intolerance?_____

Do you follow any special diet?_____

How fast do you normally eat? (circle one) Slowly Moderately Quickly

Do you snack while watching T.V.? Yes No

Do you snack while on the computer? Yes No

What eating concerns do you have?_____

PREOPERATIVE PATIENT HEALTH DATA

Physical Activity:

When you walk outside your home, circle any devices you use:	Cane	Walker	Wheelchair	Electric Cart	
Rate the effort on you ability to walk by the following areas:					
Rate using scale:	1 Not limited	2	3	4	5 extremely limited
Ankle pain	1	2	3	4	5
Knee pain	1	2	3	4	5
Hip pain	1	2	3	4	5
Back pain	1	2	3	4	5
Shortness of breath	1	2	3	4	5
Numbness in feet	1	2	3	4	5
Balance problems	1	2	3	4	5
Rate your pain in the following areas:	1	2	3	4	5
Ankle/foot	1	2	3	4	5
Knee	1	2	3	4	5
Hip	1	2	3	4	5
Back	1	2	3	4	5
Does pain interfere with sleep?	Yes_____	No_____			
Are you able to exercise	Yes_____	No_____	If yes, how often_____		

If yes, describe exercise you do and your tolerance to it: _____

On a scale of 1-5, how much do you enjoy this activity?

1 really dislike 2 3 4 5 really enjoy

What type of exercise do you plan to do to facilitate your weight loss? _____

What type of leisure activities do you enjoy? _____

PREOPERATIVE PATIENT HEALTH DATA

Review of Systems

Please place ☑ in the appropriate box

CARDIOVASCULAR DISEASE

Hypertension (high blood pressure)

- ☐ 0) none
- ☐ 1) borderline high, no medications
- ☐ 2) diagnosis of hypertension, no meds
- ☐ 3) use singe med
- ☐ 4) use more than one med
- ☐ 5) poorly controlled by meds, organ damage

Heart Failure (Congestive Heart Failure): shortness of breath, fatigue, edema

- ☐ 0) none
- ☐ 1) Class 1: symptoms with more than ordinary activity
- ☐ 2) Class II: symptoms with ordinary activity
- ☐ 3) Class III: symptoms with minimal activity
- ☐ 4) Class IV: symptoms at rest

Do you have an enlarged heart on ultrasound? ___Y ____N

Ischemic Heart Disease

- ☐ 0) none
- ☐ 1) abnormal EKG (occ skipped beats or fast heart beat or atrial fibrillation)
- ☐ 2) history of heart attack or anti-ischemic med
- ☐ 3) stent or CABG
- ☐ 4) active chest pain

Chest Pain

- ☐ 0) none
- ☐ 1) Chest pain with extreme exertion or exercise (running, swimming, etc.)
- ☐ 2) Chest pain with moderate exertion or exercise
- ☐ 3) Chest pain with minimal exertion or at rest (walking across room)
- ☐ 4) Chest pain at rest

Do you have pacemaker: ____Y ___N

Peripheral Vascular Disease

- ☐ 0) none
- ☐ 1) no symptoms with bruit
- ☐ 2) leg pain with walking, on circulation med
- ☐ 3) mini-stroke or leg pain with walking, relieved by rest
- ☐ 4) procedure for peripheral vascular disease (sent, angioplasty)
- ☐ 5) stroke, lower extremity tissue loss

Lower Extremity Edema

- ☐ 0) none
- ☐ 1) intermittent lower extremity edema, no treatment
- ☐ 2) leg edema requiring med, elevation, diuretics, stockings
- ☐ 3) stasis ulcers
- ☐ 4) disability, infections, cannot walk

PREOPERATIVE PATIENT HEALTH DATA

DVT / PE

- ☐ 0) none
- ☐ 1) history of DVT resolved with anti-coagulation
- ☐ 2) recurrent DVT, long term anti-coagulation meds
- ☐ 3) previous PE
- ☐ 4) recurrent PE, decreased function
- ☐ 5) vena caval filter

- ☐ Do you have superficial phlebitis
- ☐ Multiple miscarriages
- ☐ Do you take birth control pills
- ☐ Do you take blood thinning medications
- ☐ Do you have lupus anti-coagulant
- ☐ Do you have Factor V Leiden disorder
- ☐ Do you have an abnormality in Protein C or Protein S

METABOLIC DISEASE

Glucose Disorder

- ☐ 0) none
- ☐ 1) elevated fasting blood sugar
- ☐ 2) diabetes controlled with oral meds
- ☐ 3) diabetes controlled with insulin
- ☐ 4) diabetes controlled with oral meds and insulin
- ☐ 5) diabetes with eye, kidney, nervous or circulation problems

Lipid Disorder

- ☐ 0) none
- ☐ 1) present but no treatment
- ☐ 2) controlled with diet modification
- ☐ 3) controlled with single med
- ☐ 4) controlled with multiple meds
- ☐ 5) poorly controlled

Gout Disorder

- ☐ 0) none
- ☐ 1) high uric acid, no symptoms
- ☐ 2) high uric acid, on meds
- ☐ 3) joint abnormality
- ☐ 4) destructive joints
- ☐ 5) disability, unable to walk

RESPIRATORY DISEASE

Obstructive Sleep Apnea

- ☐ 0) none
- ☐ 1) symptoms but negative sleep study or not done
- ☐ 2) diagnosed with sleep study, no application (CPAP, BiPAP)
- ☐ 3) OSA requiring appliance (CPAP, BiPAP)
- ☐ 4) OSA with hypoxia or O_2 dependent
- ☐ 5) OSA with pulmonary hypertensions

CPAP setting: _____

BiPAP settings: _____

PREOPERATIVE PATIENT HEALTH DATA

Obesity Hypoventilation Syndrome

- ☐ 0) none
- ☐ 1) low oxygen or high CO_2 on room air
- ☐ 2) severely low oxygen or high CO_2
- ☐ 3) pulmonary hypertension
- ☐ 4) right heart failure
- ☐ 5) right and left heart failure

Pulmonary Hypertension

- ☐ 0) none
- ☐ 1) symptoms (tiredness, SOB, dizziness, fainting)
- ☐ 2) confirmed diagnosis
- ☐ 3) on meds for pulmonary hypertension (anti-coagulants or Calcium channel blockers)
- ☐ 4) on stronger meds or oxygen
- ☐ 5) needs or has lung transplantation

Asthma

- ☐ 0) none
- ☐ 1) intermittent mild symptoms, no meds
- ☐ 2) symptoms controlled with oral inhalers
- ☐ 3) well controlled with daily meds
- ☐ 4) symptoms not well controlled, on steroids or anti-cholinergics
- ☐ 5) hospitalized within the last 2 years, history of intubation

GASTROINTESTINAL DISEASE

Heartburn/GERD

- ☐ 0) none
- ☐ 1) intermittent symptoms, no meds
- ☐ 2) intermittent meds
- ☐ 3) H_2 Blockers (Zantac, Tagamet, Pepcid) or low dose PPI
- ☐ 4) high dose PPI (Prilosec, Nexium, Prevacid Protonix twice daily)
- ☐ 5) meets criteria for surgery or hand anti-reflux surgery or procedure, history of Barrett's esophagus

Gallstones

- ☐ 0) none or gallstones with no symptoms
- ☐ 1) gallstones with intermittent symptoms
- ☐ 2) gallstones with severe symptoms or had surgery for gallbladder
- ☐ 3) gallstones with complications requiring emergency surgery before bariatric surgery
- ☐ 4) history of gallbladder removal with ongoing complications not resolved

Liver Disease

- ☐ 0) none
- ☐ 1) mild liver enlargement or fatty liver, normal liver blood tests (Category 1)
- ☐ 2) moderate liver enlargement or fatty liver, abnormal liver blood tests (Category 2)
- ☐ 3) marked liver enlargement or fatty liver with inflammation or fibrosis (Category 3)
- ☐ 4) define NASH, cirrhosis, hepatic dysfunction by liver blood tests
- ☐ 5) hepatic failure, transplant indicated or done

PREOPERATIVE PATIENT HEALTH DATA

Abdominal Hernia

- ☐ 0) none
- ☐ 1) hernia but no symptoms
- ☐ 2) hernia with pain or other symptoms
- ☐ 3) successful repair of abdominal hernia
- ☐ 4) recurrent abdominal hernia or hernia larger than 15 cm
- ☐ 5) chronic prolapse through large hernia, or multiple or failed hernia repairs

Hiatal Hernia

- ☐ 0) none
- ☐ 1) small hernia
- ☐ 2) large hernia
- ☐ 3) difficulty swallowing
- ☐ 4) surgical repair of hiatal hernia

Other GI Problems

- ☐ 0) rectal bleeding
- ☐ 1) changes in bowel habits
- ☐ 2) blood in stool
- ☐ 3) diarrhea
- ☐ 4) constipation
- ☐ 5) Hemorrhoids

Back Pain

- ☐ 0) none
- ☐ 1) intermittent symptoms not requiring treatment
- ☐ 2) symptoms requiring non-narcotic treatment
- ☐ 3) symptoms requiring narcotics, objective findings on exam or study
- ☐ 4) successful surgery on back already done or pending
- ☐ 5) failed surgery on back with continued existing symptoms

Joint Pain

- ☐ 0) none
- ☐ 1) pain with ambulation out of house, no treatment
- ☐ 2) pain with walking out of house, requiring non-narcotic meds
- ☐ 3) pain with walking around house
- ☐ 4) surgery required such as arthroscopy
- ☐ 5) needs or has had joint replacement

Fibromyalgia

- ☐ 0) none
- ☐ 1) treated with exercise
- ☐ 2) treated with non-narcotic meds
- ☐ 3) treated with narcotics
- ☐ 4) surgery required or planned
- ☐ 5) disabling, treatment not effective

Functional Status

- ☐ 0) able to walk 200 feet unassisted
- ☐ 1) able to walk 200 feet with assistance (cane, walker)
- ☐ 2) unable to walk 200 feet
- ☐ 3) unable to walk more that 10 feet with assistance

PREOPERATIVE PATIENT HEALTH DATA

- ☐ 4) motorized wheelchair
- ☐ 5) bedridden

GENITOURINARY AND REPRODUCTIVE DISORDERS

Urinary Leakage

- ☐ 0) none
- ☐ 1) minimal and intermittent
- ☐ 2) frequent but not severe
- ☐ 3) daily occurrence, requires sanitary pads
- ☐ 4) disabling
- ☐ 5) operation ineffective

Polycystic Ovarian Syndrome (female)

- ☐ 0) none
- ☐ 1) symptoms of PCOS, no treatment
- ☐ 2) OCP's or anti-androgen therapy
- ☐ 3) Metformin or TZD (Avandia, Actos or Rezulin)
- ☐ 4) combination therapy
- ☐ 5) infertility

Menstrual Irregularities (not PCOS, female)

- ☐ 0) none
- ☐ 1) irregular or infrequent periods
- ☐ 2) abnormal heavy or long periods
- ☐ 3) no periods
- ☐ 4) prior total hysterectomy for irregular periods

PSYCHOSOCIAL

Psychosocial Impairment in Function

- ☐ 0) none
- ☐ 1) mild impairment, able to perform all primary tasks
- ☐ 2) moderate impairment, able to perform most primary tasks
- ☐ 3) moderate impairment, NOT able to perform primary tasks
- ☐ 4) severe impairment, NOT able to perform primary tasks
- ☐ 5) severe impairment, unable to function

Depression

- ☐ 0) none
- ☐ 1) mild, episodic, not requiring treatment
- ☐ 2) moderate, some impairment, may require treatment
- ☐ 3) moderate, significant impairment, treatment needed
- ☐ 4) severe, intensive treatment
- ☐ 5) severe, requiring hospitalization, previous suicidal behavior

Confirmed Mental Health Diagnosis

- ☐ 0) none
- ☐ 1) bipolar disorder
- ☐ 2) anxiety / panic disorder
- ☐ 3) personality disorder
- ☐ 4) psychosis

PREOPERATIVE PATIENT HEALTH DATA

- ☐ 5) suicidal tendencies
- ☐ 6) nervousness
- ☐ 7) schizophrenia
- ☐ 8) depression
- ☐ 9) hospitalized for mental illness

Alcohol

- ☐ 0) none
- ☐ 1) rare
- ☐ 2) occasional
- ☐ 3) frequent

Tobacco Use

- ☐ 0) none
- ☐ 1) rare
- ☐ 2) occasional
- ☐ 3) frequent

Substance Abuse (prescription or illegal)

- ☐ 0) none
- ☐ 1) rare
- ☐ 2) occasional
- ☐ 3) frequent

GENERAL

Psuedotumor Cerebri (PTC)

- ☐ 0) none
- ☐ 1) headaches with dizziness, nausea, and/or pain behind eyes
- ☐ 2) headaches with visual symptoms, or on diuretics
- ☐ 3) MRI confirms PCT
- ☐ 4) controlled with stronger medications
- ☐ 5) requires narcotics or surgery done or needed

Skin / Pannus

- ☐ 0) none
- ☐ 1) skin fold irritation
- ☐ 2) pannus / skin folds interfere with walking
- ☐ 3) recurrent cellulites, ulceration
- ☐ 4) surgical treatment required

Hematologic / Lymphatic

- ☐ 0) none
- ☐ 1) slow to heal cuts or bruises
- ☐ 2) anemia
- ☐ 3) phlebitis
- ☐ 4) past transfusions
- ☐ 5) enlarged glands
- ☐ 6) bleeding problems other than menses

PREOPERATIVE PATIENT HEALTH DATA

Epworth Sleepiness Scale

Please indicate the likelihood that you would fall asleep in the following situations (scale of 0-3) referring to your USUAL way of life in recent times.

Use the following scale to shoose the MOST APPROPRIATE NUMBER for each situation:

0=Would never doze, 1=Slight chance of dozing, 2=Moderate chance of dozing, 3=High chance of dozing

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (ie theatre)	
As a passenger in a car, for an hour, without a break	
Lying down to rest in the afternoon, when able	
Sitting and talking to someone	
Sitting quietly after lunch, without alcohol	
In a car, while stopped for a few minutes in traffic	
Total	

Quality of Life Assessment

Below are five statements with which you may agree or disagree. Using the 1 to 7 scale below, indicate your agreement with each item by placing the appropriate number on the line before that item. Please be open and honest with your responses.

1=Strongly disagree, 2=Disagree, 3=Slightly disagree, 4=Neither agree or disagree, 5=Slightly agree, 6=Agree, 7=Strongly agree

	In most ways, my life is close to my ideal.
	The conditions of my life are excellent.
	I am satisfied with my life.
	So far, I have gotten the important things I want in life.
	If I could live my life over, I would almost change nothing.

Based on Satisfaction with Life Scale, Diener, E. et al (1985) The Satisfaction with Life Scale. J. Personality Assessment, 49(1), 71-75

PREOPERATIVE PATIENT HEALTH DATA

SF-12® Patient Questionnaire

Examination Period: _____ Preop _____Immediate post-op _____ 6 months P.O._____
_____ 1 Year (3) _____ 2 Year _____3 Year_____4 year_____ Other (specify) : _____

SF-12®:
This information will help your doctors keep track of how you feel and how well you are able to do your usual activities. Answer every question by placing a check mark on the line in front of the appropriate answer. It is not specific for arthritis. If you are unsure about how to answer a question, please give the best answer you can and make a written comment beside your answer.

1. In general, would you say your health is:
_____ Excellent (1)
_____ Very Good (2)
_____ Good (3)
_____ Fair (4)
_____ Poor (5)

The following two questions are about activities you might do during a typical day. Does YOUR HEALTH NOW LIMIT YOU in these activities? If so, how much?

2. MODERATE ACTIVITIES, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf:
_____ Yes, Limited A Lot (1)
_____ Yes, Limited A Little (2)
_____ No, Not Limited At All (3)

3. Climbing SEVERAL flights of stairs:
_____ Yes, Limited A Lot (1)
_____ Yes, Limited A Little (2)
_____ No, Not Limited At All (3)

During the PAST 4 WEEKS have you had any of the following problems with your work or other regular
activities AS A RESULT OF YOUR PHYSICAL HEALTH?

4. ACCOMPLISHED LESS than you would like:
_____ Yes (1)
_____ No (2)

5. Were limited in the KIND of work or other activities:
_____ Yes (1)
_____ No (2)

During the PAST 4 WEEKS, were you limited in the kind of work you do or other regular activities AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

6. ACCOMPLISHED LESS than you would like:
_____ Yes (1)
_____ No (2)

7. Didn’t do work or other activities as CAREFULLY as usual:
_____ Yes (1)
_____ No (2)

PREOPERATIVE PATIENT HEALTH DATA

8. During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work outside the home and housework)?

_____ Not At All (1)
_____ A Little Bit (2)
_____ Moderately (3)
_____ Quite A Bit (4)
_____ Extremely (5)

The next three questions are about how you feel and how things have been DURING THE PAST 4 WEEKS. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the PAST 4 WEEKS –

9. Have you felt calm and peaceful?

_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)

10. Did you have a lot of energy?

_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)

11. Have you felt downhearted and blue?

_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)

12. During the PAST 4 WEEKS, how much of the time has your PHYSICAL HEALTH OR EMOTIONAL
PROBLEMS interfered with your social activities (like visiting with friends, relatives, etc.)?

_____ All of the Time (1)
_____ Most of the Time (2)
_____ A Good Bit of the Time (3)
_____ Some of the Time (4)
_____ A Little of the Time (5)
_____ None of the Time (6)

Surgeon Signature_____**Date**_____

Comments_____