

---

---

**George Isaac Crawford, Jr. MD**  
**LAP BAND**

---

---

**PATIENT INFORMATION PROFILE**

## PERSONAL DETAILS

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Zip code: \_\_\_\_\_

Telephone No: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Mobile No: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_

Health Insurance Fund: \_\_\_\_\_ Membership No: \_\_\_\_\_

### CONTACT PERSONS:

*This information is often vital to us if we need to contact you urgently and helps with achieving good follow-up. Occasionally people move or have new phone numbers and do not let us know. Please select some contacts who can inform us if you have moved and forgotten to let us know your new address.*

#### 1. NEXT OF KIN

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Telephone No: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

#### 2. ADDITIONAL CONTACT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Telephone No: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

#### 3. ADDITIONAL CONTACT:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Telephone No: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

## REFERRAL INFORMATION

Referring Doctor: \_\_\_\_\_ Date of Referral: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Contact: \_\_\_\_\_

Local Doctor: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Contact: \_\_\_\_\_

Specialist Physician/Surgeon: \_\_\_\_\_

Other: \_\_\_\_\_

## SOCIAL PROFILE

### FAMILY STRUCTURE:

Married:

Single:

Divorced:

Partner/Relationship:

Children/Ages: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Support persons/friends: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## PERSONAL MEDICAL HISTORY

Have you ever suffered with any of the following health problems:

Diabetes: Yes  No  Details: \_\_\_\_\_

Diabetes while pregnant: Yes  No  Details: \_\_\_\_\_

Asthma: Yes  No  Details: \_\_\_\_\_

Respiratory/Breathing problems: Yes  No  Details: \_\_\_\_\_

Sleep Apnea: Yes  No  Details: \_\_\_\_\_

Pains in the: Hips Yes  No  Details: \_\_\_\_\_

Feet Yes  No  Details: \_\_\_\_\_

Knees Yes  No  Details: \_\_\_\_\_

Back Yes  No  Details: \_\_\_\_\_

Kidney or urinary disorder: Yes  No  Details: \_\_\_\_\_

Incontinence of urine Yes  No  Details: \_\_\_\_\_

Stroke or nerve loss Yes  No  Details: \_\_\_\_\_

Gallstones: Yes  No  Details: \_\_\_\_\_

Heartburn or reflux: Yes  No  Details: \_\_\_\_\_

Peptic ulcer: Yes  No  Details: \_\_\_\_\_

Hepatitis or other liver disease: Yes  No  Details: \_\_\_\_\_

High blood pressure: Yes  No  Details: \_\_\_\_\_

Heart disease: Yes  No  Details: \_\_\_\_\_

High cholesterol or lipids: Yes  No  Details: \_\_\_\_\_

Infertility Yes  No  Details: \_\_\_\_\_  
 Anemia or bleeding disorder Yes  No  Details: \_\_\_\_\_  
 Thrombosis or clotting disorder: Yes  No  Details: \_\_\_\_\_  
 Varicose veins or leg swelling Yes  No  Details: \_\_\_\_\_  
 Skin conditions, especially under skin folds Yes  No  Details: \_\_\_\_\_  
 Ulcerative Colitis or Crohn's Yes  No  Details: \_\_\_\_\_  
 Lupus or Rheumatoid Arthritis Yes  No  Details: \_\_\_\_\_  
 Scleroderma Yes  No  Details: \_\_\_\_\_  
 Connective Tissue Disorders Yes  No  Details: \_\_\_\_\_  
 Barrett's Esophagitis Yes  No  Details: \_\_\_\_\_  
 Depression or other: Psychological/nervous disorder Yes  No  Details: \_\_\_\_\_

**Please identify the major illnesses or health problems:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<b>SURGICAL HISTORY</b>
-------------------------

**Please list any past operations:**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



## WEIGHT HISTORY

Please indicate your weight at the following times.  
Please indicate whether you consider your weight was below average, average, above average or very heavy in the relevant boxes..

	<b>Below Average</b>	<b>Average Weight</b>	<b>Above Average</b>	<b>Very Heavy</b>
Birth Weight				
Weight at starting school (5-6 years)				
Weight at beginning of high school (10-12 yrs)				
Weight at end of high school (15-18 years)				
Weight at time of commencing work (21 years)				
Weight at time of marriage (if applicable)				

## WEIGHT LOSS HISTORY

For how long have you been seriously trying to lose weight? \_\_\_\_\_ years

Which of the following have you tried at some time?

Dieting - fad diets, something you have read about, etc

Exercise - walking, swimming, sporting activities, etc

**Commercial weight loss groups:**

Jenny Craig

Weight Watchers

Gloria Marshall

Lite n'easy

Nutrisystem

TOWN Club

Herbal Life

Gut Busters

Others - please list: \_\_\_\_\_

\_\_\_\_\_

**Diet Pills:**

- Duromine
  - Tenuate
  - Adifax
  - Xenical
  - Reductil
  - Others - \_\_\_\_\_
- 

**Professional Advice:**

- Local Doctor
- Dietitian
- Naturopath
- Hypnotherapist
- Psychologist
- Acupuncturist

**Very low calorie diets:**

- Modifast
- Optifast

**Others:**

- Injection therapy
- Herbal remedies
- Weight loss devices

**Surgical Treatments :**

- Stomach stapling
- Fixed gastric banding
- Gastric Bypass
- Small bowel bypass
- Abdominoplasty
- Liposuction

Other cosmetic procedures - List:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## FAMILY MEDICAL HISTORY

Do you have a family history of any of the following and if so, please indicate:

	PARENT	SIBLING / CHILD	OTHER RELATIVES (cousins, aunts, grandparents etc)	NO FAMILY HISTORY	DON'T KNOW
Diabetes					
Heart Disease					
Hypertension					
Gout					
Gallstones					
Obesity					
Snoring / sleep apnoea					
Asthma					
Osteoporosis					
Hip Fractures					
Dermatitis / Eczema					
High Cholesterol					
Lupus/Scleroderma					

**ALLERGIES (including foods, medications, dressings):**    Yes     No

If yes, please give details: \_\_\_\_\_

**ALCOHOL:**

Do you drink alcohol:    Never     Rarely     Regularly

How many standard glasses do you drink per day \_\_\_\_\_

How many days do you drink per week \_\_\_\_\_

Do you drink    Beer     Wine     Spirits

**SMOKING:**

Do you smoke?     Yes     No     Never    If yes: how many per day? \_\_\_\_\_

Have you smoked in the past?     Yes     No    If so, how many per day? \_\_\_\_\_

For how many years \_\_\_\_\_    When did you stop smoking? \_\_\_\_\_

There is increasing evidence that alcohol consumption may help some of the risk factors that lead to heart disease and stroke. Indeed it may even decrease the mortality associated with these serious conditions.

We wish to look at these risk factors in people who are obese. To assist us we would like you to answer these few simple questions about your alcohol consumption and a few questions about any folate or multivitamins you may take.

Please tick your answers where appropriate.

### Part A

Do you drink any alcohol?      Yes       No  (go to part B)

How often do you have a drink containing alcohol?

Every Day       Most days       Most weeks   
Most months       Rarely (once or twice a year)

What is the main type of beverage you drink? Please check one only.

Beer       Wine       Spirits

From the list below please **circle** the **main** alcoholic beverage you drink and **check** any others you would drink at times.

beer      light beer      red wine      white wine  
sparkling wine      fortified wine      spirits (specify).....

When do you usually drink? Please circle the main one. Check any others that are relevant.

Social occasions      Parties      With meals      Before/after meals      Weekend session/s

If you indicated above that you drank every day, most days or most weeks, please circle how many standard drinks you would have in a **typical week**. ( 1 standard drink = 1 small glass of wine, 1 glass of full strength beer or a nip of spirits).

1-2      3-10      11-20      21-40      40+

**Part B- for non-drinkers only.**

Is there a reason you don't drink any alcohol?

---

---

**Part C**

1. Do you take multi-vitamin tablets or other dietary supplements?

Yes . No  (go to 2)

If yes, how often do you take them?

Rarely . Monthly . Weekly . Most days . Every day .

Please name the multi-vitamin or other dietary supplements you usually take.

.....

2. Do you take folate tablets? Yes  No

If yes, how often do you take them?

Rarely  Monthly  Weekly  Most days  Every day .

What dose do you take? 200mg  400mg

**ACTIVITY LEVEL** ~ What exercise do you do on a regular basis?

How many sessions of exercise (walking, sports, etc.)  
do you do per week for more than 30 minutes at a time. \_\_\_\_\_

What sort of activities: \_\_\_\_\_

How do you feel when exercising. Please mark level on scale:

0 \_\_\_\_\_ 10  
Awful Average Excellent

**LADIES**

Do you have regular periods (26 - 33 days) Yes  No

If not, please describe \_\_\_\_\_

\_\_\_\_\_

Do have problems with excessively heavy periods Yes  No

If Yes, please described \_\_\_\_\_

\_\_\_\_\_

Have you had difficulty in conceiving in the past? Yes  No

Do you currently have problems with infertility? Yes  No

Have you suffered from excess body hair or acne? Yes  No

Have you every been told by a doctor that you have polycystic ovaries? Yes  No

Have you had problems with pregnancy and/or childbirth? Yes  No

If so, in what way \_\_\_\_\_

\_\_\_\_\_

Have you had a C-section? Yes  No

If so, why? \_\_\_\_\_

## SLEEP HISTORY

How many hours sleep do you get a night? \_\_\_\_\_

Is there any thing else that keeps you awake at night?      Yes       No

Details: \_\_\_\_\_

Would you consider the quality of your sleep is      Good       Fair       Poor

If your sleep is a major problem to you or your partner,  
would you be prepared to have a sleep study performed  
now and after you lose weight?      Yes       No

### SYMPTOMS OF SLEEP APNEA

To answer each question, circle the star in the position that best indicates your answer.

1. How often do you snore?

NEVER      \*                      \*                      \*                      \*                      \*                      ALWAYS

2. Do you wake during the night with a choking feeling?

NEVER      \*                      \*                      \*                      \*                      \*                      FREQUENTLY

3. How often would you sleep more than 8 hours in total in a 24 hour period?

NEVER      \*                      \*                      \*                      \*                      \*                      ALWAYS

4. How often do you wake up more than once during the night?

NEVER      \*                      \*                      \*                      \*                      \*                      ALWAYS

5. Do you have a headache when you wake up in the morning?

NEVER      \*                      \*                      \*                      \*                      \*                      ALWAYS

6. Have you noticed a reduction in your libido or sex drive?

NO                      \*                      \*                      \*                      \*                      \*                      TOTAL

7. Do you feel sleepy during the day?

NEVER      \*                      \*                      \*                      \*                      \*                      ALWAYS

8. Has anyone noticed that you momentarily stop breathing during your sleep?

NO                      \*                      \*                      \*                      \*                      \*                      FREQUENTLY

9. Do you fall asleep while reading?

NEVER      \*                      \*                      \*                      \*                      \*                      FREQUENTLY

10. Do you wake up in the morning feeling confused?

NEVER \* \* \* \* \* ALWAYS

11. How often do you have a nap during the day?

NEVER \* \* \* \* \* ALWAYS

12. Do you feel sleepy in the evenings?

NEVER \* \* \* \* \* ALWAYS

13. Have you or anyone else noticed a change in your personality recently?

NO \* \* \* \* \* DEFINITELY

14. How often do you doze off or fall asleep while driving?

NEVER \* \* \* \* \* FREQUENTLY

How likely are you to **doze off or fall asleep** in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you.

Use the following table to choose the **most appropriate option** for each situation by placing a tick in the boxes below:

Situation	[0] Never doze	[1] Slight chance of dozing	[2] Moderate chance of dozing	[3] High chance of dozing
Sitting and reading				
Watching TV				
Sitting, inactive in a public place (e.g. a theatre or a meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a lunch without alcohol				
In a car, while stopped for a few minutes in the traffic				

## EMPLOYMENT

### Current Employment:

Are you currently employed? \_\_\_\_\_

Are you full-time, part-time or casual? \_\_\_\_\_

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 to find employment? \_\_\_\_\_

### If employed, please state what level of activity your job involves:

0	5	10
Little (sedentary job)	Moderately active	Very active (Labouring, etc.)

## BREATHING HISTORY

Does being at work ever make your chest tight or wheezy?

Yes  No  details: \_\_\_\_\_

Have you ever had to change your job because it affected your breathing?

Yes  No  details: \_\_\_\_\_

Have you ever worked in a job, which exposed you to vapours, gas dust or fumes?

Yes  No  details: \_\_\_\_\_

### ASTHMA

Have you ever had asthma? (tick one of the following)

Never	<input type="checkbox"/>
Current	<input type="checkbox"/>
In the past	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

Have you ever had to spend a night in hospital because of asthma / breathing problems?

Yes  No

If yes was it in the last 12 months

Yes  No

In the last 12 months, have you visited a hospital casualty department or seen a doctor urgently because you had asthma or breathing problems

Yes  No  Details: \_\_\_\_\_

In the last 12 months, have you taken a course or prednisolone because of asthma or breathing problems

Yes  No  Details: \_\_\_\_\_

In the last 12 months, have you missed work or school because of asthma or breathing problems?

Yes  No  Details: \_\_\_\_\_

**COUGH AND SHORTNESS OF BREATH:**

Do you usually have a cough?

Yes  No

Do you usually bring up phlegm from your chest when you cough?

Yes  No

Do you get short of breath on exertion?

Yes  No

Do you get short of breath walking on the flat?

Yes  No

Do you get short of breath walking uphill or doing housework?

Yes  No

In the last 12 months, have you had an attack of shortness of breath that came on when you were not exercising and without obvious cause

Yes  No

**WHEEZE (a whistling noise that comes from the chest and may cause breathlessness or difficulty in breathing)**

In the last 12 months, have you had wheezing in your chest?

Yes  No

In the last 12 months, have you had an attack of wheezing that came on after you stopped exercising?

Yes  No

In the last 12 months, have you had a feeling of tightness in your chest on waking in the morning?

Yes  No

## GASTROESOPHAGEAL REFLUX / INDIGESTION

Do you have a history of heartburn or indigestion

Yes  No  Details: \_\_\_\_\_

If yes, how often do you have reflux during the day?

Many times a day • everyday • most days • most weeks • occasionally •

Do you suffer heart burn / indigestion during the night? If so how often

Many times a night • everynight • most nights • most weeks • occasionally •

What aggravates or causes your reflux?

Details: \_\_\_\_\_

Do you have difficulty swallowing?

Yes  No  Details: \_\_\_\_\_

Does food ever get stuck?

Yes  No  Details: \_\_\_\_\_

Does food or fluid reflux into the mouth?

Yes  No  Details: \_\_\_\_\_

Do you vomit with reflux?

Yes  No  Details: \_\_\_\_\_

Do you suffer from recurrent sore throats?

Yes  No  Details: \_\_\_\_\_

Do you suffer from a hoarse voice?

Yes  No  Details: \_\_\_\_\_

Do you suffer from a regular cough at night?

Yes  No  Details: \_\_\_\_\_

Please list any treatments you may use for reflux / heartburn or indigestion

---

---

---

# MEDICATIONS

Please indicate whether you are now or have previously taken any of the following medications.  
If yes, please state the name of the medication and how long you have been or were taking it.

Medication for psychiatric disorder	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details _____
Migraine medication	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details _____
Medications to assist weight loss	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details _____
Drugs for epilepsy	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details _____
Drugs for asthma or breathing	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details _____
Hormones, e.g. The Pill	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details _____
Hormone Replacement Therapy	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details _____
Cortisone	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details _____

Please list all the tablets, drops, creams, etc that you are currently taking.
