Entered: _ _ / _ _ /20 _ _ Initials: _____ Verified: _ _ / _ _ / 20 _ _ Initials: _____

For office use only.

Pre-operative Form – Version: 01/01/2008 FORMV

Patient ID __ __ __ - **ID** __ __- __ __ **Evaluation Date PO1DAT** mm dd yy

Certification number: CERT___

Instructions: This form should be completed on all patients who provide informed consent.

Clinical sites that have the proper IRB approval should also complete this section for all patients who decline to provide informed consent.

1. Consent to LABS: ☐ 0. No → Patient's age **PTAGE** (years)

☐ 1. Yes → LABS consent date: **DOC1DAT** mm dd yy

Patient's date of birth: **~~DOBDAT~~ (replaced with AGE_C)** mm dd yy

2. Gender: ☐ 1. Male ☐ 2. Female **SEX**

3. Height: **HGTFT** (ft), **HGTIN** (in)→

3.1 How was height measured? **HGTMEAS**
- ☐ 1. Standing
- ☐ 2. Lying Flat
- ☐ 3. Estimate

4. Weight: **WGT** (lbs) →

4.1 How was weight measured? **WGTMEAS**
- ☐ 1. Tanita Scale
- ☐ 2. Other Scale
- ☐ 3. Last available bed weight
- ☐ 4. Estimate

5. Ethnicity: **ETHN**
- ☐ 0. Hispanic
- ☐ 1. Non-Hispanic

6. Race *(check all that apply)* :
- ☐ White or Caucasian **RACEW**
- ☐ Black or African-American **RACEB**
- ☐ Asian **RACEA**
- ☐ American Indian or Alaska Native **RACEI**
- ☐ Native Hawaiian or other Pacific Islander **RACEH**
- ☐ Other **RACEO** (specify ____**RACES**_____)

**** Continue ONLY if there is written informed consent for LABS. Otherwise, do not complete the rest of this form. ****

7. Smoking status: **SMOKE**
- ☐ 1. Never smoked
- ☐ 2. Current:
  Age started regularly: **CIGSTART**
  Average packs/day: **CIGAVE**
- ☐ 3. Former:
  Age started regularly:**CIGSTART**
  Age quit: **CIGQUIT**
  Average packs/day: **CIGAVE**

8. Medications in the past 90 days:
(check "no" or "yes" for each item)

	No	Yes
IMMUNO Therapeutic oral/IV immunosuppressant		
ANTIC Therapeutic anticoagulation		
NARC Narcotic		
STATIN Statin or other lipid lowering agent		
ADEPRS Antidepressant		
BETAB Beta-blocker		

9. Blood pressure: **SBP** / **DBP** (mmHg)→ Systolic / Diastolic

10.1 How was blood pressure measured? **BPMEAS**
- ☐ 1. Mercury
- ☐ 2. Gauge
- ☐ 3. Electronic

11. Comorbidity	No	Yes		*If yes, check the one best response*
a. Hypertension **HTN**	**HTNS**		→	☐ 1. No medication ☐ 2. Single medication ☐ 3. Multiple medications
b. Diabetes **DM**	**DMS**		→	☐ 1. No medication ☐ 2. Single oral medication ☐ 3. Multiple oral medication ☐ 4. Insulin ☐ 5. Oral meds and insulin
c. CHF **CHF**	**CHFS**		→	NYHC: ☐ I ☐ II ☐ III ☐ IV ☐ *Unknown*
d. Asthma **ASTH**	**ASTHS**		→	☐ 1. History of Intubation ☐ 2. No History of Intubation

e. Functional Status **FS** ☐ 1. Can walk (length of grocery store aisle) 200 ft unassisted ☐ 2. Able to walk 200 ft with assist device (cane, walker) ☐ 3. Cannot walk 200 ft with assist device ☐ -3. Unknown

Comorbidity	No	Yes		Check "No" or "Yes" for each item	
				No	**Yes**
f. History of DVT/PE **DVT**	☐	☐	→	☐	☐ Documented DVT **DOCDVT**
				☐	☐ Documented PE **DOCPE**
				☐	☐ Venous edema w/ ulceration **VEDEMA**
g. Sleep apnea **SLPA**	☐	☐	→	☐	☐ C-pap/ Bi-pap **CPAP**
				☐	☐ Supplemental oxygen dependent **OXYDEP**
h. Ischemic Heart Disease **HD**	☐	☐	→	☐	☐ History of MI **HXMI**
				☐	☐ No active ischemia **NOISCH**
				☐	☐ Abnormal EKG but unable to assess ischemia **ABNEKG**
				☐	☐ PCI, CABG **CORINTRV**
				☐	☐ Anti-ischemic medications **AISCHM**
i. Pulmonary hyp. **PULHYP**	☐	☐			

j. History of venous edema with ulcerations? ☐ 0. No ☐ 1. Yes **HXVE**

18. Are there any comorbid conditions the patient may have that could affect clinical outcome following bariatric surgery? ☐ 0. No ☐ 1. Yes **OCOND**

18.1 If yes, specify (*do not enter into database*):

_____

_____