

Application Directions for the BIB study

- 1. Read carefully the informed consent to make sure you understand the risks and benefits of the clinical trial.**
- 2. Fill out the questionnaires and fax them to Puget Sound Surgical Center at (425) 778-7701.**
- 3. Be prepared to attend an information and registration night. To be announced. Location will be Puget Sound Surgical Center lobby. 21911 76th Ave W Suite 106 Edmonds, WA 98026.**
- 4. Look at your vacation calendar and make sure in the next year you do not have any lengthy vacations that will exclude you from the study. Appointments will be scheduled on a monthly basis for the first six months and then bimonthly for the second part of the 12 month period.**

Name of Applicant: _____

Phone Number: _____

Email: _____

Age: _____

Yes No N/A

Previous stomach, intestinal or colon surgery. (Except for appendectomy or gallbladder surgery)

History or symptoms of esophageal or GI motility disorders (e.g., gastroparesis, achalasia, diffused esophageal spasm, and/or expected esophageal motility)

History of a heart attack in the previous 6 months or cardiac arrhythmia

Anemia

History or symptoms of varices, bowel obstruction, congenital or acquired GI anomalies (e.g., atresias, stenosis, stricture, and/or diverticula)

History or symptoms of severe kidney disease

History or symptoms of liver disease

History or symptoms of lung disease

History or symptoms of inflammatory bowel disease, such as Crohn's disease

History or symptoms of ulcerative colitis

History or symptoms of uncontrolled thyroid disease

History of H. Pylori

History of cancer within the last 5 years (excluding basal cell carcinoma)

History of positive test for HIV or Hepatitis C

History or symptoms in the past 24 months of significant irritable bowel

Peritonitis

	Yes	No	N/A
Active esophagitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastric or duodenal ulceration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GI Bleed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type I Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Placement of previous intragastric balloon or similar device	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ongoing treatment with any of the following that you are unwilling to discontinue for the duration of the one year study	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-steriodal anti-inflammatory drugs (NSAIDS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Current use of concomitant prescription, non-prescription, or over the counter weight loss medications or supplements that you are unwilling to discontinue for the duration of the one year study	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Evidence of untreated psychiatric or eating disorders, such as:			
Severe depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Binge eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Currently pregnant, breastfeeding or have the intention of becoming pregnant in the next year.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Currently enrolled in an investigational drug or device study or participation in such a study within 30 days of entry into this study	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor general health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HEALTH HISTORY QUESTIONNAIRE

Puget Sound Surgical Clinic

Peter S. Billing, MD, ASBS
 Robert W. Landerholm, MD, FACS, ASBS

Patient Name: _____
 Address: _____

Phone Numbers: _____ Cell: _____

Primary Care Physician: _____ Referring Physician: _____
 Address: _____

Phone Number: _____ Phone Number: _____

Weight History:

Age: _____ Height: _____ Current Weight: _____ BMI: _____

Approximate Weight:

20 yrs. ago _____ 10 yrs. ago _____ 5 yrs ago _____ 2 yrs. ago _____

1 yr. ago _____ 6 mos. ago _____

What age did you become obese? _____
 What was your lowest adult weight? _____
 What was your highest adult weight? _____
 What is your desired or goal weight? _____

For Office use only

IBW _____
 % over IBW _____
 Goal _____

Please describe your age and situation (major stress, if any) at the onset of your obesity:

WEIGHT LOSS PROGRAMS/ DIETS/ MEDICATIONS

Maximum weight loss on any program: _____
 Maximum length of time you kept the weight off: _____

- | | | |
|--|---|--|
| <input type="checkbox"/> Weight Watchers | <input type="checkbox"/> Jenny Craig | <input type="checkbox"/> Atkins Diet |
| <input type="checkbox"/> Slimfast | <input type="checkbox"/> Nutrasystems | <input type="checkbox"/> Weight Mgt. Prog. |
| <input type="checkbox"/> Optifast | <input type="checkbox"/> Medifast | <input type="checkbox"/> Cambridge |
| <input type="checkbox"/> Metabolife | <input type="checkbox"/> Xenical | <input type="checkbox"/> Meridia |
| <input type="checkbox"/> Phen-Fen | <input type="checkbox"/> South Beach Diet | <input type="checkbox"/> Redux |

Other Physician/Dietitian/Hospital Supervised Programs _____

HAVE YOU HAD ANY OF THE FOLLOWING OBESITY RELATED PROBLEMS?

- | Yes | No | |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes Mellitus |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn/ GERD |
| <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint Pain/Arthritis/DJD |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleep Apnea |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

Office Notes

SURGERY

Please list all previous surgeries and hospitalizations:

Procedure/diagnosis	Date	Hospital Name/Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ANESTHESIA

Please list any complications you have had with anesthesia:

_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL HISTORY

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a recent physical exam?
If yes, Date _____
Where/phone number _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a recent chest X-ray?
If yes, Date _____
Where/phone number _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a recent abdominal X-ray?
If yes, Date _____
Where/phone number _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a recent EKG?
If yes, Date _____
Where/phone number _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had recent blood and urine tests?
If yes, Date _____
Where/phone number _____ |

Office Notes

For Women Only

- Date of last menstrual period:** _____
- Date of last mammogram:** _____
- Date of last PAP smear:** _____
- Number of pregnancies:** _____
- Number of live births:** _____
- Are you pregnant now?** Y/N **If yes, due date** _____
- Are you using any form of birth control?** Y/N **If yes, type** _____
- Are you taking hormone replacement?** Y/N **If yes, type** _____
- Are your menstrual periods irregular?** Y/N **If yes, how often** _____
- Have you had hot flashes?** Y/N **If yes, date of onset** _____

Office Notes

HABITS

Smoking

Have you ever smoked Y/N Age started _____ Age Quit _____

Are you currently a smoker? Y/N Number of packs a day _____

Beverages

How much do you consume of the following?

Beer _____ 12oz cans per week Tea _____ cups per day

Wine _____ 4oz glasses per week Coffee _____ cups per day

Liquor _____ 2oz drinks per week

Diet

Are you on a special diet ? Y/N If yes please describe:

Where do you eat most of your meals?

- Home
- Restaurant
- Other (please explain) _____

With whom do you usually eat

- Alone
- Family
- Other (please explain) _____

Who usually prepares the food you eat at home? _____

Please list any allergies or intolerances to food _____

What are your favorite foods? _____

What eating habits do you have that bother you? _____

Notes

Family History

Please indicate which, if any of your family members had the following conditions:

	Sibling	Mother	Father	Aunt/Uncle	Grandparent
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer(breast)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer(colon)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is your father living? Y/N If not, cause of death _____
 Age of death _____

Is your mother living? Y/N If not, cause of death _____
 Age of death _____

Are any family members obese? Y/N

List family member and approximate weight:

General

	Yes	No
Do you live alone?	<input type="checkbox"/>	<input type="checkbox"/>
Are you responsible for an invalid?	<input type="checkbox"/>	<input type="checkbox"/>
Are you presently involved in any lawsuit related to an injury or operation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you often feel pressed for time?	<input type="checkbox"/>	<input type="checkbox"/>
How often do you wake up in the middle of the night?		_____
How often does your work leave you feeling exhausted?		_____

Notes:

Health System Review

Never Past Present

CONSTITUTIONAL

- Good general health
 Unexplained weight change
 Fever
 Fatigue
 Headaches

EYES

- Disease or injury
 Glasses/Contacts
 Blurred or double vision
 Glaucoma
 Cataracts

EARS/NOSE/MOUTH/THROAT

- Hearing loss or ringing
 Earaches or drainage
 Chronic sinus problems
 Chronic rhinitis
 Nose bleeds
 Mouth sores
 Bleeding gums
 Bad breath or bad taste
 Sore throat or voice change
 Swollen glands in neck

CARDIOVASCULAR

- High Cholesterol
 Heart trouble
 Hypertension
 Chest pain or angina pectoris
 Murmur
 Palpitation or racing heart
 Shortness of breath with walking or lying flat
 Swelling of feet, ankles, or hands
- Cardiac testing:
- EKG Date _____
 Echo Date _____
 Stress test Date _____
 Angiogram Date _____

Never Past Present

RESPIRATORY

- Chronic or frequent cough
 Coughing/choking at night
 Spitting up blood
 Shortness of breath
 Asthma or wheezing
 Daytime falling asleep
 Lung disease
 Tuberculosis

GASTROINTESTINAL

- Colitis: Irritable bowel
 Gallbladder Disease
 Change in bowel movements
 Painful bowel movements
 Constipation
 Frequent diarrhea
 Rectal bleeding
 Blood in or tarry stools
 Nausea or vomiting
 Loss of appetite
 Heart burn or GERD
 Peptic ulcer (stomach or duodenal)
 Abdominal pain
 Hepatitis: Liver Disease
 Colonoscopy Date _____
 Upper Endoscopy Date _____

GENITOURINARY

- Frequent urination
 Burning or painful urination
 Incontinence or dribbling
 Change in force of stream when urinating
 Blood in urine
 Kidney infection
 Kidney stones
 Sexual difficulty
 Male: Testicular pain
 Female:
 Pain with periods
 Irregular periods
 Vaginal discharge
 Pap smear Date _____
 # of pregnancies _____
 # of miscarriages _____

Office Notes

Never	Past	Present	<u>MUSCULOSKELETAL</u>	Never	Past	Present	<u>ENDOCRINE</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glandular or hormonal problem
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint stiffness or swelling				Thyroid disease:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis				hyperthyroid
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hypothyroid
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weakness of muscles or joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain or cramps				diet controlled
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	medication controlled
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	insulin controlled
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cold extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst or urination
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heat or cold intolerance
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin becoming more dry
			<u>INTEGUMENTARY (skin, breast)</u>				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rash or itching				<u>HEMATOLOGIC/LYMPHATIC</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change in skin color				Slow to heal after cuts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change in hair or nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding or bruising tendency
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suspicious moles or spots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Past transfusion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast lump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged glands
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast discharge				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mammogram Date _____				
							<u>ALLERGIC/IMMUNOLOGIC</u>
			<u>NEUROLOGICAL</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus/ Autoimmune disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or recurring headache				History of skin reaction or other adverse reaction to:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Light headed or dizzy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or other antibiotics
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Morphine, Demerol, or other narcotics
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numb or tingling sensations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Novocaine or other anesthetics
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tremors				Aspirin or other pain remedies
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus antitoxins or other serums
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine, methiolate, or other Antiseptic
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other drugs/medications
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Known food allergies
			<u>PSYCHIATRIC</u>				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss or confusion				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/nervousness				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____				

 Physician Signature

 Date

Office Notes