

Entered: \_\_/\_\_/20\_\_

Initials: \_\_\_\_\_

Verified: \_\_/\_\_/20\_\_

Initials: \_\_\_\_\_

**For office use only.**

**Pre-operative Form (PO1) – Version: 12/15/2006**

Patient ID \_\_\_\_\_

Evaluation Date \_\_/\_\_/20\_\_  
mm dd yy

Certification number: \_\_\_\_\_

**To 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 1:  0. No →  
(if no)

1.1 Reason for refusing (check all that apply):

- General lack of interest.
- Does not want to be bothered.
- Lack of trust (e.g. that personal information will remain confidential).
- Concerned that information provided will impact ability to have surgery.
- No perceived personal benefit from participating.
- Does not want to be included as subject in medical research.
- Other (Specify: \_\_\_\_\_)
- Unknown

1.2 Patient's age:

\_\_\_\_\_ (years)

1. Yes →  
(if yes)

1.3 Date of consent: \_\_/\_\_/20\_\_  
mm dd yy

1.4 Patient's date of birth: \_\_/\_\_/19\_\_  
mm dd yy

2. Gender:  1. Male  
 2. Female

3. Height: \_\_\_\_ (ft), \_\_\_\_ (in)

4. Weight: \_\_\_\_ (lbs)

3.1 How was height measured?

- 1. Standing
- 2. Lying Flat
- 3. Estimate

4.1 How was weight measured?

- 1. Tanita Scale
- 2. Other Scale
- 3. Last available bed weight
- 4. Estimate

5. Ethnicity:  0. Hispanic  
 1. Non-Hispanic

6. Race (check all that apply):

- White or Caucasian
- Black or African-American
- Asian
- American Indian or Alaska Native
- Native Hawaiian or other Pacific Islander
- Other (specify \_\_\_\_\_)

**\*\* Continue ONLY if there is written informed consent for LABS-1. Otherwise, do not complete the rest of this form. \*\***

7. Previous obesity surgery OR surgery performed on the esophagus, stomach or proximal small intestine not for the purpose of weight loss?  0. No  1. Yes

7.1 If yes, specify (check "no" or "yes" for each item):

No	Yes		Number of previous surgeries (including revisions and reversals)	Date of most recent surgery
<input type="checkbox"/>	<input type="checkbox"/>	Gastric Bypass (Roux-en-Y)	___	__/__/____
<input type="checkbox"/>	<input type="checkbox"/>	Biliopancreatic div. (BPD)	___	__/__/____
<input type="checkbox"/>	<input type="checkbox"/>	Biliopancreatic div. w/switch (BPDS)	___	__/__/____
<input type="checkbox"/>	<input type="checkbox"/>	Adjustable Gastric Band (AGB)	___	__/__/____
<input type="checkbox"/>	<input type="checkbox"/>	Vertical Banded Gast. (VBG)	___	__/__/____
<input type="checkbox"/>	<input type="checkbox"/>	Sleeve Gastrectomy (SG)	___	__/__/____
<input type="checkbox"/>	<input type="checkbox"/>	Prior surgery performed on the esophagus, stomach or proximal small intestine NOT for the purpose of weight loss.	___	__/__/____
<input type="checkbox"/>	<input type="checkbox"/>	Other previous obesity surgery 1 (Specify: _____)	___	__/__/____
<input type="checkbox"/>	<input type="checkbox"/>	Other previous obesity surgery 2 (Specify: _____)	___	__/__/____

8. Smoking status:  1. Never smoked  2. Current: → 

Age started regularly: _____ Average packs/day: _____
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 3. Former: → 

Age started regularly: _____ Age quit: _____ Average packs/day: _____
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0. No  1. Yes

9. Is this patient a good candidate for LABS-2?

9.1 If no, specify why (check "no" or "yes" for each item):

No	Yes	No	Yes	No	Yes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Planned procedure:

- 1. Gastric bypass (Roux-en-Y)
- 6. Sleeve gastrectomy- → 

<input type="checkbox"/> 1. Gastric bypass (Roux-en-Y) <input type="checkbox"/> 2. BPD <input type="checkbox"/> 3. BPDS
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- 2. Biliopancreatic diversion (BPD)
- 7. Other (Specify: \_\_\_\_\_)
- 3. Biliopancreatic diversion with Doudenal Switch (BPDS)
- 8. Banded Gastric bypass (Gastric bypass + non-adjustable band)
- 4. Laparoscopic adjustable gastric band (LAGB)
- 9. Vertical Banded Gastroplasty
- 5. Sleeve gastrectomy-initial stage
- 3. Unknown at this time

11. Planned approach:  1. Laparoscopic  2. Open  -3. Unknown

12. Is the planned procedure a revision?  0. No  1. Yes  
If yes,

12.1 Patient status at time of <u>previous</u> procedure:	<input type="checkbox"/> 1. LABS-1 Registered patient
	<input type="checkbox"/> 2. Non-LABS-1 Patient

13. Is the planned procedure a reversal?  0. No  1. Yes  
If yes,

13.1 Patient status at time of <u>previous</u> procedure:	<input type="checkbox"/> 1. LABS-1 Registered patient
	<input type="checkbox"/> 2. Non-LABS-1 Patient

14. Most recent laboratory value within 180 days:

	Blood Draw Date	Not done		Blood Draw Date	Not done
Fasting Glucose: _____ mg/dl	__/__/____	<input type="checkbox"/>	AST (SGOT): _____ IU/L	__/__/____	<input type="checkbox"/>
Creatinine: _____ mg/dl	__/__/____	<input type="checkbox"/>	Hematocrit: _____%	__/__/____	<input type="checkbox"/>
Albumin: _____ g/dl	__/__/____	<input type="checkbox"/>	Triglycerides: _____ mg/dl	__/__/____	<input type="checkbox"/>
HbA1C: _____ %	__/__/____	<input type="checkbox"/>	HDL: _____ mg/dl	__/__/____	<input type="checkbox"/>
Normal HbA1C <b>High</b> range: _____%			Total Cholesterol: _____ mg/dl	__/__/____	<input type="checkbox"/>
ALT (SGPT): _____ IU/L	__/__/____	<input type="checkbox"/>	Alkaline Phosphatase: _____ IU/L	__/__/____	<input type="checkbox"/>

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

<input type="checkbox"/> No	<input type="checkbox"/> Yes	
<input type="checkbox"/>	<input type="checkbox"/>	Therapeutic oral/IV immunosuppressant
<input type="checkbox"/>	<input type="checkbox"/>	Therapeutic anticoagulation
<input type="checkbox"/>	<input type="checkbox"/>	Narcotic
<input type="checkbox"/>	<input type="checkbox"/>	Statin or other lipid lowering agent
<input type="checkbox"/>	<input type="checkbox"/>	Antidepressant
<input type="checkbox"/>	<input type="checkbox"/>	Beta-blocker

16. Blood pressure: \_\_\_\_\_ / \_\_\_\_\_ (mmHg)  
Systolic / Diastolic

16.1 How was blood pressure measured?  
 1. Mercury  
 2. Gauge  
 3. Electronic

17. Comorbidity	No	Yes		<i>If yes, check the <u>one</u> best response</i>					
a. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/> 1. No medication	<input type="checkbox"/> 2. Single medication	<input type="checkbox"/> 3. Multiple medications			
b. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/> 1. No medication	<input type="checkbox"/> 2. Single oral medication	<input type="checkbox"/> 3. Multiple oral medication	<input type="checkbox"/> 4. Insulin	<input type="checkbox"/> 5. Oral meds and insulin	
c. CHF	<input type="checkbox"/>	<input type="checkbox"/>	→	NYHC:	<input type="checkbox"/> I	<input type="checkbox"/> II	<input type="checkbox"/> III	<input type="checkbox"/> IV	<input type="checkbox"/> Unknown
d. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/> 1. History of Intubation		<input type="checkbox"/> 2. No History of Intubation			
e. Functional Status				<input type="checkbox"/> 1. Can walk (length of grocery store aisle) 200 ft unassisted	<input type="checkbox"/> 2. Able to walk 200 ft with assist device (cane, walker)	<input type="checkbox"/> 3. Cannot walk 200 ft with assist device	<input type="checkbox"/> -3. Unknown		

Comorbidity	No	Yes		Check "No" or "Yes" for each item	
				No	Yes
f. History of DVT/PE	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/> Documented DVT
				<input type="checkbox"/>	<input type="checkbox"/> Documented PE
				<input type="checkbox"/>	<input type="checkbox"/> Venous edema w/ ulceration
g. Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/> C-pap/ Bi-pap
				<input type="checkbox"/>	<input type="checkbox"/> Supplemental oxygen dependent
h. Ischemic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	→	<input type="checkbox"/>	<input type="checkbox"/> History of MI
				<input type="checkbox"/>	<input type="checkbox"/> No active ischemia
				<input type="checkbox"/>	<input type="checkbox"/> Abnormal EKG but unable to assess ischemia
				<input type="checkbox"/>	<input type="checkbox"/> PCI, CABG
				<input type="checkbox"/>	<input type="checkbox"/> Anti-ischemic medications
i. Pulmonary hypertension	<input type="checkbox"/>	<input type="checkbox"/>			
j. History of venous edema with ulcerations?				<input type="checkbox"/> 0. No	<input type="checkbox"/> 1. Yes

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

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_