Bariatric Questionnaire

Please complete form accurately to avoid delay in insurance pre-authorization or delivery of care.

DEMOGRAPHIC INFORMATION:

Name: _____ Name you like us to call you: _____
Date of Birth _____/_____/_____ Age _____ Present Weight _____ Height _____
Telephone: _____ Email: _____
Address: _____
Primary care physician: _____ Ob/Gyn (if applicable) _____
Other physicians currently providing care and their specialty: _____

DIETARY HISTORY:

A. Weight History: At what age did you develop a weight problem? _____
Highest Adult weight _____

B. Dietary History: Please choose eating habits that best describe you (check all that apply):
☐ Large Portion Size ☐ Frequent Snacks ☐ Eating sweets ☐ Eating Out a Lot ☐ Skip Meals
☐ Compulsive Eating ☐ Emotional eating ☐ Eat late at night ☐ Read Food labels ☐ Watch Calories

C. Exercise History: Do you exercise regularly? ☐ Yes ☐ No

D. Medical Weight loss History:
Have you ever received medication from a physician to lose weight? ☐ Yes ☐ No
If yes, please describe: _____

Have you ever tried to lose weight through exercise? ☐ Yes ☐ No Please record your experience below:

Exercise Program	Year	Length of Time on program	Pounds Lost	Pounds Regained
Health Club				
Walking				
Other				

Please record below any diet that you have tried in your life of any duration

Type of Diet	Year	Duration	Pounds Lost	Pounds Regained

MEDICAL HISTORY (check all that apply)

Have you ever been diagnosed with any of the following conditions commonly associated with obesity?

High Blood Pressure	☐ Yes	☐ No	Osteoarthritis	☐ Yes	☐ No
High Cholesterol/lipids	☐ Yes	☐ No	Lower back pain	☐ Yes	☐ No
Diabetes Mellitus	☐ Yes	☐ No	Urinary Incontinence	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No	Fatty Liver	☐ Yes	☐ No
If yes, do you use a CPAP?	☐ Yes	☐ No	Gall Stones	☐ Yes	☐ No
Reflux Disease (Heartburn)	☐ Yes	☐ No	Pseudo tumor Cerebri	☐ Yes	☐ No
If yes, indicate: ☐ Mild ☐ Moderate ☐ Severe			Plantar Fasciitis	☐ Yes	☐ No

Please indicate if you have ever been diagnosed with any of the other conditions listed below

Cardiac

☐ Coronary Artery Disease
☐ Heart Attack
☐ Angina (Chest Pain)
☐ Congestive Heart Failure
☐ Arrhythmia (Irregular Heart Beat)
☐ Heart Valve Disease
☐ Other: _____

Endocrine

☐ Hypothyroid
☐ Adrenal (Cushings)
☐ Other: _____

Pulmonary

☐ COPD (Emphysema/Bronchitis)
☐ Asthma
☐ Loud Snoring
☐ Gasping for Breath at Night
☐ Other: _____

Gastrointestinal

☐ Inflammatory Bowel Disease (Crohn's, Ulcerative Colitis)
☐ Hiatal Hernia
☐ Peptic Ulcer Disease
☐ Cirrhosis of Liver
☐ Other: _____

Renal

☐ Kidney Stones
☐ Other: _____

Psychological & Psychiatric Disorders

☐ Depression
☐ Anxiety
☐ Bipolar Depression
☐ Schizophrenia
☐ Other: _____
☐ Were you ever hospitalized for a psychiatric condition? ☐ Yes ☐ No Year admitted _____

Blood Disorders

☐ Anemia
☐ Bleeding or clotting problems
☐ Other: _____

Musculoskeletal & Nervous System

☐ Gout
☐ Autoimmune Disease
-If yes, please explain (Eg., Lupus, Rheumatoid Arthritis) _____

Cancer

Ever diagnosed with Cancer? ☐ Yes ☐ No
Type of cancer _____
Year Diagnosed _____ Physician _____
Treatment _____

Other Medical Conditions not listed above

Condition _____
Year Diagnosed _____ Physician _____
Treatment _____

REVIEW OF SYSTEMS

*Please **circle** any of the following symptoms you might have experienced over the past 3 months*

Constitutional: Fever, Chills, Tiredness, Weight loss >10%
Psychologic: Anxiety, Depression, Difficulty Sleeping
Neurologic: Dizziness, Hand/Feet Tingling or Numbness
Eyes: Blurry vision, Eye pain
Ear/Nose/Throat: Ear ache, Nose Bleed, Change in Voice
Heart: Chest Pain, Shortness of Breath, Palpitation
Lungs: Cough, Sputum, Shortness of Breath, Wheezing
Gastrointestinal: Abdominal pain, Heartburn, Nausea, Vomiting, Bloating, Diarrhea, Constipation, Blood from Rectum
Genitourinary: Burning with Urination, Increased Frequency, Difficulty Controlling Bladder, Penile or Vaginal Discharge
Musculoskeletal: Pain in Joints, Muscles, or Bones
Skin: Skin Rash, Excessive Itching, Eczema, Dry skin
Hematologic: Excessive Bruising, Swollen Glands

OB/GYN HISTORY (If applicable)

Number of Pregnancies _____ Natural Deliveries _____ Cesarean sections _____
Are you: ☐ Menstruating ☐ Post-menopausal
Have you had Tubal Ligation? ☐ Yes ☐ No Have you had Hysterectomy? ☐ Yes ☐ No

SURGICAL HISTORY

Please list all of your previous surgical procedures

	Surgery	Year
1.		
2.		
3.		
4.		
5.		

Have you ever had complication after surgery? ☐ Yes ☐ No If yes, describe _____

CURRENT MEDICATIONS

Please list all prescribed and over-the-counter medications, **include nutritional and herbal supplements**

	Medications	Dose	Frequency/day	Year Started	Purpose
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Name, telephone, address of your pharmacy _____

ALLERGY INFORMATION

Please list any known allergies to medications:

Medication	Reaction

FAMILY HISTORY

Has anyone in your family reacted adversely to anesthesia? ☐ Yes ☐ No
If yes, please explain: _____

Has anyone in your family had excessive bleeding after a surgery? ☐ Yes ☐ No
If yes, please explain: _____

SOCIAL HISTORY

Occupation: Occupation _____ Employer _____ Years at this job _____

Tobacco: Do you currently smoke tobacco or use nicotine products? ☐ Yes ☐ No
If a current smoker, you have smoked an average of ____ cigarettes/day for _____ years
If a past smoker, you smoked an average of ____ cigarettes/day for _____ years and quit _____ years ago

Alcohol: Do you currently drink alcohol? ☐ Yes ☐ No
If yes, indicate type of alcohol _____ and number of drinks/week _____
If a past consumer, type of alcohol _____ , number of drinks/week _____and quit _____ years ago

Drugs: Have you ever used recreational drugs? ☐ Yes ☐ No
If yes, please indicate which and how long ago? _____

PREVIOUS DIAGNOSTIC PROCEDURES

Please indicate the date for any diagnostic procedures within the last two years.

Test	Date	Test	Date
☐ Echocardiogram	_____	☐ Upper Endoscopy	_____
☐ Stress test	_____	☐ CT Scan	_____
☐ Cardiac Catheterization	_____	☐ Abdominal Ultrasound	_____
☐ Pulmonary Function Study	_____	☐ Other: _____	_____
☐ Sleep Study	_____		

How long have you been considering bariatric surgery? _____

How did you hear about us? _____

Which one of the choices best describes you?
☐ I am quite sure I want to have bariatric surgery soon, and I know what procedure: _____
☐ I am quite sure I want to have bariatric surgery soon, but not sure which procedure.
☐ I want to have bariatric surgery, but I am not sure when.
☐ I have not completely decided that I want bariatric surgery, but I am very eager to learn more.
☐ I am just not sure about bariatric surgery, and need some general information.

Has any family member or friend, or someone you know undergone Bariatric Surgery?
☐ Yes, Name type of surgery _____ ☐ No

Please list any specific question or concern that you may have about your surgical procedure, so that we can address them during your consultation.
_____
_____
_____
_____

The information provided in this form is correct to the best of my knowledge.

_____ _____ _____
Patient Name (please print) ***Patient Signature*** ***Date***