Weight Loss Surgery Department
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For Office Use Only

Received: _____

Scheduled: _____

MRN: _____

BMI: _____

Referral #: _____

Acct. Balance: $_____

How heard: _____

❑ Spreadsheet

Patient Questionnaire

Information Session Attendance Date:

In-Person: _____/_____/_____ On-Line: _____/_____/_____

Surgery of Interest: ❑ Gastric Bypass ❑ Gastric Sleeve ❑ Duodenal Switch ❑ Revision

Please Print

Patient Full Legal Name: _____

Home Phone: _____ Cell Phone: _____

Address: _____
City State Zip

E-mail Address: _____ Sex: ❑ Male ❑ Female

DOB: _____ Age: _____ Marital Status: _____ Ethnicity: _____ Race: _____

Spoken Language: _____ Interpreter needed? ❑ Yes ❑ No

Emergency Contact Name: _____ Phone: _____

Okay to share information about you with person listed above? ❑ Yes ❑ No

Employer: _____ ❑ Full Time ❑ Part Time ❑ Unemployed

Primary Care Provider (PCP): _____

Insurance Information – ***please attach a copy of your insurance card***

Name of Insurance Company: _____

Phone #: _____ ID #: _____ Group #: _____

If spouse is guarantor: Name: _____ DOB: _____

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Current Medications – list all prescription and over the counter medications, vitamins, herbs and supplements

Drug Name	Dosage	Frequency	# years taking

Allergies – list all medication allergies

Medication	Reaction

Medication	Reaction

Operations – list all past surgeries

Surgery	Year

Did you experience any problems with anesthesia? ❑ Yes ❑ No
If yes, please describe:

Most recent mammogram: _____

Contraceptive method: _____

Most recent colonoscopy: _____

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Medical History – If yes to any medical conditions, please explain as needed

Medical Condition	Mark Yes or No		Please explain as needed
Cardiac:			
a. Angina or chest pain	❑ Yes	❑ No	
b. Bleeding problems	❑ Yes	❑ No	
c. Congestive Heart Failure (CHF)	❑ Yes	❑ No	
d. Deep Venous Thrombosis (DVT-clot in leg)	❑ Yes	❑ No	
e. Edema or water retention	❑ Yes	❑ No	
f. Heart attack	❑ Yes	❑ No	
g. High Blood Pressure	❑ Yes	❑ No	
h. High Cholesterol	❑ Yes	❑ No	
i. Irregular heartbeat	❑ Yes	❑ No	
j. Pacemaker	❑ Yes	❑ No	
k. Peripheral Vascular disease	❑ Yes	❑ No	
l. Pulmonary Embolism (PE-clot in lung)	❑ Yes	❑ No	
m. Stroke	❑ Yes	❑ No	
Endocrine:			If yes for Diabetes, please write year of onset below
a. Diabetes - Type 1	❑ Yes	❑ No	
b. Diabetes - Type 2	❑ Yes	❑ No	
c. Thyroid problems	❑ Yes	❑ No	
d. Polycystic Ovarian Syndrome (PCOS)	❑ Yes	❑ No	
Pulmonary:			
a. Asthma	❑ Yes	❑ No	
b. COPD or Emphysema	❑ Yes	❑ No	
c. Sleep Apnea	❑ Yes	❑ No	
If yes, do you use a CPAP/BiPAP machine	❑ Yes	❑ No	
GI:			
a. Colon or intestinal problems	❑ Yes	❑ No	
b. Gallbladder problems	❑ Yes	❑ No	
c. GERD/ reflux	❑ Yes	❑ No	
d. Hernia (if yes, what type?)	❑ Yes	❑ No	
e. Stomach ulcers	❑ Yes	❑ No	
f. Swallowing problems	❑ Yes	❑ No	
Musculoskeletal:			
a. Arthritis	❑ Yes	❑ No	
b. Back pain	❑ Yes	❑ No	
c. Degenerative Joint Disease	❑ Yes	❑ No	
d. Fibromyalgia	❑ Yes	❑ No	
e. Gout	❑ Yes	❑ No	
f. Joint replacement	❑ Yes	❑ No	
Mental Health:			
a. Depression	❑ Yes	❑ No	
b. Psychiatric condition (bipolar disorder, etc.)	❑ Yes	❑ No	
c. Eating disorder	❑ Yes	❑ No	
Cancer (If yes, what type?)	❑ Yes	❑ No	
Kidney problems	❑ Yes	❑ No	
Liver problems	❑ Yes	❑ No	

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Family History

Relationship	Mother	Father	Sister	Brother	Daughter	Son	Grandmother, maternal	Grandfather, maternal	Grandmother, paternal	Grandfather, paternal	Auth, maternal	Uncle, maternal	Aunt, paternal	Uncle, paternal
Diabetes														
Heart Disease														
Hyperlipidemia														
Hypertension														
Osteoporosis														
Thyroid Cancer														
Thyroid Disease														

Social History

Work information: ❑ Full Time ❑ Part Time ❑ Self-Employed ❑ Homemaker
❑ Student ❑ Retired ❑ Disabled ❑ Unemployed

Occupation: _____

Marital Status: ❑ Single ❑ Married ❑ Partnered ❑ Divorced ❑ Widowed

Number of children: _____ Ages of children: _____

Social Habits

Do you drink alcohol? ❑ Yes ❑ No If yes, how often? [redacted]

Do you currently smoke or chew tobacco? ❑ Yes ❑ No

If yes, what type? ❑ Cigarettes ❑ Pipe ❑ Cigars ❑ Chew

Have you ever smoked or chewed tobacco? ❑ Yes ❑ No If yes, when did you quit? [redacted]

Do you use recreational drugs? ❑ Yes ❑ No

If yes, what type? ❑ Cocaine ❑ Opioids ❑ PCP ❑ Marijuana

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Review of Symptoms: Check yes if you experience any of the following symptoms:

Please check any symptoms you currently have. If you don't have any of these symptoms check here ❑

General:
- ❑ Chills
- ❑ Fatigue
- ❑ Fever
- ❑ Night sweats
- ❑ Sleep disturbance
- ❑ Weight gain
- ❑ Weight loss

Psychological:
- ❑ Anxiety
- ❑ Concentration difficulties
- ❑ Depression
- ❑ Memory difficulties

Ophthalmic:
- ❑ Blurry vision
- ❑ Decreased vision
- ❑ Double vision
- ❑ Eye pain

Ear, Nose & Throat:
- ❑ Nose bleeds
- ❑ Hearing change
- ❑ Runny nose
- ❑ Sore throat

Allergy & Immunology:
- ❑ Hives
- ❑ Seasonal allergies
- ❑ Sinus problems
- ❑ Stuffy nose

Hematological & Lymphatic:
- ❑ Bleeding problems
- ❑ Blood clots
- ❑ Bruising

Endocrine:
- ❑ Hair pattern changes
- ❑ Hot flashes
- ❑ Stretchmarks
- ❑ Temperature intolerance
- ❑ Increased urination

Breast:
- ❑ New or changing breast lumps
- ❑ Nipple discharge

Respiratory:
- ❑ Cough
- ❑ Shortness of breath
- ❑ Wheezing

Cardiovascular:
- ❑ Chest pain
- ❑ Swelling of hands, feet, legs
- ❑ Irregular heartbeat
- ❑ Loss of consciousness

Gastrointestinal:
- ❑ Abdominal pain
- ❑ Blood in stools
- ❑ Constipation
- ❑ Diarrhea
- ❑ Heartburn
- ❑ Nausea/vomiting
- ❑ Difficulty swallowing

Genito-Urinary:
- ❑ Irregular/heavy menstrual cycle
- ❑ Erectile dysfunction
- ❑ Genital discharge
- ❑ Loss of bladder control
- ❑ Urinary urgency
- ❑ Urinary frequency
- ❑ Change in urinary stream

Musculoskeletal:
- ❑ Joint pain
- ❑ Joint stiffness
- ❑ Joint swelling
- ❑ Muscle pain
- ❑ Muscular weakness

Neurological:
- ❑ Dizziness
- ❑ Headaches
- ❑ Impaired balance
- ❑ Numbness/tingling
- ❑ Seizures
- ❑ Speech problems
- ❑ Shakiness

Dermatological:
- ❑ Acne
- ❑ Dry skin
- ❑ Eczema
- ❑ Nail changes
- ❑ Rash

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Weight History

Height: _____ft _____ inches Current Weight: _____ lbs

Since age 18:

The **least** you have weighed: _____ lbs.

The **most** you have weighed: _____ lbs.

Have you ever had any of the following surgical procedures for weight loss?

Surgery		**Year**
Gastric Stapling	❑ Yes ❑ No	
Gastric Bypass	❑ Yes ❑ No	
Gastric Band	❑ Yes ❑ No	
Intragastric balloon	❑ Yes ❑ No	
Jaw wiring	❑ Yes ❑ No	

If you have had weight loss surgery, was it later reversed? ❑ Yes ❑ No Date: ___/___/_____

Diet History – list all diets and/or medications you have tried

Diet Program	Start Date	End Date	Duration	Start Weight	End Weight	Weight Change

Examples:

Diet: American Heart Association, Atkins, Blood Type, Cabbage Soup, Calorie counting, Cambridge, DASH, Dean Ornish, Diabetic Diet, Grapefruit, HMR, Increased exercise, Jenny Craig, LA Weight Loss, Mayo Clinic, MD Supervised, Metabolife, Nutrisystems, Optifast/Medifast, Overeaters Anonymous, Portion control, Prism, Pritikin, Slimfast, South Beach, Sugar Busters, Suzanne Sommers, TOPS, Weight Watchers, Zone

Diet Pills/Medications: Alli, Dexatrim, Meridia, Metabolife, Phen/Fen, Phentermine, Trimspa, Xenical

Physical Activity

Are you able to exercise? ❑ Yes ❑ No

If yes, how often? _____

What type of exercise do you do? _____

If no, please describe the reason(s) why not: _____

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STOP-BANG (Sleep Apnea) Screening Quiz

Do you have symptoms of sleep apnea? Take the STOP-BANG screening quiz and speak to your provider about your score!

Scoring of at least three points is associated with a higher risk of Obstructive Sleep Apnea in the moderate range of severity, or worse. Please count one point for each applicable risk factor and total, the total is the STOP-BANG score.

Risk Factor	Score/Points
Snoring	❑ 0 ❑ 1
Tiredness during the day	❑ 0 ❑ 1
Observed apneas	❑ 0 ❑ 1
High blood **p**ressure	❑ 0 ❑ 1
BMI ≥ 30	❑ 0 ❑ 1
Age ≥ 50	❑ 0 ❑ 1
Neck circumference: Men > 17 inches Women > 16 inches	❑ 0 ❑ 1
Gender (male)	❑ 0 ❑ 1
TOTAL	

Epworth Sleepiness Scale

How likely are you to nod off or fall asleep in the following situations, in contrast to feeling just tired? This refers to our usual way of life in recent times.

Even if you have not done some of these things recently, try to work out how they would have affected you. It is important that you answer each question as best you can.

Use the following scale to choose the most appropriate number for each situation.

Add up your points to get your total score. A score of 10 or greater raises concern: you may need to get more sleep, improve your sleep practices or seek medical attention to determine why you are sleepy.

	Would never nod off 0	**Slight chance of nodding off 1**	**Moderate chance of nodding off 2**	**High chance of nodding off 3**
Sitting and reading				
Watching TV				
Sitting, inactive, in a public place (e.g. in a meeting, theater or dinner event)				
As a passenger in a car for an hour or more without stopping for a break				
Lying down to rest when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a meal without alcohol				
In a car, while stopped for a few minutes in traffic or at a light				

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