

Bariatric Questionnaire

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

I. DEMOGRAPHIC INFORMATION:

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

II. 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

III. MEDICAL HISTORY (check all that apply)

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

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

IV. OB/GYN HISTORY (If applicable)

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

V. SURGICAL HISTORY

- Please list all of your previous surgical procedures
- Surgery _____ Year _____
- Surgery _____ Year _____
- Surgery _____ Year _____

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

VI. CURRENT MEDICATIONS

Please list all prescribed and over-the-counter medications, **including nutritional and herbal supplements** you are currently using.

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

Name, telephone, address of your pharmacy _____

VII. ALLERGY INFORMATION

Please list any known allergies to medications:

Medication _____ Allergic Reaction _____ Medication _____ Allergic Reaction _____
Medication _____ Allergic Reaction _____ Medication _____ Allergic Reaction _____

VIII. SOCIAL HISTORY

Tobacco: Do you currently smoke tobacco? 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? _____

Occupation: Occupation _____ Employer _____ Years at this job _____

IX. 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: _____

X. PREVIOUS DIAGNOSTIC PROCEDURES

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

<u>Test</u>	<u>Date</u>	<u>Test</u>	<u>Date</u>
<input type="checkbox"/> Echocardiogram	_____	<input type="checkbox"/> Upper Endoscopy	_____
<input type="checkbox"/> Stress test	_____	<input type="checkbox"/> CT Scan	_____
<input type="checkbox"/> Cardiac Catheterization	_____	<input type="checkbox"/> Abdominal Ultrasound	_____
<input type="checkbox"/> Pulmonary Function Study	_____	<input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> 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

Information reviewed by Dr. Zaré on ___/___/_____