Patient Questionnaire

Please complete the attached questionnaire in its entirety. First appointment will not be scheduled until this questionnaire has been received.

Name: ___________________________________ Date: ________________

DOB: ___/___/______ Height: __________ Weight: ______________

I am interested in the following procedures (***check all that apply***):

□ Laparoscopic Sleeve Gastrectomy

□ Laparoscopic Roux-en-Y Gastric Bypass

□ Revision of previous bariatric surgery

Social History:

Marital status: □ Single □ Married □ Divorced □ Separated □ Widow □ Life Partner

Who lives in the home with you? ____

□ **Yes** □ **No** Do you have children? If yes, how many do you have? __________

□ **Yes** □ **No** Have you ever used tobacco products?

If yes, did you use (check all that apply):□ Cigarettes □ Cigars □ Pipe □ Chewing tobacco □ Vaping

Quit Date:____________

□ **Yes** □ **No** Do you currently use tobacco products? Packs/Pouches per day:________________

□ **Yes** □ **No** Have you ever used illegal or street drugs? □ Marijuana □ Other

If yes, did you use illegal drugs? □ Rarely □ Occasionally □ Frequently

Have you stopped using street drugs? □ Yes □ No Quit Date:__________

□**Yes** □ **No** Do you use medical Marijuana, If yes: □ inhaled □ edibles

Do you have a current medical marijuana card ? □ Yes □ No □**Yes** □ **No**

Do you drink alcohol?

If yes, How often do you have a drink containing alcohol?

□ Monthly or less □ 2-4x/month □ 2-4x/week □ 4x/week or more

How many drinks containing alcohol do you have on a typical day when you are drinking?

□ 1-2 □ 3-4 □ 5-6 □ 7-9 □ 10 or more

□**Yes** □**No** Have you ever had an addiction problem that required treatment or rehab?

If yes, please check all that apply: □Alcohol □ Illegal (street) drugs □ Prescription drugs

□ Other addiction(s): ________________ Dates of treatment/rehab: _______________

Medical History

Have you ever been diagnosed with:

	Check if Yes	
ENDOCRINE		**Pre Diabetes or High Blood Sugar**
		Diabetes Do you take insulin? □Yes □No Do you take oral diabetic medication? □Yes □No Do you use diet only to treat your diabetes? □Yes □No Is your most recent A1C > 8.0 mg/dl □Yes □No
		Hypothyroidism
		Thyroid Cancer
		Thyroid disease
		Marfans Syndrome
		Sickle cell disease or trait
		Ehlers Danlos Syndrome

PULMONOLOGY		**Asthma** Do you use an inhaler daily? □Yes □No Do you use nebulizer treatments? □Yes □No Do you use oxygen? □Yes □No Have you been hospitalized for asthma □Yes □No
		Do you: □ Snore □ Have daytime sleepiness □ Sleep in a recliner □ Wake up at night trying to catch your breath
		Sleep Apnea Do you use a CPAP? □ Yes □ No
		COPD/Emphysema Do you require oxygen? □Yes □No
		Bronchitis

CARDIAC		**HTN or high blood pressure**
		Leg, ankle, or foot ulcers (venous status ulcers)
		IVC filter placed for blood clots
		Stroke or TIA
		Leg, ankle, or feet swelling
		Blood clots in your legs (DVT)
		High Cholesterol
		Heart Disease
		Heart Attack
		Congestive Heart Failure
		Irregular Heart Beat or Heart Murmur
		Abnormal EKG
		Mitral Valve Prolapse
		Angioplasty
		Angina/Chest Pain

CARDIAC CONT.		**Stent Placement**
		High Triglycerides

GI/STOMACH/INTESTINES		**Acid Reflux/GERD** □ Prescription medication □ Over the Counter medication □ Diet Controlled □ Surgery
		Constipation
		Diarrhea
		Crohn's Disease
		Ulcerative Colitis
		Irritable bowel syndrome
		Hiatal hernia
		cirrhosis
		Hepatitis
		Fatty Liver Disease
		Pancreatitis
		Barrett's esophagus
		Stomach or duodenal ulcer
		Celiac Sprue

HEENT/NEURO (HEAD)		**Memory loss/dementia/Alzheimer's**
		Chronic balance problems (vertigo)
		Pseudotumor cerebri
		Frequent headaches/Migraines

BONES/JOINTS/MUSCLES		**Arthritis** □Rheumatoid arthritis □Osteoarthritis □Degenerative joint disease □Other arthritis not listed above
		Joint pain that limits your activity Circle: Hip, Knee, Ankle, Shoulder, Feet
		Gout
		Cane or Walker to ambulate
		Motorized Scooter
		Herniated Discs
		Back Injury
		Lupus
		Osteoporosis

HEMATOLOGY/ONCOLOGY		**Cancer** If yes, what kind of cancer: _________________
		Clotting/bleeding disorder
		DVT (deep vein thrombosis
		Blood clot in your lung (pulmonary embolism)
		Anemia

BLADDER/KIDNEY		**Urinary Tract Infection**
		Kidney stones
		Chronic Kidney Disease
		Urinary Incontinence
		Renal Failure- acute or chronic
PSYCHOLOGICAL		**Depression** □Yes □No Do you require medications for your depression? □Yes □No Are you currently receiving care by a psychologist, psychiatrist, or therapist for your depression? □Yes □No Is your depression being treated by your family doctor?
		Anxiety/panic attacks If yes, Do you require medications for anxiety? □Yes □No Are you currently receiving care by a psychologist, psychiatrist, or therapist for your anxiety? □Yes □No Is your anxiety being treated by your family doctor? □Yes □No
		Bipolar Disorder If yes, Do you require medications for your bipolar disorder? □Yes □No Are you currently receiving care by a psychologist, psychiatrist, or therapist for your bipolar disorder? □Yes □No Is your bipolar disorder being treated by your family doctor? □Yes □No
		Schizophrenia or any other form of personality disorder or mental illness
		Have you been hospitalized for any form of mental Illness? If yes: Dates of hospitalization: ________________________
		Post Traumatic Stress Disorder
Eating Disorders		**Binge Eating**
		Compulsive Eating
		Food Addiction
		Anorexia
		Bulimia

Other Medical History: ____

Do you see any of the following Specialists? If yes, please provide the specialist's name

Gastroenterology (GI): ______________________

Cardiology: ______________________________

Pulmonology: ___________________________

Nephrology: _________________________

Psychiatrist: __________________________

Endocrinology: __________________________

Hematology: ____________________________

Oncology: ______________________________

Orthopedic: _____________________________

Pain Specialist: ____________________________

Counselor: ______________________________

Other: ____________________________________

MEDICATION LOG (***please include over the counter medications, vitamins, herbal supplements, supplements***)

Medication	Dosage	Frequency	Date Treatment Started

Drug Allergies:

Drug: ____________________________ Reaction: ____

Drug: ____________________________ Reaction: ____

Drug: ____________________________ Reaction: ____

Drug: ____________________________ Reaction: ____

Surgical History: (***Please list all previous surgeries including previous weight loss surgeries***)

Type: ______________________________ Reason: ________________________ Year___________

Type: ______________________________ Reason: ________________________ Year___________

Type: ______________________________ Reason: ________________________ Year___________

Type: ______________________________ Reason: ________________________ Year___________

Type: ______________________________ Reason: ________________________ Year___________

Type: ______________________________ Reason: ________________________ Year___________

Family History (***check all appropriate boxes***):

	Obesity	Cancer	Hypertension	Diabetes	Heart Disease	Lung Disease	Kidney Disease	Bleeding Disorder	Bariatric Surgery
Father									
Paternal Grandfather									
Paternal Grandmother									
Mother									
Maternal Grandfather									
Maternal Grandmother									
Brothers									
Sisters									
Sons									
Daughters									

For Females:

Do you have monthly periods? □Yes □No

If yes: Do you have abnormality heavy or prolonged menstrual periods? □Yes □No

□Yes □No Are you currently going through or in menopause?

□Yes □No Are you currently using oral contraceptives?

□Yes □No Are you currently using any other form of contraception?

□Yes □No Have you ever been diagnosed with polycystic ovarian disease (PCOS)?

If yes:

□Yes □No Are you being treated with oral contraceptives?

□Yes □No Are you being treated with metformin?

□Yes □No Are you being treated with any other medication(s)?

Number of pregnancies: ________ Normal vaginal deliveries: _________ C-Sections: _________

□Yes □No Do you plan to become pregnant in the future

Weight Gain Pattern:

□No pattern

□ Steady, gradual increase of weight over the years

□Sudden increase of weight with pregnancies

□ Variable weight gain/loss due to intermittent diet and exercise (regained weight when stopped program)

Previous Weight Loss Attempts:

Are you currently or have you in the past worked with a Dietitian, Diabetes Educator, or Physician on diet or weight loss:
□ Yes □ No If yes, please describe when, for how long, and what you did:

____

____

____

Are you currently or in the past used prescription or over the counter weight loss medications such as: Meridia, Orlistat (Xenical), Qsymia, Belviq, Fen Phen, Adipex, Alli, HCG injections, Dexatrim, Trim Spa, Metabolife, Stacker III, etc.

□ Yes □ No If yes, please list below.
Name of Medication Year used Length of time Pounds lost

____

____

Please list all previous weight loss attempts not already listed:

Weight loss attempts may include things you've done on your own or part of a structured program such as: Self modifying diet, self-monitoring, diet and exercise, , nutrition classes, Weight Watchers, Medifast, Jenny Craig, Overeaters Anonymous, Atkins, NutriSystem, Optifast, HMR, etc.

Name of diet Year Length of time Pounds lost

____

____

____

____

____

Food Preferences/Tolerances:

Do you have any food intolerances? □ Yes □ No
If yes please list: ___________________________
Do you have any food allergies? □ Yes □ No
If yes please list: _______________________________
List any personal, religious, cultural, ethnic practices or restrictions that affect your health care or diet:

____

Beverages

How much of the following do you drink on an average DAY?

Juice	□ None	□ 1-2 servings	□ 3-5 servings	□ 6+ servings
Regular Soda	□ None	□ 1-2 servings	□ 3-5 servings	□ 6+ servings
Diet Soda	□ None	□ 1-2 servings	□ 3-5 servings	□ 6+ servings
Sweet Tea	□ None	□ 1-2 servings	□ 3-5 servings	□ 6+ servings
Coffee	□ None	□ 1-2 servings	□ 3-5 servings	□ 6+ servings
Milk	□ None	□ 1-2 servings	□ 3-5 servings	□ 6+ servings
Water	□ None	□ 1-2 servings	□ 3-5 servings	□ 6+ servings

Other Beverages: ____

Eating Habits

List which of your current eating and lifestyle habits will be the top 3 most challenging to change or require the most work to maintain? 1: ____

2: _____________________________________3: _____________________________________

1. How many times do you eat in a day (on average)?
   □ Once □ 2-3 times □ 4-6 times □ 7+ times □ No routine - varies
2. How often do you skip meals: □ Rarely □ 2-3 times/week □ 4-6 times/week □ Daily
3. How many times do you eat breakfast in a week?
   □ Rarely □ 2-3 times/week □ 4-6 times/week □ Daily
4. Do you often snack, nibble or graze throughout the day? □ Yes □ No
   If yes, describe snack. ____
5. How long do your meals typically last?
   □ 5 minutes or less □ 5-15 minutes □ 20 – 30 minutes □ 30 minutes or more
6. How often do you feel uncomfortably full after eating?
   □ every meal/daily □ 1-6 times/week □ couple times a month □ less than once a month
7. Where do you typically eat? □ Table □ In front of TV □ Office □ Car/On the go □ Other _________
8. With whom do you typically eat? □ Alone □ With spouse/partner/family/friends/coworkers
9. Meals consumed or prepared away from home (including fast food, sit down, carry out, cafeteria):
   □ ______/day □ ______/week □ ______/month
   Where (list typical choice)?____
10. How often do you consume convenient foods such as: ready-made, boxed meals, frozen entrée?
    □ ______/day □ ______/week □ ______/month
    Please list examples: ____
11. How many servings of fruits or vegetables combined/day are you eating?
    □ 1 serving or less □ 2-3 servings □ 4-5 servings □ Greater than 5 servings
    Please list common choices: ____
12. How often do you consume sweets (candy, cookies, cake, etc)?
    □ ______/day □ ______/week □ ______/month
    List any specific sweets you eat: ____

Daily Activities:

Average hours of sleep per night: __________ Is your sleep restful? □ Yes □ No

How would you rate your daily stress level?

□ Not at all/somewhat stressed □ Moderately stressed □ Very stressed

What things/techniques do you use to manage or reduce stress? _______________________________

How often do you find yourself eating in response to stress, emotions, boredom (in last 6 months)?

□ Never/less than once/month □ 1-3/month □ 1/week □ 2-4/week □ 5+/week

List any specific foods you have at this time: ____

Exercise History:

Do you exercise regularly? ☐ Yes ☐ No

If Yes, describe the type and frequency? ____

If No , Why? ____

What factors interfere with exercise?

☐ Joint Pain ☐ Time Constraints ☐ Shortness of breath ☐ Lack of Motivation ☐ Other Medical Issues

Personal History:

Highest Level of Education: ____________________

Occupation: ________________________ ☐ Full time ☐ Part time

How would you describe your job activity:

☐ Sedentary ☐ Light Activity ☐ Moderate Activity ☐ Heavy Activity

Do you have a support person and how do they feel about your interest in weight loss surgery?

____

Who does your grocery shopping: □ Self

If not self, please list: _________________________________

Who does the cooking: □ Self

If not self, please list: ____

Are you on a limited food budget or rely on food stamps, food pantry, or similar for food:

□ Yes □ No If yes please describe: ____

OTHER RELEVANT INFORMATION PERTINENT TO YOUR DIAGNOSIS OF OBESITY:

____

____

____