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PRE-OP BARIATRIC PATIENT QUESTIONNAIRE

The following information is very important to your health. Please take the time to fully and completely fill out this important information. Thank you.

Name Of Patient _____
Last First Initial

Address _____
Street City, State Zip

Home Phone _____ **Work/Cell Phone** _____

Email _____

Date Of Birth _____ **Age** _____ ☐ Male ☐ Female **Height** _____ **Weight** _____

Primary Insurance Companuy _____

Address _____ **Policy #** _____

Insured's Name: _____ **Phone #:** _____ **Group #** _____

Employer _____ **Social Security #** _____

Secondary Insurance Company _____

Address _____ **Policy #** _____

Insured's Name: _____ **Phone #:** _____ **Group #** _____

Employer _____ **Social Security #** _____

What Type of Work Do You Do? _____

Spouses Employer _____

Race ☐ Caucasian ☐ Black ☐ Asian ☐ Hispanic ☐ Other _____

Marital Status _____ **Number Of Children** _____

Maximum Lifetime Weight _____ **At What Age Became 75# Overweight** _____

Number Of Weight Loss Modes Tried Preop *(Please Provide A Number Even If You Are Unsure)* _____

Counting Yourself, Full Brothers And Sisters And Your Parents, how many Are In Your Family? _____

How Many People In Your Immediate Family Are 75# Or More Overweight? _____

Main Reason For Wanting Weight Loss Surgery: _____

_____

_____

List All Previous Operations

Operations: Date:

1) _____ _____

2) _____ _____

3) _____ _____

4) _____ _____

5) _____ _____

Any blood relatives ever had difficulty or problems with anesthesia? _____

List All Serious Illnesses _____

_____

_____

List Medications *(Do Not Forget Such Things As Aspirin, Cortisone, Thyroid, And Tranquilizers, Hormones, Birth Control, Laxatives, Etc.)*

_____ _____

_____ _____

_____ _____

_____ _____

Allergies *Please List With The Reaction*

Allergy	**Reaction**

Do you have any food allergies ☐ **Yes** ☐ **No** If **YES**, please list

Allergy	**Reaction**

For The Following Five Questions

Answer "**YES**" If They Occur 3 Or More Times A Week-Otherwise Answer "**NO**"

Do You Eat Breakfast?	☐ **Yes**	☐ **No**
Do You Snack At Night?	☐ **Yes**	☐ **No**
Do You Drink Soda Or Other	☐ **Yes**	☐ **No**
Sugary Liquids?	☐ **Yes**	☐ **No**
Do You Eat Desserts	☐ **Yes**	☐ **No**
Fried Foods?	☐ **Yes**	☐ **No**
Do You Binge Eat?	☐ **Yes**	☐ **No**

(Bingeing Means You Ate A Lot More Than You Felt You Should Have).

Are the meals that you eat small, medium or large as compared to normal weight people eating the same meal?
☐ Small ☐ Medium ☐ Large

How Many Days A Week Do You Exercise? _____

How many cigarettes do you smoke a day? (Packs)_____

Do you drink alcohol? ☐ Never ☐ Rarely (2 times a month) ☐ Occasionally ☐ Daily

Have you ever been in a drug rehab program? ☐ Yes ☐ No

Have you ever used drugs? ☐Never
☐ Rarely (less than 5 times)
☐ Occasionally (more than 5 times in life)
☐ Daily (daily for 2 weeks or more at some point in your life)

Have you ever seen a psychiatrist? ☐ Yes ☐ No
If **YES**, Please Supply Name, Address, And Telephone #_____

_____

Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No

Are you employed? ☐ Yes ☐ No

Are you satisfied with your social life? ☐ Yes ☐ No

With regards to your body weight, how do you see yourself as being?
☐ Less Than Normal Weight
☐ Normal Weight
☐ Overweight (75# Or Less)
☐ Very Overweight (More Than 75# Overweight)

Using the same criteria, do you believe that others perceive you the same way? ☐ Yes ☐ No
Were you ever severely abused? *(check all that apply)* ☐ Emotionally ☐ Physically ☐Sexually
Are you satisfied with your sex life? ☐ Yes ☐ No
How would you rate your self-esteem level? ☐ Low ☐ Normal ☐ High
Have you been told that you have gallstones? ☐ Yes ☐ No
Have you ever been diagnosed or treated for diabetes? ☐ Yes ☐ No
If so, were you prescribed medication? ☐ No ☐Oral Med ☐Insulin
Have you been diagnosed or treated for high blood pressure? ☐ Yes ☐ No
If **YES**, were you prescribed medicine? ☐ No ☐1 Med ☐ 2 Meds ☐ 3 Or More
Have you ever been treated or diagnosed with asthma? ☐ Yes ☐ No
If so, were you prescribed medication? ☐No Inhaler ☐ Oral Med ☐ Steroids

Does any one in your immediate family (Father, Mother, Brothers, Sisters, Grandparents) have any of the following?

☐ Cancer?	If So,	Who_____	Type:_____
☐ Diabetes?	If So,	Who_____	
☐ High Blood Pressure?	If So,	Who_____	
☐ Heart Disease?	If So,	Who_____	
☐ Gall Stones?	If So,	Who_____	

Do you have menstrual difficulties? ☐ None ☐ Irregular Periods ☐ Heavy Periods ☐ Painful

How would you rate your energy level? ☐ Low ☐ Medium ☐ High

In the past year, has anyone told you that you held your breath for a long time while asleep? ☐ Yes ☐ No

For the following questions, answer "YES" if this occurs 2 or more days per week-otherwise answer "NO"

Do you lose small amounts of urine with coughing or straining? ☐ Yes ☐ No
Do you have heartburn? ☐ Yes ☐ No
Bloating or bloated feeling? ☐ Yes ☐ No
Belching, burping after meals? ☐ Yes ☐ No
Unusual fullness after eating? ☐ Yes ☐ No
Do you have swelling of the ankles? ☐ Yes ☐ No
Shortness of breath after climbing stairs? ☐ Yes ☐ No
Do you have joint pain? Back ☐ Yes ☐ No
Ankle ☐ Yes ☐ No
Foot ☐ Yes ☐ No
Do you have restless sleep or frequent awakening? ☐ Yes ☐ No
Do you have night sweats? ☐ Yes ☐ No
Do you snore? ☐ Yes ☐ No
Do you have daytime sleepiness? ☐ Yes ☐ No
Do you have morning headaches? ☐ Yes ☐ No

Respiratory

Spitting of blood? ☐ Never ☐ Past ☐ Present
Bronchitis? ☐ Yes ☐ No
Emphysema? ☐ Yes ☐ No
How many blocks can you walk without having to stop to catch your breath? _____
Year of last chest xray? _____ Results? _____

Cardiovascular

Chest Pain Or Angina? ☐ Never ☐ Past ☐ Present
Heart Murmur? ☐ Never ☐ Past ☐ Present
Have You Ever Had Palpitations/Arrhythmia? ☐ Yes ☐ No
Varicose Veins? ☐ Never ☐ Past ☐ Now
Have You Ever Had Blood Clots Or Phlebitis? ☐ Yes ☐ No
Year Of Last EKG _____ Results _____
Where At? _____

Gastrointestinal

Tarry Black Stool Or Blood In Bowel Movements? ☐ Yes ☐ No ☐ Now
Crampy Abdominal Pain? ☐ Yes ☐ No ☐ Now
Chronic Constipation? ☐ Yes ☐ No ☐ Now
Frequent Diarrhea? ☐ Yes ☐ No ☐ Now
Hemorrhoids? ☐ Yes ☐ No ☐ Now
Have you been diagnosed as having stomach or intestinal ulcers or other disorders of the gastrointestinal system? ☐ Yes ☐ No ☐ Now
Have you had hepatitis or liver problems? ☐ Yes ☐ No ☐ Now
Ever vomit blood? ☐ Yes ☐ No ☐ Now

Genitourinary

Have you had kidney problems? ☐ Yes ☐ No ☐ Now
Have you had gynecologic problems? ☐ Yes ☐ No ☐ Now
Burning or painful urination? ☐ Yes ☐ No ☐ Now
Frequent urination? ☐ Yes ☐ No ☐ Now
Feeling you must go immediately? ☐ Yes ☐ No ☐ Now
Blood in urine? ☐ Yes ☐ No ☐ Now
Kidney stones? ☐ Yes ☐ No ☐ Now
Are you or might you be pregnant? ☐ Yes ☐ No ☐ Unsure

Musculoskeletal

Arthritis, swollen or painful joints? ☐ Yes ☐ No ☐ Past

Pain in calves or buttocks when walking that is relieved by rest? ☐ Yes ☐ No ☐ Past

Skin

Frequent infections? ☐ Yes ☐ No ☐ Past

Unusual moles or lumps? ☐ Yes ☐ No ☐ Past

Please describe_____

Head

Eye disease or injury? ☐ Yes ☐ No ☐ Past

Double vision? ☐ Yes ☐ No ☐ Past

Headaches? ☐ Yes ☐ No ☐ Past

Epilepsy or seizures ☐ Yes ☐ No ☐ Past

Emotional

Do you have trouble sleeping? ☐ Yes ☐ No ☐ Past

Are you usually tired? ☐ Yes ☐ No ☐ Past

Are you often depressed? ☐ Yes ☐ No ☐ Past

Anxious or nervous? ☐ Yes ☐ No ☐ Past

Do you ever wish you were dead and away from it all? ☐ Yes ☐ No ☐ Past

Hematologic

Anemia? ☐ Yes ☐ No ☐ Past

Excessive bleeding or bruising? ☐ Yes ☐ No ☐ Past

Ever received blood transfusions? ☐ Yes ☐ No ☐ Past

Endocrine

Hormone Therapy? ☐ Yes ☐ No ☐ Past

Thyroid Problems? ☐ Yes ☐ No ☐ Past

Methods of weight control used in the past:_____

_____

Doctor supervised programs (weight loss pills etc) please supply name and address of Dr. who prescribed.

_____

_____

_____

Patient of Mercy Weight Management Clinic at Regency? ☐ Yes ☐ No

Surgical Weight Loss Procedures *(please explain, give facility and dates, physician, etc)*

- ☐ Vertical Band Gastroplasty _____
- ☐ Vertical Ring _____
- ☐ Roux En Y Gastric Bypass _____
- ☐ Gastric Sleeve _____
- ☐ Duodenal Switch _____
- ☐ Lap Gastric Band _____

Please Provide Full Name, Address, And Phone Number Of Your Personal Physician.

Physician's Name: _____

Address: _____

City, State Zip: _____

Area Code and Telephone #: _____

Pharmacy Name _____

Address and Telephone _____

THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY BELIEF

Patient Signature: _____ Date: _____

Self Diet *(please explain and document attempts)*

- ☐ Slim Fast _____
- ☐ Dieters Tea _____
- ☐ Accutrim _____
- ☐ Dexatrim _____
- ☐ Calban _____
- ☐ Caolrad _____
- ☐ Hoodia Blast _____
- ☐ Blast and Burn _____
- ☐ Alli _____
- ☐ Fasting _____
- ☐ Other _____

_____

_____

Nutritional Programs *(Please Explain, Give Facility And Dates)*

In Hospital_____ When_____

Hospital/Clinic_____ When_____

Outpatient_____ When_____

Please List Exercise Programs: *(YMCA, Aerobics, Walking, Videos, Etc)*

How many days do you miss from work, etc., related to weight conditions? (please provide examples: back or joint pain, reflux, Doctor appointments, etc)_____

_____