

Your Name _____ Your Date of Birth _____

Medical Information Questionnaire

Your height (inches) _____ Your weight (pounds) _____

How did you become interested in Bariatric Surgery, and how did you learn about our practice? _____

What problems is obesity causing for you? _____

What are your main motivating factors for surgery? _____

How do you think Bariatric Surgery may help you? _____

What was your weight at the following times in your life?

6th grade _____ At your wedding _____

High School Graduation _____ Birth of 1st child _____

Age 21 _____ Age 40 _____

Age 30 _____ Age 50 _____

What has been your maximum weight? _____

What has been your lowest weight (not due to illness) after age 21, which you have maintained for at least 1 year? _____ lbs at _____ yrs old, maintained for _____ yrs.

Was this weight reached after a weight loss effort? (*circle one*)..... yes/no

Check the statement that best describes you: "During the past 6 months my weight has ..."

- decreased more than 10 lbs
- decreased 5-10 lbs
- stayed about the same
- increased 5-10 lbs
- increased more than 10 lbs

Physician Information: Please list all doctors that you have seen and are helping in your care:

| Name MD or DO or other (NP, PA) | Address | Phone | Specialty, Primary, or other Please list type |
|--|---------|-------|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

Please list your medical problems and year diagnosed.

| | | | |
|---|--|----|--|
| 1 | | 8 | |
| 2 | | 9 | |
| 3 | | 10 | |
| 4 | | 11 | |
| 5 | | 12 | |
| 6 | | 13 | |
| 7 | | 14 | |

A list of common medical diagnoses is listed as a reminder for you:

- Diabetes
- High Blood pressure (Hypertension)
- Sleep Apnea, Pickwickian syndrome
- Asthma, Reactive Airway Disease
- Heart Failure
- Angina, Coronary Artery Disease
- Gallstones
- GE Reflux disease (“GERD”)
- Arthritis
- Back pain
- Urinary incontinence
- Menstrual irregularity, infertility
- Hirsutism
- Venous thrombosis (DVT) or PE
- Cancer (type?)
- Depression
- High cholesterol, high lipids
- Hypothyroidism
- Other Endocrine problem
- Other??

Have you been treated at a hospital (inpatient or outpatient) within the last year? _____

If yes, please provide further information: _____

Please list your past surgical history and year surgery performed.

| | | | |
|---|--|----|--|
| 1 | | 6 | |
| 2 | | 7 | |
| 3 | | 8 | |
| 4 | | 9 | |
| 5 | | 10 | |

Have you undergone any surgical procedure for obesity in the past? _____ *If so:*

Name of Procedure: _____ When performed: _____

Name of Surgeon: _____ Office location: _____

Your weight prior to that procedure _____

Maximum weight lost, or lowest weight after surgery: _____

Reason you are seeking another surgical evaluation: _____

More than one prior surgical procedure for weight loss? _____

Have any of your family members or close friends undergone weight loss surgery? If yes, please describe:

Are you **allergic** to any medications? Yes No

If yes, please list: *please describe your reaction to the medications listed*

Please list all medications that you are currently taking:

| | Medication | Strength | How many at one time | How many a day |
|----|---------------------|----------|----------------------|----------------|
| | Example: TYLENOL | 250 mg | 2 | twice a day |
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |
| 11 | | | | |
| 12 | | | | |
| 13 | | | | |
| 14 | | | | |

Do you take birth control pills, or any hormone related medications? _____

Do you use any non-prescription (over-the-counter) drugs, vitamins, or herbal remedies? Please describe:

General Symptom Review:

Circle a number that corresponds with your general energy level:

(1 = lowest, 5 = highest)

1 2 3 4 5

Have you experienced more than one week of fever in the last year? yes/no

Do you have severe headaches? yes/no

Have you experienced any visual changes in the last year? yes/no

Do you fall asleep unexpectedly? yes/no

Do you snore loudly? yes/no

Do you wake frequently at night? yes/no

How many times? _____

Do you experience shortness of breath with exercise? yes/no
Do you experience chest pain with exercise? yes/no
How many flights of stairs can you climb without stopping? _____
How many times per week do you have heartburn? _____
Do you experience abdominal pain or nausea after eating fatty foods? yes/no
Do you have difficulty swallowing, or feel a “catching” sensation
when eating thick or bulky foods?..... yes/no
Do you have difficulty with leaking of urine when you cough or laugh? yes/no
Have you had more than one urinary infection in the last year? yes/no
Do you have persistent skin irritation, rash, ulcers? yes/no
Where? _____
Do you have severe joint pain? yes/no
What joints are worst? _____
Do you have persistent ankle or foot pain? yes/no
Have you noticed any changes in your hair in the last year? yes/no
Have you noticed any changes in your energy level in the past year? yes/no
Has your thyroid function been checked by your physician in the past? yes/no
Do you feel depressed or hopeless? yes/no
Have you ever had a blood clot in your legs or lungs? yes/no

Family History:

Has anyone in your immediate family had any of the following diseases? (*use: M = mother, F = father, S = sister, B = brother, G = grandparent*)

Diabetes _____
Hypertension _____
Severe Obesity _____
Cancer (what type?) _____
Blood Clotting _____

Social History:

Are you married? Yes/No/Divorced If married, how long? _____
If you have children, please list their names and ages below.

Where do you work? What does your job involve? How long have you had this job?

Do you smoke now? _____ How much? _____ How many years? _____

Did you ever smoke? ___ *If yes:*

How many packs/day? _ How many years? _____

When did you quit? _____

Do you drink alcohol? _____ If so, how much? _____

Do you use drugs like marijuana, cocaine, etc? _____

What do you aim for your weight to be, five years from now? _____

Diet History:

List the supervised diet plans you have tried in your life (supervised diets include the following: Physician/dietitian supervised diet, Weight Watchers, Medifast, Optifast, LA Weight Loss center, Jenny Craig and others). Do not list unsupervised diets like Atkins, Slimfast, or anything else that you have done on your own.

| Year | Supervised | Diet Name | Duration 3,6,9 months etc. | Wt. Lost | Wt. Regained Y or N | Documentation Available Y or N |
|------|------------|-----------|-------------------------------|----------|------------------------|--------------------------------------|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Please list below any medication you have tried including: Phen-fen, Phenteramine, Meridia, Redux, Xenicol, or Metabolife.

| Year | Supervised | Diet Name | Duration 3,6,9 months etc. | Wt. Lost | Wt. Regained Y or N | Documentation Available Y or N |
|------|------------|-----------|-------------------------------|----------|------------------------|--------------------------------------|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

What is the most weight you have lost during any diet program? _____

Dietary History:

1. Are you a vegetarian? Yes No

If yes, what type? Vegan Lacto-ovo

Answer each question to the best of your ability. Circle your responses in both the frequency and time frame sections

| How Often Do You: | Frequency Circle One | | | | | | | | Time Frame Circle One |
|---|-------------------------|---|---|---|---|---|---|---|--------------------------|
| | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| 1. Drink 100% juice | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 2. Drink other fruit drink | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 3. Drink regular soda | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 4. Drink diet soda | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 5. Drink coffee | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 6. Drink tea | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 6. Drink alcohol | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 7. Drink milk (any kind, i.e, whole, skim, soy, etc.) | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 8. Eat yogurt | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 8. Drink water (#of glasses) | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 9. Have meal replacement drinks | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |

| | | | | | | | | | |
|---------------------------------|-------|---|---|---|---|---|---|---|----------------------|
| 10. Eat beef | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 11. Eat pork | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 12. Eat chicken | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 13. Eat turkey | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 15. Eat fish | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 16. Eat cheese | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 17. Eat cottage cheese | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 18. Eat eggs | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 19. Eat fruits | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 20. Eat vegetables | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 21. Eat fried foods | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 22. Eat fast food | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 23. Eat at restaurants | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 24. Use artificial sweetener | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 25. Binge eat | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 26. Purge(make your self vomit) | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 27. Take a vitamin supplement | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| 28. Take a herbal supplement | Never | 1 | 2 | 3 | 4 | 5 | 6 | 7 | per day/ week/ month |
| Name Type(s)_____ | | | | | | | | | |

Dietary History (cont.):

2. How many meals do you eat per day?_____ How many snacks? _____

3. Do you have any food allergies? Yes No If yes please list _____

4. Do you have any food intolerances? Yes No. If yes please list _____
