

Barrington Surgeons Bariatric Surgery Questionnaire

Name: _____ DOB: _____ Age: _____

Home: _____ Cell: _____ Work: _____

Primary Care Provider's Name: _____

Primary Care Provider's Address: _____

Bariatric Surgery

How long have you been considering weight loss surgery? _____

How did you hear about us? _____

Which operation would you prefer?

- Laparoscopic roux-en-y gastric bypass
- Laparoscopic adjustable gastric band
- Laparoscopic sleeve gastrectomy

What have been your main sources of information about weight loss surgery? _____

Do you know other people that have had surgery for morbid obesity? Yes ___ No ___

Have those operations been successful? Yes ___ No ___

Are your family and friends supportive of your decision to undergo an operation to help you lose weight?

Why do you want bariatric surgery? _____

Weight History

Age	Maximum Weight	Important Events (pregnancy, marriage, etc.)
0-13		
13-18		
18-30		
30-40		
40-50		
2 years ago		
5 years ago		

Diet History

List the diets, diet programs and/or medications that you have tried (including approximate dates and amount of weight lost).

Program	Dates	Weight Loss	Weight Regained	Physician Supervised? Y/N	Dietician Supervised? Y/N

Obesity Related Medical Problems

- | | | |
|---|--|--|
| <ul style="list-style-type: none"> ○ Diabetes ○ High Blood Pressure ○ Sleep Apnea ○ Asthma ○ Shortness of Breath with exertion ○ Low back pain ○ Joint pain ○ Arthritis ○ High cholesterol | <ul style="list-style-type: none"> ○ High triglycerides ○ Heartburn (GERD) ○ Stress Urinary Incontinence ○ Heart Failure ○ Peripheral Edema (swelling of the legs and ankles) | <ul style="list-style-type: none"> ○ Varicose veins or Venous stasis problems ○ Deep Venous Thrombosis (Blood clots in your legs) ○ Pulmonary embolus |
|---|--|--|

Other Medical Problems

- | | | |
|--|---|--|
| <ul style="list-style-type: none"> ○ Bipolar ○ Schizophrenia ○ Depression ○ History of sexual abuse ○ Migraine headaches ○ Abnormal bleeding or bruising | <ul style="list-style-type: none"> ○ Seizure or epilepsy ○ Cancer ○ Osteoporosis ○ Anemia ○ Menopause ○ Plan to become pregnant | <ul style="list-style-type: none"> ○ Liver problems or Hepatitis ○ Rheumatic fever ○ Tuberculosis ○ Other: _____ _____ _____ |
|--|---|--|

List any hospitalizations you have had for an illness or accident not requiring surgery:

1. _____
2. _____
3. _____
4. _____

List any previous operations you have had:

<u>Operation</u>	<u>Date</u>	<u>Problems</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Medications

Medication	Dosage	Number of times taken per day

Please attach a separate sheet if necessary.

Allergies

<u>Medication/medical product</u>	<u>Type of reaction</u>
1. _____	_____
2. _____	_____
3. _____	_____

Habits

Have you ever smoked?

- Never
- Yes, but I quit ____ years ago, and smoked about ____ packs per day for ____ years
- Yes, I smoke ____ packs per day and have smoked for ____ years

Do you drink alcoholic beverages?

- Yes, more than 7 drinks per week
- Yes, less than 7 drinks per week
- I used to drink, but I quit
- No

Do you use any recreational or illegal drugs? Yes____ No____

Family History

(Please explain which relative and type of problem in the space provided)

- Heart Disease _____
- Diabetes _____
- Lung disease _____
- Stroke _____
- Kidney Disease _____
- Liver disease _____
- Cancer _____
- Rheumatoid arthritis _____
- Alcoholism _____
- Mental illness _____
- Other illnesses that run in your family _____

Have you or any of your blood relatives had a serious problem with anesthesia?

- No
- Yes, Please specify which one and the type of reaction: _____

List the approximate weights of all family members. (ideal and overweight)

Maternal Grandmother _____ Paternal Grandmother _____

Maternal Grandfather _____ Paternal Grandfather _____

Mother _____ Father _____

Sister(s) _____ Brother(s) _____

Children _____

General Symptoms

Do you currently have any of the following symptoms?

- Chest pain
- Blackouts or periods of dizziness
- Chest palpitations or irregular heart beats
- Swelling of the ankles
- Shortness of breath when walking up one flight of stairs
- Chronic cough or phlegm production
- Blood in your phlegm production
- Black or tarry stools
- Diarrhea
- Frequent or new constipation
- Temporary loss or blurring of vision
- Temporary weakness of one or more limbs
- Facial weakness or numbness
- Burning with urination or frequent urination
- Arthritis or severe joint pains
- Back pain
- Excessive bleeding following minor cuts or dental surgery
- Pregnancy
- Fever
- Weight gain or loss greater than 10 pounds in the past 3 months

Social History

Who lives with you? _____

What is your occupation? _____

How many hours a day are you employed outside your house? _____

How many hours a day do you watch TV? _____

If you are disabled, it is because: _____

Could someone help care for you if you were seriously ill? _____

Are there people for whom you are the primary care giver? _____

What hobbies do you have that are important to you? _____

Have you used any of the following to control your weight?

- Bingeing and purging
- Bingeing followed by food restriction
- Vomiting
- Diuretics
- Laxatives

Current Habits

How many carbonated beverages do you drink a day? _____ Diet or Regular?

How many times a week do you eat out? _____ In a Fast Food restaurant (Yes ___ No ___)

How much water do you drink a day? _____

How much milk do you drink a day? _____ Which Type? _____

How many cups of coffee do you drink a day? _____ Decaffeinated or Regular?

Do you drink alcoholic beverages? Yes___ No___

If yes, describe weekly intake_____

Who does the cooking in your household? _____

Who does the food shopping in your household? _____

How many meals a day do you eat? _____

Do you snack? Yes___ No___

If yes, please describe _____

Do you eat in the middle of the night? Yes___ No___

How many calories do you think you eat a day? _____

Why do you think you are overweight? _____

Exercise

Do you exercise? Yes___ No___

If yes, please describe _____

If no, what is the most strenuous physical activity that you do in a week _____

Which of the following activities can you do without stopping to rest?

- Walk to a building from a distant parking spot
- Climb one flight of stairs
- Climb two flights of stairs
- None of the above

If you stop to rest, what are the main reasons you stop? (check all that apply)

- Shortness of breath
- Fatigue
- Chest pain
- Joint discomfort
- Back pain
- Other: _____

Thank you for completing this questionnaire. It will help your surgeon understand your health more thoroughly.

I have carefully completed this questionnaire in its entirety and have reported all of my medical history. This is complete, accurate and correct to the best of my knowledge.

Patient Signature and Date