

Hamot Bariatric Surgery Center
 104 East 2nd Street, Erie PA 16507
 Tel: (814) 877 – 6997 or (800) 248-0227 Fax: (814) 877-6356

PATIENT QUESTIONNAIRE BEFORE WEIGHT LOSS SURGERY FOR MORBID OBESITY

Patient Information:

Last name, first, middle initial		Date of Birth	Sex	Marital Status M D S W	
Street Address		Home Phone		E-mail Address	
City	State	Zip Code	Work Phone		Telefax Number
Social Security Number			Occupation / Type of Work		
Employer's Name			Employer's Street Address		
Emergency Contact:		Relationship	City	State	Zip Code
Street Address			Religious Preference		Do you smoke?
Home Phone		Cell Phone		Primary Care Physician	

Insurance Information:

Primary Insurance	Secondary Insurance
Address	Address
Customer Service Phone Number	Customer Service Phone Number
Policy or ID Number	Policy or ID Number
Subscribers Name	Subscribers Name
Relationship to Patient	Relationship to Patient
Subscriber's Employer	Subscriber's Employer

How did you hear about us? (circle one and complete information) **Lecture:** Date: _____ **Friend:**

(Name) _____ **Internet:** website:www.----- **Other:**-----

I authorize release of medical information necessary to process claims for health insurance and disability benefits.

A copy of this authorization will be accepted as valid as the original.

Signature: _____ **Date:** _____

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TO BE COMPLETED BY THE STAFF:		Date:	
Age:	Height:		
Actual Body Weight:		BMI:	
Ideal Body Weight:		Waist: (inches)	Hips: (inches)
Excess Body Weight:		Neck: (inches)	
Target Body Weight:			
Body Frame (Circle One)	Small Medium Large		

PATIENT HISTORY QUESTIONNAIRE

The information requested in this questionnaire is very important. To give you the best care, and to obtain your insurance approval, we must have complete answers. Please be thorough.

WEIGHT HISTORY

Please estimate as closely as possible for all that applies.

Life Event	Age	Weight
Birth Weight:		
Start of High School:		
High School Graduation:		
Marriage:		
1 year ago:		
3 years ago:		
5 years ago:		
10 years ago:		

1. **Adult Lowest weight** (after age of 18): _____ pounds

2. **Adult Highest weight** (after age of 18): _____ pounds

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PATIENT-REPORTED DIET ISSUES:

Grazer: (do you “pick” throughout the day? Do you seem to be “always eating something?”)

yes no PLEASE DESCRIBE: _____

Night-eater: (do you routinely eat after dinner, before bed, in the middle of the night?)

yes no PLEASE DESCRIBE: _____

Binge-eater: (eat large quantities at one time: ex: a whole bag of chips, container of ice cream, breads, pasta?)

yes no PLEASE DESCRIBE: _____

Voluntary overeating: (do you eat large portions?)

yes no PLEASE DESCRIBE: _____

Dietary fat intake: (is your diet high in fat? Ex: fried foods, fast foods, cakes, cookies, chips, “junk food”?)

yes no PLEASE DESCRIBE: _____

Socioeconomic factors: (do you feel your income limits you to the types of foods you purchase?)

yes no PLEASE DESCRIBE: _____

Psychosocial factors: (“emotional eater” -do you eat because you’re stressed, bored, depressed, angry, etc)

yes no PLEASE DESCRIBE: _____

Genetic disorders/factors: (do you have any genetic disorders that contribute to obesity or is there a family history of obesity?)

yes no PLEASE DESCRIBE: _____

Sedentary lifestyle: (are you physically inactive? Has inactivity contributed to weight gain?)

yes no PLEASE DESCRIBE: _____

Ethnic factors: (has your family background /cultural food choices contributed to weight gain?)

yes no PLEASE DESCRIBE: _____

Medication-induced: (have any medications caused you to gain weight?)

yes no PLEASE DESCRIBE: _____

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DIETARY HISTORY

Approximate age when you first seriously dieted: _____

List the diets, programs and medications you have tried:

<u>PROGRAM:</u>		Dates	Duration	MD Supervised (yes/no)	Max Loss
Jenny Craig	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
Nutri-System	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
Weight Watchers	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
LA Weight Loss	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
Opti/Medi Fast	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
T.O.P.S.	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
O.A.	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
Other: (exercise, Curves)	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____

MEDS:

Fen/Phen/Redux	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
Meridia	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
Xenical	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
Other Meds:	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
“Over The Counter” Meds:	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____

(ex: dexatrim, stackers, Trim Spa, Metabolite, Hebalife, appetite suppressants, etc.)

FAD DIETS:

Atkins	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
South Beach	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
Zone	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
Cabbage Soup	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
Grapefruit	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
Fasting	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
Hypnosis	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
Acupuncture	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
Slimfast/Meal replacement	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____
Other	yes <input type="checkbox"/> no <input type="checkbox"/>	_____	_____	_____	_____

• What was your **LONGEST WEIGHT LOSS ATTEMPT/TREATMENT**: Months: ___ Years: ___ Weight Lost: ___ lbs

TYPE: what did you do to lose the weight? _____

-Maintained? yes no -Regained? yes no - Regained Plus? yes no - if yes, _____ lbs

List any physician-supervised/dietitian-supervised documented weight loss attempts _____

List all other diets and/or weight loss attempts: (ex: calorie counting, carbohydrate counting, food groups, etc.) _____

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WEIGHT RELATED ILLNESSES (CPT code to be filled in by office staff)

Have you had, or do you have, any of the following illnesses or symptoms?

1. Heart Disease yes no
 CPT CODE _____
 ◆ year diagnosed _____
(check all that apply to you)
 Angina
 M.I. (myocardial infarction or heart attack)
 CABG (coronary artery bypass graft)
 Abnormal EKG
 Stress test to rule out cardiac problems
 Palpitations
2. High Cholesterol yes no
 CPT CODE _____
 ◆ year diagnosed _____
 ◆ list medications _____

 ◆ Physician who diagnosed _____
 high triglycerides CPT CODE _____
3. High blood pressure yes no
 CPT CODE _____
 ◆ year diagnosed _____
 ◆ average pressure _____
 ◆ list medications _____

 ◆ list dietary restrictions _____
4. Diabetes yes no
 CPT CODE _____
 ◆ year diagnosed: _____
 ◆ gestational: yes no
 ◆ neuropathy yes no
 ◆ type of treatment: diet
 insulin
 oral medications (list below) _____

 ◆ last fasting bld sugar: _____
5. Asthma yes no
 CPT CODE _____
 ◆ year diagnosed: _____
 ◆ ER visits in last 2 years: _____

 ◆ hospitalizations in last 2 years: _____

 ◆ steroids used in last 2 years: yes no
6. Shortness of breath yes no
 CPT CODE _____
 ◆ can walk on level ground how long: _____ blocks(12 blocks = 1 mile)
 ◆ how many stairs: _____ flights
 *Count only stairs going up, not down (10 steps = 1 flight)

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7. Sleep Apnea Syndrome yes no
 CPT CODE _____

- ◆ year diagnosed: _____
- ◆ last sleep study: _____ month/year
- ◆ CPAP used: yes no
- ◆ CPAP setting: _____ cmH₂O
- ◆ morning headaches yes no
- ◆ daytime drowsiness yes no
- ◆ restless sleep yes no
- ◆ snoring yes no
- ◆ awakenings a night yes no
- ◆ observed apnic episodes yes no
- ◆ family history of sleep apnea yes no

sleep study ordered _____ initials where _____

8. Obesity hypoventilation syndrome? yes no
 CPT CODE _____

9. Coughing or choking at night? yes no
 CPT CODE _____

10. Heartburn/esophagitis/hiatus hernia? yes no
 CPT CODE _____

- ◆ year diagnosed: _____
- ◆ upper GI series? yes no
- ◆ endoscopy? yes no
- ◆ medications: _____
- ◆ frequency of use: _____

UGI/endoscopy ordered _____ initials

11. Belching acid or sour fluid in back of throat? yes no
 CPT CODE _____

12. Gallbladder disease? yes no
 CPT CODE _____

- ◆ how was it diagnosed? ultrasound physical exam
- ◆ was your gallbladder removed? yes no

13. Peptic Ulcer disease yes no
 CPT CODE _____

- ◆ how was it diagnosed? Upper GI Endoscopy
- ◆ diagnosed to have H. Pylori infection of stomach yes no
- ◆ treatment given for H. Pylori yes no When _____

14. (For female patients only) Leakage of urine with laughing/coughing/sneezing? yes no
 CPT CODE _____

- ◆ wears pads frequently? yes no

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15. Low back strain/pain/sciatica? yes no Attributed to weight. Year Diagnosed _____
 CPT CODE _____

◆ seen by chiropractor / orthopedic surgeon / family physician / none (Circle One)

◆ medications taken: _____

◆ frequency and dose: _____

16. Pain in joints? (Check affected joints and mention the worse side)
 CPT CODE _____

Hips Knees Ankles Feet Neck Shoulders Heels Hands/Wrists

◆ seen by chiropractor / orthopedic surgeon / family physician / none (Circle One)

◆ medications taken: _____

◆ frequency and dose: _____

Attributed to weight. _____

17. Weight related injuries and trauma: (e.g. twisted ankles, etc)
 CPT CODE _____

18. Circulatory Problems

◆ venous stasis disease yes no CPT CODE _____

◆ edema yes no CPT CODE _____

◆ history of DVT (blood clot) yes no CPT CODE _____
 location: _____

◆ history of Pulmonary Embolism (PE) yes no CPT CODE _____

◆ history of varicose veins yes no CPT CODE _____

19. Thyroid disease? yes no
 CPT CODE _____

◆ Mark One:

Hyperthyroid (High) Hypothyroid (Low)

◆ are you presently taking medications? yes no name: _____

◆ other endocrine diseases: (e.g. Cushing's disease) _____ CPT CODE _____

20. (For female patients) Menstrual periods regular irregular

21. (For female patients) Infertility

◆ are you suffering from infertility yes no

◆ are you taking any medications for infertility yes no

◆ medications taken: _____

SYSTEM REVIEW

Please circle all symptoms you **CURRENTLY** experience. Feel free to add any additional problems or information.

1. **GENERAL:** Headache, dizzy spells, fatigue, weakness, marked weight loss, night sweats, persistent fever, sensitivity to heat, sensitivity to cold.
2. **EYES:** Blurry vision, double vision, halos around lights, loss of night vision, trouble seeing, eye pain, floaters, inflamed eyes, cataracts, wearing glasses or contact lenses, blindness, spots.
3. **EARS:** Loss of hearing, tinnitus, discharge from ear, ear ache, vertigo, frequent ear infections.
4. **NOSE:** Stuffy nose, hay fever, loss of smell, sinus trouble, frequent colds, obstruction to breathing, excessive rhinorrhea, epistaxis, snoring.
5. **MOUTH:** Oral lesions, dentures, sore mouth, sore gums, sore tongue, bleeding gums, dental problems, tooth aches.
6. **THROAT:** post nasal drainage, sore throat, hoarseness, difficulty swallowing, goiter, neck stiffness, painful swallowing
7. **RESPIRATORY:** cough – wheezing – shortness of breath at night – use of two pillows – blood in sputum – out of breath with exertion – wake up at night short of breath – wake up at night coughing or choking – asthma – emphysema – bronchitis
8. **CARDIOVASCULAR:** palpitations – pounding heart – skipping heartbeat – pains in chest – pains in neck – pains in arms – squeezing of chest – heart attacked – heart murmur – abnormal electrocardiogram – irregular heartbeat – high blood pressure – pains in legs – cold feet – blue toes – blue fingers – loss of pulses
9. **GASTROINTESTINAL:** heartburn – nausea – vomiting – belching fluid in throat – burning in throat – food sticking in chest – pains in stomach – burning in stomach – acid stomach – diarrhea – constipation – pain with bowel movement – blood in stools – hemorrhoids – fissures – cramps – gassiness – irritable colon – colitis
10. **GENITOURINARY:** pain with urination – trouble starting urine – trouble stopping urine – small urine stream – blood in urine – kidney stones – bladder stones – kidney failure – nephritis – urinary tract infections – frequent urination – getting up at night to urinate – leakage of urine with cough or sneeze
 - ◆ **Men:** discharge from penis – loss of erection – painful erection
 - ◆ **Women:** vaginal discharge – vaginal bleeding – pain with intercourse – irregular periods
11. **ENDOCRINE (GLANDULAR):** low thyroid – hyperthyroid – goiter – Grave’s Disease – thyroid nodules – x-ray to thyroid – diabetes – adrenal gland tumor – frequent flushing – frequent heavy sweating
12. **MUSCULOSKELETAL:** pain in joints – swelling of joints – redness of skin over joints – warm joints – fluid in joints – arthritis – broken bones – sprains – low back pain – hip pain – knee pain – ankle pain – foot pain – flat feet – slipped disc – herniated disc – sciatica
13. **NEUROLOGICAL:** dizziness – vertigo – falling to the side – falling at night – numbness – tingling – pins and needles feelings – weakness of any muscles – twitching of muscles – weakness of grip – shakiness – tremors – fainting – convulsions – fits – loss of consciousness
14. **PSYCHOLOGICAL:** nervousness – anxiety – depression – thoughts of suicide – suicide attempts – hospitalization for emotional problems – psychiatric treatment – psychological counseling

How did you learn about weight loss surgery?

- friend/colleague/relative internet. Website _____
 tv shows _____ newspaper/journal articles _____ information seminars/support group meetings _____
 other _____

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FAMILY HISTORY

Family Member	Living?	Age	Deceased at age	Illness/Cause of Death
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Fraternal Grandmother				
Fraternal Grandfather				
Sibling				
Sibling				
Sibling				
Sibling				

Please indicate if there is a family history of:

- | | |
|--|--|
| <input type="checkbox"/> obesity | <input type="checkbox"/> lung disease, asthma or emphysema |
| <input type="checkbox"/> bleeding tendency or blood disorder | <input type="checkbox"/> breast cancer |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> colon cancer |
| <input type="checkbox"/> high blood cholesterol | |

Please list all the physicians whose care you are under:

	Name	Location	Telephone
Primary Care Physician	_____		
Internist	_____		
Gynecologist	_____		
Orthopedist	_____		
Psychiatrist	_____		
Psychologist	_____		
Therapist	_____		
Other	_____		

Describe the changes you will need to make in your lifestyle to achieve good long term weight loss after surgery.
