Patient Name ____________________

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	Martial 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:

		Dates	Duration	MD Supervised (yes/no)	Max Loss
PROGRAM:					
Jenny Craig	yes ☐ no ☐				
Nutri-System	yes ☐ no ☐				
Weight Watchers	yes ☐ no ☐				
LA Weight Loss	yes ☐ no ☐				
Opti/Medi Fast	yes ☐ no ☐				
T.O.P.S.	yes ☐ no ☐				
O.A.	yes ☐ no ☐				
Other: (exercise, Curves)	yes ☐ no ☐				
MEDS:					
Fen/Phen/Redux	yes ☐ no ☐				
Meridia	yes ☐ no ☐				
Xenical	yes ☐ no ☐				
Other Meds:	yes ☐ no ☐				
"Over The Counter" Meds:	yes ☐ no ☐				
(ex: dexatrim, stackers, Trim Spa, Metabolite, Hebalife, appetite suppressants, etc.)					
FAD DIETS:					
Atkins	yes ☐ no ☐				
South Beach	yes ☐ no ☐				
Zone	yes ☐ no ☐				
Cabbage Soup	yes ☐ no ☐				
Grapefruit	yes ☐ no ☐				
Fasting	yes ☐ no ☐				
Hypnosis	yes ☐ no ☐				
Acupuncture	yes ☐ no ☐				
Slimfast/Meal replacement	yes ☐ no ☐				
Other	yes ☐ no ☐				

- 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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FOR FEMALE PATIENTS ONLY:

Pregnancy #1 year___________ weight at start____________ at delivery___________
Pregnancy #2 year___________ weight at start____________ at delivery___________
Pregnancy #3 year___________ weight at start____________ at delivery___________
Pregnancy #4 year___________ weight at start____________ at delivery___________

Do you skip meals? yes ☐ no ☐ Which meal? ________________

Number of meals per day ________ Number of snacks per day ___________

Usual snack choices ____

How much water do you drink each day? _____________________

What beverages do you drink? ☐ Diet ☐ Regular ___________________

Number of beverages per day? ________

Describe your eating pattern for the last 3 days:

	Day 1	Day 2	Day 3
Breakfast			
Lunch			
Dinner			
Snacks			
Beverages			
Other			

Major Surgery **Date** **Open or laparoscopic**

____
____
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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: _________cmH_2O
- 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: ____ ____

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PAST MEDICAL HISTORY

Please identify which of the following illnesses you have experienced:

☐ rheumatic fever
age ____________
year ____________

☐ heart murmur
☐ bleeding disorders
☐ Pseudotumor cerebri

☐ irritable bowel disease
☐ Other conditions____

For female patients only:

Number of pregnancies: _______________
Number of live births: _______________
Miscarriages/abortions: _______________
Obstetric complications: ____

Age at first period: _______________
Date of last period: _______________
Post menopausal: ☐ yes ☐ no

Do you presently use:

Birth control pills ☐ yes ☐ no list type: ______________________________
Estrogens ☐ yes ☐ no list type: ______________________________

Please list below all serious illnesses and hospitalizations you have experienced in adulthood:

Major Illnesses Date Treatment

Psychiatric History

- ♦ Sexual abuse or Trauma ☐ yes ☐ No ♦Stress Level in life (on a scale of 1-10)_____
- ♦ Depression ☐ yes ☐ No Year diagnosed______ ♦ History of Anxiety/Panic Attacks ☐ yes☐ No
- ♦ Eating Disorders ☐ yes ☐ No. Year diagnosed______ (Anorexia Nervosa, Bulimia, Binge Eating Disorder)
- ♦ Biploar Disorder ☐ yes ☐ No. Year diagnosed______ Schizophrenia ☐ yes ☐ No. Year diagnosed_____.
- ♦ Other psychiatric problems e.g. Borderline personality/multiple personality etc.____________________ ____________________Year diagnosed. ______
- ♦ What describes your eating behavior?
  - ♦ SWEET EATER: ☐ yes ☐ No ☐ May be. ♦ STRESS EATER: ☐ yes ☐ No ☐ May be
  - ♦LATE NIGHT EATER: ☐ yes ☐ No ☐ May be. ♦ BINGE EATER: ☐ yes ☐ No ☐ May be
- ♦ Do you exercise on a regular basis? ☐ yes ☐ No
- ♦ Do you see a psychologist / psychiatrist on a regular basis? ☐ yes ☐ No
  - ♦ How often? ______________________________
- ♦ Have you ever been hospitalized for a psychiatric condition? ☐ yes ☐ No
  - ♦ When and where? ______________________________
- ♦ Have you ever tried to commit suicide. ☐ yes ☐ No
- ♦ Have you ever filed a lawsuit against a health care provider? ☐ yes ☐ No

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SYSTEM REVIEW

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

1. **GENERAL:** Headache, dizzy spells, fatique, 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 rhinorhea, 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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☐ doctor's office

Please list below all medications you currently use: (May attach a list)

Medication	Dose and Frequency

Do you use any natural medicines, supplements ☐ yes ☐ no. If yes, please mention their names____________
(e.g. Ginseng, Biloba, St. John's Wort, Ginger, Garlic, Vitamin E, etc)

Allergic to any medications ☐ yes ☐ no If yes, please list medication and reaction:
____
____

Allergic to surgical tape/latex: ☐ yes ☐ no

Do you currently use **tobacco**? ☐ yes ☐ no

- Amount/Day: ☐ 1/2 pack or less ☐ 1 – 1 ½ packs ☐ 1 ½ - 2 packs ☐ 2 ½ packs or more
- How many years have you been smoking? _________ ♦ Are you willing to quit? ☐ yes ☐ no

Did you smoke in the past? ☐ yes ☐ no If yes, when did you quit? ___________

Do you use **alcohol**: ☐ yes ☐ no Frequency: ________

- Number of drinks/week 1. Wine _______ 2. Beer _______ 3. Liquor ________
- Have you been treated for complications related to alcohol abuse? ☐ yes ☐ no
  ☐ Pancreatitis ☐ Liver disease ☐ Intoxication / Alcohol Overdose ☐ Other ______________________

History of **drug/substance abuse** ☐ yes ☐ no If yes, What drug _______________ When ______________

- Do you currently use: ☐ Marijuana ☐ Cocaine ☐ Heroine ☐ Amphetamine ☐ Other: ______________
- How long have you been using drugs? __________

Marital History: Please check all the choices that apply to you: ☐ Single. ☐ In a relationship.

☐ Married, If yes, for how long ___________☐ Divorced ☐ Widowed
Who is your closest family member /support person? (name and relationship)___________________________
Have you discussed your plans to have weight loss surgery with your family/spouse? ☐ Yes ☐ No

What is the highest level of education you achieved? ☐ High School ☐ College ☐ Professional Degree

☐ Other___________________

☐ Have you attended surgical weight loss support group meetings. ☐ yes ☐ no Where ____________
☐ What kind of research have you done about weight loss surgery. ☐ Met other patients. ☐ Read on the internet.
☐ read a book/ newspaper/ magazine article about it. ☐ other____
What do you do for living? The type of work____

Patient Name ___________________

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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:

☐ obesity
☐ lung disease, asthma or emphysema
☐ bleeding tendency or blood disorder
☐ breast cancer
☐ heart disease
☐ colon cancer
☐ 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.

____

____

____