Barrington Surgeon's Bariatric Surgery Questionnaire

Name:_____ DOB:_____ Age:_____

E-Mail:_____

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

- Diabetes
- High Blood Pressure
- Sleep Apnea
- Asthma
- Shortness of Breath with exertion
- Low back pain
- joint pain
- Arthritis
- High cholesterol
- High triglycerides
- Heartburn (GERD)
- Stress Urinary Incontinence
- Heart Failure
- Peripheral Edema (swelling of the legs and ankles
- Varicose veins or Venous stasis problems
- Deep Venous Thrombosis (Blood clots in your legs)
- Pulmonary embolus

Other Medical Problems

- Bipolar
- Schizophrenia
- Depression
- History of sexual abuse
- Migraine headaches
- Abnormal bleeding or bruising
- Seizure or epilepsy
- Cancer
- Osteoporosis
- Anemia
- Menopause
- Plan to become pregnant
- 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:

	Operation	Date	Problems
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Medications

Medication	Dosage	Number of times taken per day

Please attach a separate sheet if necessary.

Allergies

	Medication/medical product	Type of reaction
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 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?

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

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

- o Shortness of breath
- o Fatigue
- o Chest pain
- o Joint discomfort
- o Back pain
- o 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