Patient name			
MHN	DOB	Age	Gender

Bariatric Surgery

Questionnaire

Personal Information *(At time of information session registration)*

Today's date (month/day/year) ____/____/____

Home address	City	State	ZIP

Telephone number:
Home Work Other

Occupation

Employment status:
☐ Full-time ☐ Part-time ☐ Self-employed ☐ Homemaker ☐ Student ☐ Retired ☐ Disabled ☐ Unemployed

Insurance *(list all)*

Referred by	Primary care provider (M.D., N.P., P.A.)

Race *(check all that apply)*:
☐ Caucasian ☐ Hispanic ☐ Asian ☐ Afrian American ☐ Native American ☐ Pacific Islander/Hawaiian ☐ Other

Weight History

Highest weight/date	Lowest weight/date	Current weight	Height:	Childhood – overweight:
			_____ feet _____ inches	☐ Yes ☐ No

How many years have you been obese _____

Why do you think you are overweight – check (✓) all that apply:
☐ Overeat at meals ☐ Lack of exercise ☐ Snack too much ☐ Eat "wrong" foods ☐ Heredity
☐ Other _____

List all previous diets, including dates and results:

Date (m/d/y)	Diet	How Long Did You Stay on Diet	Results

What do you consider your ideal body weight _____

What weight do you expect to maintain after bariatric surgery _____

Do you know anyone who has had bariatric surgery: ☐ Yes ☐ No

Questionnaire (Continued)

Patient name	MHN	DOB	Age	Gender

Medical and Surgical History

Date (month/day/year)	List All Past Operations

Any complications with previous operations or anesthesia: ☐ Yes ☐ No

How would you characterize your usual health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Medication allergies/reaction

List all your medications including the dose and how often you take them. Include any nonprescription medicine, vitamins, and herbal preparations. (Use additional sheet of paper if necessary.)

Medication	Dose	Frequency

Patient name	MHN	DOB	Age	Gender

Medical and Surgical History (continued)

Check (✓) any illness that you have now or have had in the past:	Yes	No	If Yes, Describe
High blood pressure			
Heart problem/chest pain			
Shortness of breath If yes: ☐ With activity ☐ At rest			
Blood flow problem/stroke			
Lower leg swelling or sores			
Blood clots – leg or lung			
Blood sugar problem or diabetes If diabetes: ☐ Type 1 ☐ Type 2			
Thyroid problem			
High cholesterol/triglycerides			
Gout			
Excessive snoring			
Sleep apnea If yes, do you use CPAP: ☐ Yes ☐ No			
Lung high blood pressure			
Asthma/Chronic obstructive pulm. disease			
Acid reflux or heart burn			
Stomach ulcers			
Gallbladder problems or stones			
Liver disease			
Joint pain or back pain			
Arthritis/Muscle pain			
Infertility, ovary or menstrual problems			
Urinary problems or leaking			
Kidney problem or stones			
Bowel problems or irregularity			
Hernia – belly, groin, hiatal			
Headache or migraine problem			
Anxiety			
Depression			
Other psychological illness			
Have you ever been hospitalized for psychological reasons? If yes, when _____			

Patient name	MHN	DOB	Age	Gender

Medical and Surgical History (continued)

	Yes	No	If Yes, Describe
Chemical dependency			
Have you ever had treatment for drug or alcohol dependence			
Walking problem			
Belly fat apron/skin problem			

Family History

List any significant family illnesses, especially diabetes, high blood pressure, heart disease, and cancer in your parents, grandparents brothers or sisters. If family member is deceased, list their age at the time of death.

Social History

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Number of children and their ages
Smoking history: ☐ Past For _____ years Packs per day _____ ☐ Present For _____ years Packs per day _____	Date stopped (m/d/y) _____ /_____ /_____ Stop date goal (m/d/y) _____ /_____ /_____
Alcohol use: ☐ Past Date stopped (m/d/y) _____ /_____ /_____ ☐ Present How often _____	How much _____
Drug use: ☐ Past Date stopped (m/d/y) _____ /_____ /_____ ☐ Present How often _____	How much _____

Explain how your weight is adversely affecting your health or your life

Anything else you feel your doctor should know

Thank you for your help. This information will be kept confidential and will assist your doctor to better understand your situation; it will be discussed further with you at the time of your preoperative consultation.

Patient signature (Patient's legal representative) _____ (Relationship) _____ Date (month/day/year) ____/____/____

Return completed questionnaire to Bariatric Nurse, General Surgery, 3F1