



# Medical Questionnaire

Please do not leave anything blank

Your Name \_\_\_\_\_

Your Date of Birth \_\_\_\_\_

Your height (inches) \_\_\_\_\_

Your weight (pounds) \_\_\_\_\_

How did you become interested in Bariatric Surgery, and how did you learn about our practice? \_\_\_\_\_

\_\_\_\_\_

What problems is obesity causing for you? \_\_\_\_\_

\_\_\_\_\_

What makes you think seriously about bariatric surgery **now**? \_\_\_\_\_

\_\_\_\_\_

How do you think Bariatric Surgery may help you? \_\_\_\_\_

\_\_\_\_\_

What was your weight at the following times in your life?

6<sup>th</sup> grade \_\_\_\_\_

At your wedding \_\_\_\_\_

High School Graduation \_\_\_\_\_

Birth of 1<sup>st</sup> child \_\_\_\_\_

Age 21 \_\_\_\_\_

Age 40 \_\_\_\_\_

Age 30 \_\_\_\_\_

Age 50 \_\_\_\_\_

What has been your maximum weight? \_\_\_\_\_

What has been your lowest weight (not due to illness) after age 21, which you have maintained for at least 1 year? \_\_\_\_\_ lbs at \_\_\_\_\_ yrs old, maintained for \_\_\_\_\_ yrs.

Was this weight reached after a weight loss effort? (*circle one*).....yes/no

Check the statement that best describes you: "During the past 6 months my weight has ....."

- decreased more than 10 lbs
- decreased 5-10 lbs
- stayed about the same
- increased 5-10 lbs
- increased more than 10 lbs

**Please check the medical conditions that apply:**

**\*\*What year was it diagnosed?**

Diabetes \_\_\_\_\_  
 High Blood pressure (Hypertension) \_\_\_\_\_  
 Sleep Apnea (do you use CPAP?) \_\_\_\_\_  
 Asthma, Reactive Airway Disease \_\_\_\_\_  
 Heart Failure \_\_\_\_\_  
 Angina, Coronary Artery Disease \_\_\_\_\_  
 Gallstones \_\_\_\_\_  
 GE Reflux disease ("GERD") \_\_\_\_\_  
 Arthritis \_\_\_\_\_  
 Back pain \_\_\_\_\_

Cancer (type?) \_\_\_\_\_  
 Venous thrombosis (DVT) or PE \_\_\_\_\_  
 (Blood clot in legs or lungs) \_\_\_\_\_  
 Stress Urinary incontinence \_\_\_\_\_  
 Menstrual irregularity, infertility \_\_\_\_\_  
 Hirsutism (*hair on face*) \_\_\_\_\_  
 Depression \_\_\_\_\_  
 High cholesterol, high lipids \_\_\_\_\_  
 Hypothyroidism \_\_\_\_\_  
 Other Endocrine/hormone problem \_\_\_\_\_  
 Other? \_\_\_\_\_

Have you been treated at a hospital (inpatient or outpatient) within the last year? \_\_\_\_\_

If yes, please provide further information: \_\_\_\_\_

Please list the physicians who participate in your care:

Primary MD: \_\_\_\_\_

Other physicians and their role for you: \_\_\_\_\_

Have you ever undergone colonoscopy (lower scope?) \_\_\_\_\_

If yes, when was it done, and who was the GI doctor? \_\_\_\_\_

**Please list your past surgical history and year surgery performed.**

1		8	
2		9	
3		10	
4		11	
5		12	
6		13	
7		14	

Have you undergone any surgical procedure for obesity in the past? \_\_\_\_\_ *If so:*

Name of Procedure: \_\_\_\_\_ When performed: \_\_\_\_\_

Name of Surgeon: \_\_\_\_\_ Office location: \_\_\_\_\_

What was your weight prior to that procedure? \_\_\_\_\_

Maximum weight lost, or lowest weight after surgery: \_\_\_\_\_

Reason you are seeking another surgical evaluation: \_\_\_\_\_

More than one prior surgical procedure for weight loss? \_\_\_\_\_

Have any of your family members or close friends undergone weight loss surgery? If yes, please describe:

\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to **Latex**? Yes No If yes, what happens when you are exposed to latex?

Are you **allergic** to any medications? Yes No If yes, Please list the medication/s and what happens when you take it.

Please list all medications that you are currently taking:

	Medication	Strength	How many at one time	Schedule for dosing
	Example: TYLENOL	250 mg	2	twice a day
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				

Please list birth control pills or any hormone related medications: \_\_\_\_\_

Please list any non-prescription (over-the-counter) drugs, vitamins, or herbal remedies: \_\_\_\_\_

Are your immunizations up to date: **Y N Unsure** When was your last Tetanus shot? \_\_\_\_\_

***Family History:***

Has anyone in your immediate family had any of the following diseases? (use: M = mother, F = father, S = sister, B = brother, G = grandparent)

Diabetes \_\_\_\_\_

Cancer (what type?) \_\_\_\_\_

Hypertension \_\_\_\_\_

Blood Clotting \_\_\_\_\_

Severe Obesity \_\_\_\_\_

\_\_\_\_\_

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***Social History:***

Married? Yes/No/Divorced If married, how long? \_\_\_\_\_

Do you use any of the following? :

Alcohol Yes No How often? \_\_\_\_\_ Type \_\_\_\_\_

Tobacco Yes No How often? \_\_\_\_\_ Type \_\_\_\_\_

Cocaine Yes No How often? \_\_\_\_\_ Type \_\_\_\_\_

Street Drugs Yes No How often? \_\_\_\_\_ Type \_\_\_\_\_

What is your primary language? \_\_\_\_\_

Is there anything about your religious or cultural practices that will influence the planning of your care and education?

\_\_\_\_\_  
\_\_\_\_\_

***General Symptom Review:***

Circle a number that corresponds with your general energy level:  
(1 = lowest, 5 = highest)

1                      2                      3                      4                      5

Have you experienced more than one week of fever in the last year?.....yes/no

Do you have severe headaches? .....yes/no

Have you experienced any visual changes in the last year? .....yes/no

Do you fall asleep unexpectedly? .....yes/no

Do you snore loudly? .....yes/no

Do you wake frequently at night?.....yes/no

How many times? \_\_\_\_\_

Do you experience shortness of breath with exercise? .....yes/no

Do you experience chest pain with exercise? .....yes/no

How many flights of stairs can you climb without stopping? \_\_\_\_\_

How many times per week do you have heartburn? \_\_\_\_\_

Do you experience abdominal pain or nausea after eating fatty foods? .....yes/no

Do you have difficulty swallowing, or feel a “catching” sensation when eating thick or bulky foods? .....yes/no

Do you have difficulty with leaking of urine when you cough or laugh? .....yes/no

Have you had more than one urinary infection in the last year? .....yes/no

Do you have persistent skin irritation, rash, ulcers? .....yes/no  
Where? \_\_\_\_\_

Do you have severe joint pain? .....yes/no  
What joints are worst? \_\_\_\_\_

Do you have persistent ankle or foot pain? .....yes/no

Have you noticed any changes in your hair in the last year? .....yes/no

Have you noticed any changes in your energy level in the past year? .....yes/no

Has your thyroid function been checked by your physician in the past? .....yes/no

Do you feel depressed or hopeless? .....yes/no

Have you ever had a blood clot in your legs or lungs? .....yes/no

Please list previous weight loss attempts: (**\*required**)

Program	Year you started	How much you lost	How long you tried it	How long did you maintain wt loss?
Weight Watchers				
Wt Loss Medications				
Jenny Craigs				
Hypnosis				
Adkins				
South Beach				
Exercise program				
M.D. supervised diet				
Other:_____				

Signature:\_\_\_\_\_ Date:\_\_\_\_\_