

Sentara Metabolic & Weight Loss Surgery Center

Bariatric Patient Questionnaire

Last Name: _____ First Name: _____

Birth Date: ____/____/____ Age: _____ Phone: _____

Primary Care Physician: _____

Address: _____

Phone: _____

Specialty Physicians (i.e.: Endocrine, Cardiologist, Pulmonologist, Etc):

1) _____ Phone: _____

Specialty: _____

2) _____ Phone: _____

Specialty: _____

Height: _____ Weight: _____ BMI: _____

Highest Weight: _____ Age Obesity First Noted: _____

Weight At Age: 25: _____ 35: _____ 45: _____ 55: _____

Medication Allergies & Reactions? _____

Latex Allergy? _____

Current Medications And Doses:

1) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

7) _____ 8) _____

Do You Take?

- Coumadin? Yes No
Plavix? Yes No
Aspirin? Yes No

Do You Smoke?

- Yes No
Check One: Never
 Quit Date Quit: _____
 Yes Packs per day: _____ Years: _____

Do You Drink Alcohol?

- Check One: No
 Yes How Many Per Week?

CO-MORBID CONDITIONS

- High Blood Pressure? Number of Years _____
- Heart Attack Chest Pain With Exercise? Yes No
- Congestive Heart Failure
- Diabetes Number of Years _____ Insulin? Yes No
- Sleep Apnea
- Snoring? Waking? CPAP?
Do You Have Your Own CPAP Machine? Yes No Pressure Setting? _____
- Severe Heartburn or Reflux (GERD)
History Of Ulcers? Yes No
- Blood Clot (DVT)
Pulmonary Embolism (Blood Clot In Lung) Yes No What Year? _____
- Pain In Weight Bearing Joints? Yes No
 Back Hips Knees/Feet
- Limitations With Exercise Mild Moderate Severe
- Arthritis
- Shortness Of Breath
 Asthma Emphysema COPD
- Urinary Stress Incontinence
- Ankle Swelling
- Varicose Veins
- Fatty Liver Cirrhosis/Liver Disease
- High Cholesterol/Triglycerides
- Gallstones
- Anemia
- Bleeding Disorder? Yes No Name Of Disorder? _____
- Hypothyroidism
- Polycystic Ovary Syndrome (PCOS)
- Chronic Headaches Migraines Blurred Vision
- Depression
- Suicide Attempts
- Bipolar Disorder

OTHER MEDICAL HISTORY

(Please Give Dates If Possible)

- Glaucoma _____
- Pneumonia _____
- Sarcoidosis _____
- Hepatitis (A, B, or C) _____
- HIV/AIDS _____
- Rectal Bleeding _____
- Prostate Problems Or Cancer (Men Only) _____
- Cancer (Skin, Breast, Lung, Colon, Other) _____
- Other (Please Explain) _____

FOR WOMEN ONLY:

- Age Started Menses: _____ Last Period: _____
- Date Of Last Pap/Pelvic Exam: _____ Normal? Yes No
- Date Of Last Breast Exam: _____
- Date Of Last Mammogram: _____ Normal? Yes No
- Number Of Pregnancies: _____ Number Of Children: _____
- Do You Plan To Have More Children? Yes No

PAST SURGICAL HISTORY:

- Gallbladder Surgery Laparoscopic? Yes No
- Hernia Surgery Umbilical? Groin?
Previous Surgery Site Hernia? _____
- C-Sections What Years? _____
- Reflux Surgery _____
- Other Please List: _____

SURGICAL COMPLICATIONS:

- Bleeding
- Problems With Anesthesia
- Blood Transfusions
- Blood Clot
- Infections

SOCIAL HISTORY:

Marital Status: Single Married Divorced Widowed

Level of Education: High School College Advanced Degree

Religious Preference: _____

FAMILY HISTORY:

	Age	Weight	Medical Conditions
Mother	_____	_____	_____
Father	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

PSYCHOLOGICAL HISTORY:

Do You Have Problems With Self-esteem? Yes No

Have You Been Sexually Or Physically Abused? Yes No

Have You Ever Been Down or Depressed Every Day For 2 Weeks? Yes No

Have You Ever Had A Suicide Attempt? Yes No

Have You Ever Had A Problem With Alcohol or Drugs? Yes No

Have You Ever Been Hospitalized for Psychiatric Reasons? Yes No

Have You Used Vomiting, Excessive Exercise or Laxatives to Lose Weight? Yes No

Do You Eat for Comfort? Yes No

Does Your Spouse/Family Support Your Decision for Gastric Bypass? Yes No

Describe Your Support System:

WEIGHT LOSS HISTORY

PROGRAM	YEAR	# OF MONTHS	# WGT LOSS
MD Supervised			
Medifast	_____	_____	_____
Optifast	_____	_____	_____
Primary Care	_____	_____	_____
Other _____	_____	_____	_____
Dietitian or Nutritionist			
Name: _____	_____	_____	_____
Non-MD Supervised			
Weight Watchers	_____	_____	_____
Nutri-Systems	_____	_____	_____
Jenny Craig	_____	_____	_____
TOPS	_____	_____	_____
Overeater's Anonymous	_____	_____	_____
Medication Assisted			
Phen-Phen	_____	_____	_____
Xenical (Orlistat)	_____	_____	_____
Sibutramine (Meridia)	_____	_____	_____
Redux	_____	_____	_____
Other _____	_____	_____	_____
Other Treatments			
Hypnosis	_____	_____	_____
Acupuncture	_____	_____	_____
Self-Monitored Diets (i.e., Atkins, South Beach, Zone, etc.)			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Eating Habits:

Number of Meals per Day: _____

Number of Sodas per Day: _____

Caffeinated Drinks/Coffee per Day: _____

Preferences:

- Sweets (candy, chocolates, cakes)
- Starches (pasta, bread, pizza)
- Snacks (chips)

REVIEW OF SYSTEMS

Check symptoms you currently have or have had in the past year.

GENERAL

- Weight loss
- Fevers
- Night sweats
- Fatigue

SKIN

- Rashes
- Color change
- Sores

NECK

- Swollen glands
- Pain
- Stiffness

LUNGS

- Chronic cough
- Coughed-up blood
- Asthma or bronchitis
- Pneumonia or tuberculosis
- Emphysema

HEART

- Chest pain
- Shortness of breath
- Leg swelling
- Irregular heart beat
- Rapid heart beat

GASTROINTESTINAL

- Trouble swallowing
- Heartburn
- Nausea or vomiting
- Change in your appetite
- Vomiting blood
- Blood in your bowel movements
- Black bowel movements
- Diarrhea
- Constipation
- Jaundice or liver trouble
- Gallstones

KIDNEY

- Burning or pain when urinating
- Kidney stones
- Urinate frequently during the night
- Urin infections
- Blood in urine

VASCULAR

- Leg cramps
- Varicose veins
- Blood clots

BLOOD

- Low blood count or anemia
- Easy bruising or bleeding
- Ever had a blood transfusion

ENDOCRINE

- Heat or cold intolerance
- Excessive sweating
- Excessive thirst or hunger

WOMEN ONLY

- Breast lumps
- Breast pain
- Nipple discharge
- Breast skin dimpling
- Perform breast self-exams
- Vaginal discharge
- Abnormal vaginal bleeding

MEN ONLY

- Breast lump
- Lump in testicle
- Discharge from penis
- Sore on penis
- Bulge in groin or hernia

OTHER

Doctor's Initials _____

PULMONARY QUESTIONNAIRE FOR BARIATRIC SURGERY

Have you ever been told by a Dr. that you have a lung problem? Yes No

If yes, what problem? _____

Have you ever been told by a Dr. that you have asthma, COPD or emphysema? Yes No

If the answer is yes, which one? _____

Has a Dr. ever given you medicines to inhale? Yes No

If yes, what was the name of the medicine? _____

Why was it given? _____

Are you still using it? Yes No

Have you ever been to the hospital because of breathing problems? Yes No

If yes, please describe. _____

Are you ever short of breath while seated, laying in bed, or doing simple activities such as cleaning the house, walking a short distance, or doing the marketing? Yes No

If yes, please describe. _____

Do you cough frequently? Yes No

Do you wheeze? Yes No

Have you ever been a smoker? Yes No

Are you still smoking? Yes No

How many years total have you smoked? _____

Over your years of smoking, how many packs a day on average would you estimate having smoked? _____

OSA SCREENING SURVEY

please CHECK best answer

1. Do you snore regularly? Yes No
2. Have you ever been told that you stop breathing while asleep? Yes No
3. Do you frequently urinate at night? Yes No
4. Are you tired during the day? Yes No
5. Do you fall asleep unintentionally or nap? Yes No
6. Have you nodded off or fallen asleep during driving? Yes No
7. While driving over the past year, have you run off the road or had an accident due to sleepiness? Yes No
8. Do you have high blood pressure? Yes No
9. Has a doctor ever told you that you have sleep apnea? Yes No
10. Do you awaken with headaches in the morning? Yes No

If you have answered YES to 2 or more of these questions,
you may have a sleeping disorder and should be referred to a sleep specialist

Authorization for Release of Information

Date: _____

Patient Name: _____

Date of Birth: _____ Soc. Sec # _____

To: _____

Phone # _____ Fax # _____

I hereby authorize the release of my complete medical records to:

Sentara Metabolic & Weight Loss Surgery Center
Sentara Heart Hospital
600 Gresham Drive
6th Floor, Suite 8630
Norfolk, Virginia 23507

Signature of Patient or Legal Representative

Date

Signature of Witness

Date

Name: _____
(Please put your first and last name on each page.)

