

Please answer ALL questions as completely as possible.

The reason you are seeing the doctor today is: _____

Height _____ Weight _____

Allergies or Adverse Reactions

State type, including all medications, tape, latex, food, creams, animals, other

Type Allergy

Effects/Reactions

1. _____
2. _____
3. _____
4. _____
5. _____

Previous Weight Loss Surgery If Requesting A Revision

Type Procedure

Surgeon's Name

Hospital

Date of Surgery

Weight Loss

1. _____
2. _____
3. _____

Past Hospitalizations and Surgeries

Kind of Surgery or Hospitalization

Approximate Date

1. _____
2. _____
3. _____
4. _____
5. _____

Past Hospitalizations and Surgeries cont.

- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____

Current Medications

<u>Name</u>	<u>Dosage</u>	<u>Reason for Taking</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____
12. _____	_____	_____
13. _____	_____	_____
14. _____	_____	_____

Do You...

Drink coffee or caffeinated drinks? YES NO Amount daily _____

Drink beer, wine, or other alcoholic beverages? YES NO Drinks per day _____

Use aspirin or ibuprofen? YES NO Amount per day _____

Smoke cigarettes, cigars, or use chewing tobacco? YES NO _____ per day

Eat sweets frequently? YES NO Daily? YES NO Weekly? YES NO

What Over The Counter Medications Are You Taking

(Including vitamins, herbals, supplements, diet, sleeping, sinus, headache & other medications)

<u>Name</u>	<u>Dosage</u>	<u>Reason for Taking</u>
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		

Check Any Condition That Affects You Currently

Genitourinary

Bladder Control Problems Blood in Urine Frequent Urination Stones

Kidney Disease Night Urination Painful Urination

Other _____

Musculoskeletal

Joint Pain Hip Pain Arthritis Back Pain Neck Pain

Knee Replacement Hip Replacement Gout Inability To Walk

Other _____

Hematological

Abnormal Bleeding Anemia Blood Transfusion – Past Coumadin

AIDS History of Cancer

Other _____

Respiratory

Asthma or Wheezing Can't Breathe When Lying Flat Chest Colds

Cough Up Blood Cough Up Sputum Frequent Cough Frequent Cough

Shortness of Breath Pulmonary Embolism C-Pap Bi-Pap

Other _____

Cardiovascular

Artificial Valve Chest Pain Aortic Stenosis/Insufficiency Fainting Spells

Heart Attack In Past DVT Heart Disease Heart Murmur Pacemaker

High Blood Pressure High Cholesterol Irregular Heartbeat Mitral Valve

Prolapse Rheumatic Fever Swollen Ankles

Other _____

Gastrointestinal

Abdominal Pain Appetite Loss Bloody or Tarry Stools Ulcers

Bowel Control Problems Change in Bowel Habits Colon Cancer in Past

Constipation Diarrhea Frequent Heartburn Gallbladder Trouble

Hemorrhoids Hiatal Hernia Nausea Jaundice or Liver Trouble

Milk Intolerance Rectal Bleeding Swallowing Problems Vomiting

Vomiting Blood

Other _____

Women Only

Breast Lump or Mass Change in Periods Discharge – Nipple Hot Flashes
 Menopause Date of Last Period _____
 Date of Last Pap Smear _____
 Date of Last Mammogram _____
 Pregnant Now YES NO
 Other _____

Family Health History

Check Correct Box	Father	Mother	Brothers	Sisters	Father's Father	Father's Mother	Mother's Father	Mother's Mother	Other
Heart Attack									
Cancer									
Diabetes									
Gall Bladder Disease									
High Blood Pressure									
Strokes									
Other									

SLEEP DISORDERS SCREENING QUESTIONNAIRE

Developed by Dr. J. Kern

Patient Name _____ Age _____ Sex _____

Height _____ Weight _____ Collar Size _____

Do you snore? Y N

If yes, do others say your snoring is interrupted by choking or snoring sounds? Y N

Do others say you stop breathing while you are asleep? Y N

Do you have trouble staying awake when you want or need to be awake? Y N

Do you fall asleep during any of the following?

Watching TV?	Never	Rarely	Sometimes	Frequently
While at work?	Never	Rarely	Sometimes	Frequently
At movies, church?	Never	Rarely	Sometimes	Frequently

Have you ever fallen asleep while driving? Y N

Do you fall asleep frequently while reading books or newspapers? Y N

Do you have trouble getting to sleep or staying asleep when you want to be asleep? Y N

Do you still feel tired after eight hours of sleep? Y N

Do you frequently get less than seven hours of sleep out of 24 hours? Y N

Do you have restless or crawling feelings in your legs when you sit or lie down? Y N

Do you say you have jerking movements of your legs during your sleep? Y N

How much of the following caffeine sources do you have each day:

Coffee _____ Soft Drinks _____ Tea _____ Other _____

Do you believe you have any other sleep related problems? Y N

Please describe: _____

WEIGHT LOSS HISTORY

Please spend time completing this questionnaire in as complete detail as possible. This information is extremely important in determining your appropriateness for weight loss surgery.

Patient Name _____ Date _____

Age at first weight loss attempt _____ Hospitalization for weight loss _____

Check all boxes below that apply to you

- | | | | |
|--|--|---|---|
| Medi-Fast <input type="checkbox"/> | Opti-Fast <input type="checkbox"/> | Jenny Craig <input type="checkbox"/> | Richard Simmons <input type="checkbox"/> |
| Weight Watchers <input type="checkbox"/> | Nutri-Systems <input type="checkbox"/> | Gloria Marshall <input type="checkbox"/> | Pritikin <input type="checkbox"/> T.O.P.S. <input type="checkbox"/> |
| Scarsdale <input type="checkbox"/> | Herbal Life <input type="checkbox"/> | Susan Powter <input type="checkbox"/> | Sweet Success <input type="checkbox"/> |
| Cal Ban 3000 <input type="checkbox"/> | Accutrim <input type="checkbox"/> | Slim Fast <input type="checkbox"/> | Beverly Hills <input type="checkbox"/> |
| Dieter's Tea <input type="checkbox"/> | Atkins <input type="checkbox"/> | Physician's Weight Loss Center <input type="checkbox"/> | |
| Diurex <input type="checkbox"/> | Amphetamines <input type="checkbox"/> | Fen-Phen <input type="checkbox"/> | Hypnosis <input type="checkbox"/> |
| Fat Burners <input type="checkbox"/> | Cambridge <input type="checkbox"/> | Stillman <input type="checkbox"/> | Thyroid Supplements <input type="checkbox"/> |
| Cabbage Soup <input type="checkbox"/> | Dexatrim <input type="checkbox"/> | Gastric Bubble <input type="checkbox"/> | Acupuncture <input type="checkbox"/> |
| Jaw Wiring <input type="checkbox"/> | Cal Slim <input type="checkbox"/> | Injections: B-6 <input type="checkbox"/> B-12 <input type="checkbox"/> H.C.G. <input type="checkbox"/> Urine <input type="checkbox"/> | |
| Others <input type="checkbox"/> | _____ | | |

Give complete details of all boxes checked

Name of Method _____ Date Tried _____ To _____

Weight Lost _____ Weight Gained _____ Results _____

Name of Method _____ Date Tried _____ To _____

Weight Lost _____ Weight Gained _____ Results _____

Name of Method _____ Date Tried _____ To _____

Weight Lost _____ Weight Gained _____ Results _____

Name of Method _____ Date Tried _____ To _____

Weight Lost _____ Weight Gained _____ Result _____

Name of Method _____ Date Tried _____ To _____

Weight Lost _____ Weight Gained _____ Results _____

Name of Method _____ Date Tried _____ To _____

Weight Lost _____ Weight Gained _____ Results _____

Name of Method _____ Date Tried _____ To _____

Weight Lost _____ Weight Gained _____ Results _____

Patient Name _____

THROMBOSIS RISK FACTOR ANALYSIS

Patient Name _____ SS number _____

Please read the list of risk factors below, and check all the factors that pertain to you. Then, total the number of points you have accumulated and review the score chart to assess your level of risk for thrombosis or blood clotting.

Each checked category is equal to 1 point

- _____ **Age above 40**
- _____ **Previous DVT, deep vein thrombosis**
- _____ **Immobilization or inability to walk more than a few steps**
- _____ **Previous history of cancer**
- _____ **Obesity**
- _____ **Cardiac Disease/ CHF**
- _____ **Varicose Veins**
- _____ **Limb Trauma/ Injury**
- _____ **Undergoing Surgery, including proposed bariatric surgery**
- _____ **Hormone Replacement**
- _____ **History of Auto Immune Disease e.g. Lupus, SLE, rheumatoid arthritis**
- _____ **Diseases affecting the clotting of blood, Coagulopathy**

SCORE

- 1 Factor = Low Risk**
- 2 Factor = Moderate Risk**
- 3 Factor = High Risk**
- 4 Factor = Very High Risk**

NUTRITIONAL QUESTIONNAIRE

Please answer the following questionnaire as completely and honestly as you can.

1. Do you consider yourself a picky eater Yes No

1. How many meals do you usually eat per day? _____

2. Do you awaken in the middle of the night and eat? Yes No

3. Have you awaked in the morning and found evidence that you have eaten in the night but do not recall? _____

4. How many snacks do you eat per day? _____

5. At what times/times daily do you typically snack? _____

6. What is your favorite snack? _____

7. How many times per day/week/month do you consume the following foods?
 _____ day _____ week _____ month candy
 _____ day _____ week _____ month pastries, /pies/cakes/doughnuts
 _____ day _____ week _____ month ice cream/shakes
 _____ day _____ week _____ month chips/pretzels/popcorn
 _____ day _____ week _____ month fast food/restaurants
 _____ day _____ week _____ month caffeine
 _____ day _____ week _____ month carbonated beverages
 _____ day _____ week _____ month alcohol
 _____ day _____ week _____ month fruits
 _____ day _____ week _____ month vegetables

8. How many ounces of water do you consume daily? _____

9. Please list any food allergies. (e.g. lactose intolerance, shellfish) _____

10. Do you drink milk regularly? _____ Do you like milk? _____ Will you drink milk if we ask you to as part of your post-op recovery plan? _____

11. Who prepares the meals in your home? _____

12. Who does your grocery shopping in your home? _____

13. Are you currently employed outside the home? _____ If so, where do you obtain your meals? (e.g. take from home, cafeteria, local restaurants, vending machines, don't eat, etc.) _____

14. Do you frequently fast as part of your diet plan? _____
15. Do you eat breakfast? _____
16. Please list your hobbies _____

17. Do you weigh yourself? _____ If so, how often? _____
18. What is your personal goal weight? _____ Why? _____
19. Do you consider yourself a binge eater? _____ If so, how often do you
binge, and when do you do it? _____
20. Do you ever cause yourself to vomit to help control your weight?
_____ If so, how often? _____
21. Do you use laxatives to control your weight? _____ If so, how often? _____
22. Have you ever been treated for an eating disorder? _____ If so, list the dates of
treatment and person or facility providing treatment. _____

23. What is your best source of protein that you consume on a regular basis? _____

24. What vegetables do you consume on a regular basis? _____

25. What fruits do you consume on a regular basis? _____

26. How often do you eat fried foods? _____
27. Is there a food that you think that you cannot live without? _____
28. Do you currently participate in any physical activity? _____ If so, what? and
how often? _____
29. Do you have access to a health club, YMCA, treadmill, bike, etc.? _____
30. Why do you feel that you can make the lifestyle changes necessary to be
successful after bariatric surgery vs. dieting in the past? _____

