

Patient Questionnaire

Gastric Bypass

TODAY'S DATE: _____

First name _____ Last name _____

Address: _____

Home Telephone _____ Work Telephone _____

SS# _____ Occupation _____

I was referred by: _____ Telephone _____

DOB _____ Age _____ Height _____ Weight _____

Medical History

Do you have or have you ever had any of the following:

Diabetes: _____ Yes ___ No

If yes, since when and form of treatment (list medications prescribed) _____

High Blood Pressure: _____ Yes ___ No

If yes, since when and form of treatment (list medications prescribed) _____

Heart Disease: _____ Yes ___ No

If yes, check if you have any of the following:

___ Chest pain:
___ Heart attack

___ Heart pain (angina):
___ Coronary artery disease:
___ Congestive heart failure

If yes, since when and form of treatment (list medications prescribed) _____

o Sleep Problems: Yes No

If yes, check any of the following:

Sleep apnea

Snoring

Other _____

If yes, since when and form of treatment (list medications prescribed) _____

o Breathing Problems: Yes No

If yes, check any of the following:

Asthma

Shortness of breath

Difficulty of breathing

Other _____

If yes, since when and form of treatment (list medications prescribed) _____

o Gastro-esophageal reflux: Yes No

If yes, check any of the following:

Heartburn

Difficulty swallowing

If yes, since when and form of treatment (list medications prescribed) _____

o Cancer: Yes No

If yes, since when and form of treatment (list medications prescribed) _____

o Venous Insufficiency: Yes No

If yes, since when and form of treatment (list medications prescribed) _____

- Thrombophlebitis: __Yes __No

If yes, since when and form of treatment (list medications prescribed) _____

- Gallbladder disease: __Yes __No

If yes, since when and form of treatment (list medications prescribed) _____

- Do you experience bladder incontinence? __Yes __No

If yes, since when and form of treatment (list medications prescribed) _____

- Do you experience bowel incontinence? __Yes __No

If yes, since when and form of treatment (list medications prescribed) _____

- GYN problems: __Yes __No

If yes, check any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Difficulty achieving pregnancy | <input type="checkbox"/> Fibroids/tumor in uterus |
| <input type="checkbox"/> Ovarian cyst | <input type="checkbox"/> Painful periods |
| <input type="checkbox"/> Heavy periods | <input type="checkbox"/> Cessation of periods |
| | <input type="checkbox"/> Post menopausal |

If yes, since when and form of treatment (list medications prescribed) _____

- Medications: Yes No

List any other medications you are or have taken not included above

- Allergies: Yes No

Surgical History

List any surgeries:

Type	Date	Hospital
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

- Did you have general anesthesia? If yes, did you experience any problems?

- Did any family member have general anesthesia? If yes, any problems? _____

Family Medical History

- Family history:
- | | | |
|---------------------|------------------------------|-----------------------------|
| Obesity | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High blood pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Other: _____

Psycho-Social

- o Depression/Anxiety/Phobias: Yes No

If yes, since when and form of treatment (list medications prescribed) _____

Other psychiatric disorder _____

- o History of suicide attempt(s) Yes No

If yes, how long ago _____

- o History of hospitalization Yes No

If yes, how long ago _____

- o Who prescribes your medication? _____

Diet/Weight History

If you attempted to lose weight in the past, please answer the following questions (most insurance companies want to know that efforts have been made to lose weight):

- o **Since when have you been overweight?** _____
- o **When you lose weight, do you always regain it?** _____
- o **Do you usually gain back more than you lose?** _____
- o **What was the biggest loss in pounds you had and how long did it take to regain weight?** _____

Insurance companies want to know the duration of your attempts to lose weight and professionals you've consulted. So please answer the following accordingly.

- o **Have you participated in commercial weight loss programs?**
If yes, please indicate how long you participated in the program, amount of weight loss and period of maintaining weight loss:

Program	Duration of Program	Total Weight Loss	Duration of Loss	Year
Weight Watchers				
Richard Simmons				
Nutrisystem				
Slimfast				
Jenny Craig				
Susan Powter				
Overeaters Anonymous				
Health Spas				
Gym/Exercise Program				
Other				

- o Have you tried various calorie and fat-reduction diets, "fad" diets or diets which required the purchase of books or tapes? If yes, please list. _____

- o Have you been involved in medically or professionally supervised programs? If so, please list.

Doctor/Nutritionist	Type of Program	Duration	Outcome

- o Have you been prescribed weight loss medications like Phen-Fen or Redux?

If yes, please answer the following:

Medication	Duration of Use	Weight Loss	Duration of Loss	Reason for Discontinuing

- o 24 Hour Intake Recall (Typical Day):

Breakfast:

Lunch:

Dinner:

Snacks: am:

pm:

overnight eating:

High Caloric Liquids: (i.e. regular soda, sweetened iced tea, fruit juices, fruit punches, etc.)

Alcohol: (if yes, how often?)

Sweets:

Salty Snack items:

Fried/Fast foods:

Pizza:

Binges:

- **Have you had psychological or psychiatric counseling for weight loss or problems associated with loss?** Yes No

If yes, please describe, and list the name of counselor with address and telephone number.

- o **Do you feel that your weight affects your life?** Yes No

If yes, please check any of the following:

- **Physically:** 1) How do you manage ordinary chores/activities of daily life? _____

2) Do you feel restricted in participating in recreational activities? _____

- **Socially:** Does your weight affect your relationship with family and friends? If yes, please describe: _____

- **Financially:** Does your weight affect your ability to work? _____

- **Other:** _____

Insurance Information.

- o **Name and address of Insurance Provider:** _____

- o **Membership ID #:** _____ **Group #:** _____
- o **If you are insured under another person's coverage, please list that person's name and social security number:** _____ **or Insurance ID #** _____
- o **Insurance company's phone #:** _____
- **Primary care physician: name, address, and telephone number:** _____

Please list physicians (including name, address, and telephone number) who will provide letters in support of surgical procedure to your insurance company.

Physician	Address	Telephone

* Please provide any and all documentation of attempted weight loss programs. (i.e. - copies of letters from any medical doctors or weight loss programs stating completion of program or certificate of completion)