Your Name _____ **Your Date of Birth** _____

Medical Information Questionnaire

Your height (inches) _____ **Your weight** (pounds) _____

What problems is obesity causing for you? _____

_____

_____

What makes you think seriously about bariatric surgery now (at this stage of your life)?

_____

_____

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

6th grade	HS graduation	At your wedding	Birth of 1st child
_____	_____	_____	_____
Age 21	Age 30	Age 40	Age 50
_____	_____	_____	_____

What has been your maximum weight? _____

What has been your lowest weight (not due to illness) after age 21, which you 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

What diet was most successful for you: _____
Weight loss during above diet: _____

Please list your medical problems and year diagnosed. If you need more space, use the reverse side of this page.

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

A list of common medical diagnoses is provided as a reminder for you>

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)
Urinary incontinence
Menstrual irregularity, infertility
Hirsutism
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? *(circle one)* **Yes** **No**

If yes, please provide further information: _____

_____

_____

Please list the physicians who participate in your care.

Primary MD (PCP) _____

Other physicians and their roles for you:

Name Role

_____ _____

_____ _____

_____ _____

Have you ever undergone colonoscopy (lower scope?) *(circle one)* **Yes** **No**

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

Please list your past surgical history and year surgery performed. If you need more space, use the reverse side of this page.

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*(circle one)* **Yes No**

If yes:

Name of Procedure: _____ When performed: _____

Name of Surgeon: _____ Office location: _____

Your weight prior to that procedure _____

Maximum weight lost, or lowest weight after surgery: _____

Have you undergone more than one prior surgical procedure for weight loss? *(circle one)* **Yes No**

Reason you are seeking another surgical evaluation: _____

_____

Have any of your family members or close friends undergone weight loss surgery? *(circle one)* **Yes No**

If yes, please describe: _____

_____

Do you take birth control pills, or any hormone related medications? *(circle one)* **Yes No**

Do you use any non-prescription (over-the-counter) drugs, vitamins, or herbal remedies? *(circle one)* **Yes No**

If yes, please describe: _____

_____

_____

_____

_____

_____

Are you allergic to any medications? *(circle one)* **Yes** **No**

If yes, please list and describe your reaction to the medications listed:

_____

_____

_____

_____

_____

Please list all medications that you are currently taking. If you need more space, use the reverse side of this page.

	Medication	Strength	Dosage	Schedule for dosing
	Example: TYLENOL	250 mg	2	Each morning, twice a day, etc.

Has anyone in your immediate family had any of the following diseases?

(use: M = mother, F = father, S = sister, B = brother, G = grandparent)

Diabetes _____ Hypertension _____ Severe Obesity_____ Blood Clotting _____

Cancer _____ What type?_____

Relevant Social History

Are you… *(circle one)* Married Single Divorced

If married, how long? _____

If you have children, please list their names and ages below.

Where do you work? What does your job involve? How long have you had this job?

_____

_____

_____

Do you smoke now? *(circle one)* **Yes** **No** **If no**, d**id you ever smoke?** *(circle one)* **Yes** **No**

If yes either above:

How many packs/day? _____ How many years? _____ When did you quit? _____

Do you drink alcohol? *(circle one)* **Yes** **No** **If so, how much?** _____

Do you use drugs like marijuana, cocaine, etc? *(circle one)* **Yes** **No**

What do you aim for your weight to be, five years from now? _____

Please use this space to provide any other information that you think is important to understanding your medical situation, or how we may help you be most successful with the program.

_____

_____

_____

_____

_____

_____

_____

_____

_____

General Symptom Review

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

1 2 3 4 5

Please answer each question by circling yes or no. Provide additional answers where indicated.

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**