

BARIATRIC SURGERY CENTER PATIENT QUESTIONNAIRE

Date you attended the Salem Hospital Bariatric Surgery Information Session: _____

DEMOGRAPHIC INFORMATION

LAST NAME FIRST NAME MI AGE

PHONE NUMBER: _____ (H) _____ (W) _____ (C)

MAILING ADDRESS: _____

E-mail: _____ DATE OF BIRTH _____

EMPLOYER (Name of Company): _____

HEIGHT: _____ WEIGHT: _____ How long have you been at this weight: _____

How did you hear about our program? _____

PRIMARY HEALTH CARE PROVIDER

NAME: _____ PHONE _____

ADDRESS: _____

How long has he/she provided medical care for you?: _____

Conditions treated: _____

Please list other physicians and conditions treated: _____

Please make a copy of your insurance card for our records

PRIMARY INSURANCE INFORMATION

Company: _____ Member ID #: _____

Phone Number: _____

SECONDARY INSURANCE INFORMATION

Company: _____ Member ID #: _____

Phones Number: _____


PERSON TO NOTIFY IMMEDIATELY FOLLOWING SURGERY

NAME: _____ RELATIONSHIP: _____

Phone: _____ This number is: Home Work Cell

Will he/she be waiting at the hospital during your surgery? No Yes

May we fully disclose your medical information to this person? No Yes

Patient Label	 <p>SALEM HOSPITAL REGIONAL HEALTH SERVICES</p>
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LIST ANY MAJOR ILLNESSES (PAST OR PRESENT)

ILLNESS	DATE	TREATMENT	OUTCOME

LIST ANY SURGERIES

SURGERY	DATE	REASON

Have you ever had surgery to aid in weight loss? **No** **Yes**

If yes, please describe: _____

When? _____

MEDICATIONS

Current medications – including vitamins, over the counter medications, and intermittently-used drugs:

NAME	STRENGTH (dose)	How many pills each time?	How often?	WHEN STARTED

Are you allergic to any medications? No Yes

Are you allergic to any foods? No Yes

ALLERGIES AND REACTIONS

Allergy	Reaction

NUTRITION HISTORY

Height _____ Weight _____ How long have you been at your current weight? _____

Your Weight AT: Birth _____ Start of High School _____ HS Graduation _____

What is the most you have ever weighed? _____ How old were you at the time? _____

What is the least you have ever weighed as an adult? _____ How old were you at the time? _____

Have you tried diet pills? **No** **Yes** If yes, what kind?: _____

What kind of exercise program(s) have you tried?: _____

Which of the following weight loss program(s) have you tried:

	Age & for how long?		Age & for how long?		Age & for how long?
AIR FORCE		MAGAZINE DIETS		OVEREATERS ANONYMOUS	
DIET MEDICATIONS		MAYO CLINIC		PHYSICIAN SUPERVISED DIET	
HERBAL LIFE		MEDIFAST		RADER INSTITUTE	
HIGH PROTEIN		METABOLIFE		SELF-IMPOSED FAST	
HYPNOSIS		NUMEROUS BOOK DIETS		SLIMFAST	
JENNY CRAIG		NUTRI-SYSTEM		SUBLIMINAL TAPES	
LIQUID PROTEIN		OPTIFAST		TOPS	
LIVING WELL LADY		OVER THE COUNTER PREPS		WEIGHT WATCHERS	
LOW CALORIE DIET		ADKINS		SOUTH BEACH	

OTHER: _____

What was your most successful weight loss program?: _____

How much weight did you lose and why did this work for you?: _____

How long did you maintain the weight loss?: _____

Do you exercise regularly (3 or more time/week)? **No** **Yes**

If no, why not?: Joint pain _____ Shortness of Breath _____ Dislike Exercise _____

Other, Please explain _____

If you do exercise regularly, what do you do? _____ And how often? _____

What are your favorite foods? _____

What are your favorite snacks? _____

PSYCHIATRIC HISTORY

Have you been treated for a psychiatric condition? No Yes If yes, were you hospitalized? No Yes

Who treated you? Psychiatrist Therapist Psychologist Physician

When was your treatment?: _____

Where?: _____

Have you ever been diagnosed with an eating disorder? No Yes

Current psychiatric medications and dosages: _____

Psychiatric diagnosis and/or reason for treatment: _____

SOCIAL HISTORY

Are you currently employed? No Yes

If you are, what is your occupation?: _____

How long have you been employed at your current job?: _____

If not, what was your most recent job and when?: _____

Why are you not employed now?: _____

Are you currently married? No Yes If yes, how long? _____

Is this your first marriage? No Yes If no, how many previous marriages? _____

On a scale of 1 to 5 (1 being least happy and 5 being most happy) circle your answers to the following:

How happy are you in your present marriage? 1 2 3 4 5 N/A

How happy are you with your present job? 1 2 3 4 5 N/A

How would you rate your overall satisfaction with yourself? 1 2 3 4 5

Have you ever used tobacco products in the past? No Yes What type: Smoke _____

Smokeless _____

If yes, how many packs (cigarettes, cigars, pipes) per day? _____ For how long? _____

When did you quit smoking? _____ I have not quit yet.

Do you drink alcohol currently? No Yes

If yes, what beverages? _____ How many drinks per day? _____

Do you currently, OR have you in the past, consumed alcohol heavily? No Yes If so, when? _____

Do you consume caffeine (coffee, cocoa, colas, Mountain Dew, chocolates, No-Doz, Aqua Ban)? No Yes

If yes, in what form?: _____ How much per day?: _____

Have you ever used recreational or street drugs? No Yes If so, when? _____

When did you quit? _____ I have not quit yet.

FAMILY HISTORY (parents and siblings only)

Family member	Living or Dead?	Age now or at death	Please list any Health problems	Cause of death	Thin	Normal weight	Slightly overweight	Moderately overweight	Very overweight
Mother									
Father									
Sib (B/S)									
Sib (B/S)									
Sib (B/S)									
Sib (B/S)									
Sib (B/S)									

OBESITY-RELATED COMORBIDITIES

URINARY PROBLEMS

Do you ever involuntarily lose your urine? **No** **Yes**
 If yes, what cause you to lose your urine:
 Coughing Jumping Sneezing
 Walking Bending Forward
 Do you wear pads for protection? **No** **Yes** If so, how many per day? _____
 Have you ever had bladder surgery? **No** **Yes** If yes, when? _____

REPRODUCTIVE HISTORY (Women Only)

At what age did your periods start? _____
 Have you gone through menopause? **No** **Yes** If yes, at what age _____
 Are (or were) your periods: Regular Irregular
 What was the date of the first day of your last menstrual period _____
 Have you ever been pregnant? **No** **Yes** If yes, how many times? _____

Pregnancy #	Year	Weight at start of pregnancy	Weight at delivery

Any Miscarriages or abortions? **No** **Yes** Number of miscarriages: _____ Number of abortions: _____

Date of Last Pap Smear _____ Was it normal? **No** **Yes** (Please get a path report)

Date of Last Mammogram _____ Was it normal? **No** **Yes** (Please get an X-ray report)

HEARTBURN AND/OR INDIGESTION

Do you have indigestion or heartburn? **No** **Yes** If yes, for how long? _____ How often? _____

What foods or drinks cause digestive problems for you:

FOOD/DRINK

RESULT OF EATING/DRINKING

OTHER GASTROINTESTINAL PROBLEMS

Any changes in bowel movements? **No** **Yes** If yes, describe _____

Any bloody stools? **No** **Yes** If yes, frequency _____

History of hemorrhoids? **No** **Yes** If yes, when? _____

Have you had a colonoscopy? **No** **Yes**

If so, when and by whom? _____ Any abnormalities? _____

Have you had a flexible sigmoidoscopy? **No** **Yes**

If so, when and by whom? _____ Any abnormalities? _____

SHORTNESS OF BREATH / PULMONARY

Do you experience shortness of breath with physical activity? **No** **Yes**

How long have you been aware of this (be specific)? _____ Years _____ Months

When walking up stairs, how many steps can you climb before noticing shortness of breath? _____ Steps _____ Flights

When do you have to stop and rest? After _____ Steps **OR** After _____ Flights

OBSTRUCTIVE SLEEP APNEA

In what position do you sleep? Sitting up Lying flat on my back Lying on my side Lying on my stomach

How many pillows do you use under you head? _____

Do you awaken from sleep to catch your breath? **No** **Yes** If so, how often? _____

Do you snore? **No** **Yes**

Have you ever been told by someone that you sometimes stop breathing while you are asleep? **No** **Yes**

Do you occasionally doze off while you are talking to someone? **No** **Yes**

Have you ever had an evaluation for Sleep Apnea (i.e. a sleep study)? **No** **Yes**

If so, when and where? _____

ENDOCRINE ABNORMALITIES (INCLUDING DIABETES)

Do you experience thyroid problems? **No** **Yes** If yes, please describe: _____

Do you have diabetes? **No** **Yes** How long? _____

What have you been taking for your diabetes? _____

Do you monitor your blood sugars? **No** **Yes** How often? _____

HEART DISEASE

Do you have high blood pressure? **No** **Yes** How long? _____

What are you taking for your high blood pressure?: _____

Do you have high Cholesterol? **No** **Yes** High triglycerides? **No** **Yes**

If so, for how long? _____

What are you taking for your high cholesterol or triglycerides?: _____

Do you experience swelling of the ankles? **No** **Yes** If yes, how long?: _____

What do you do to decrease the swelling in your ankles?: _____

Do you experience chest pain? **No** **Yes** How long?: _____

BONE OR JOINT PROBLEMS

Do you have any of the following problems: (Check all that apply)

LOCATION	SWELLING	PAIN	STIFFNESS	POPPING OR CRACKING
ANKLES				
KNEES				
HIPS				
BACK				

Have you ever sought treatment for bone or joint problems or injuries? Give details (including Physical Therapy and Chiropractic Therapy).

DOCTOR	DATE OF TREATMENT	DIAGNOSIS/TREATMENTS

Have you taken any medications for your joint or bone problems? **No** **Yes**

If yes, what? _____

Have you ever been told you have degenerative or early arthritic changes in your joints? **No** **Yes**

If yes, in which joints? _____

REVIEW OF SYMPTOMS

UNLESS OTHERWISE SPECIFIED, ANSWER THE FOLLOWING REFERRING TO YOUR CURRENT STATUS:

CONDITION	NO	YES	DETAILS OR COMMENTS
Any condition not listed below			
AIDS/HIV			
Anemia			
Anxiety			
Asthma			
Birth control (Please state method)			
Bleeding tendency			
Breast lump, pain or discharge			
Chest pain with exercise or activity			
Chronic sinus congestion			
Chronic skin rash or hives			
Convulsions, seizures			
Coughing			
Deep vein thrombosis or blood clots in legs			
Dental problems			
Dentures			
Depression			
Diabetes			
Drug or Alcohol abuse			
Ear Pain			
Eyeglasses or Contact Lenses			
Fever, chills or night sweats			
Frequent bloody nose			
Frequent or severe headaches			
Frequent or severe weakness			
Frequent or severe fatigue			
Hay fever			
Hearing problems			
Heart Murmur			
Hepatitis			
High blood pressure readings			
History of head injury with loss of consciousness			
Infertility or irregular menses			
Memory Loss			
Mood Swings			
Nasal Congestion			
Numbness or Tingling			
Paralysis			
Sexually Transmitted Disease (left untreated)			
Sleeping problems			
Sleep Apnea (Diagnosed)			
Sores in mouth			
Thyroid problems			
Visual Problems that aren't correctable			
Wheezing			

Please state in your own words why you are making the decision to have weight loss surgery and what you feel the changes will be in your life due to the surgery (feel free to use back of this sheet if you need more space):
