Bariatric Surgery Clinical Questionnaire

Please complete form accurately to avoid delay in insurance pre-authorization or delivery of care.

I. DEMOGRAPHIC INFORMATION:

Name: _____ Name you like us to call you: _____
Date of Birth ___/___/___ Age ___ Present Weight ____ Height ____Telephone: Cell _____ Work _____
Address: _____ Email: _____
Primary care physician: _____ Ob/Gyn (if applicable) _____
Other physicians currently providing care and their specialty: _____

II. DIETARY HISTORY:

A. Weight History: At what age did you develop a weight problem? _____ Highest Adult weight _____
Number of years at current approximate weight: _____ Highest weight you ever lost by any method: _____

B. Exercise History: Do you exercise regularly? ☐ Yes ☐ No If yes, how frequently? __ times/week
What level of day-to-day activity best describes you: ☐ Sedentary ☐ Minimally Active
☐ Moderately Active ☐ Very Active

Have you ever tried to lose weight through exercise? ☐ Yes ☐ No Please record your experience below:

Exercise Program	Year	Length of Time on program	Pounds Lost	Pounds Regained
Health Club				
Walking				
Other				

C. Behavioral Modification History

Have you ever received Behavioral Modification therapy for weight loss? ☐ Yes ☐ No
If yes, describe treatment _____

D. Medical Weight loss History

Have you ever received medication from a physician to loose weight? ☐ Yes ☐ No
If yes, please describe treatment _____

C. Dietary History: Please choose eating habits that best describe you (check all that apply):
☐ Large Portion Size ☐ Frequent Snacks ☐ Eating sweets ☐ Eating Out a Lot ☐ Skip Meals
☐ Compulsive Eating ☐ Emotional eating ☐ Eat late at night ☐ Read Food labels ☐ Watch Calories

Please record below any diet that you have tried in your life of any duration

Type of Diet	Year	Duration	Pounds Lost	Pounds Regained

III. MEDICAL HISTORY (check all that apply)

Have you ever been diagnosed with any of the following conditions commonly associated with obesity?

High Blood Pressure	☐ Yes	☐ No	Lower back pain	☐ Yes	☐ No
High Cholesterol/lipids	☐ Yes	☐ No	Urinary Stress Incontinence	☐ Yes	☐ No
Diabetes Mellitus	☐ Yes	☐ No	Fatty Liver	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No	Gall Stones	☐ Yes	☐ No
Reflux Disease (Heartburn)	☐ Yes	☐ No	Pseudo tumor Cerebri	☐ Yes	☐ No
Osteoarthritis (joints:_____)	☐ Yes	☐ No	Plantar Fasciitis	☐ Yes	☐ No

Please indicate if you have ever been diagnosed with any of the other conditions listed below:

Cardiac
☐ Coronary Artery Disease
☐ Heart Attack
☐ Angina (Chest Pain)
☐ Congestive Heart Failure
☐ Arrhythmia (Irregular Heart Beat)
☐ Heart Valve Disease
☐ Other _____

Endocrine
☐ Hypothyroid
☐ Adrenal (Cushings)
☐ Other _____

Pulmonary
☐ COPD (Emphysema/Bronchitis)
☐ Asthma
☐ Loud Snoring
☐ Gasping for Breath at Night
☐ Other _____

Gastrointestinal
☐ Inflammatory Bowel Disease (Crohn's, Ulcerative Colitis)
☐ Hiatal Hernia
☐ Peptic Ulcer Disease
☐ Cirrhosis of Liver
☐ Other _____

Renal
☐ Kidney Stones
☐ Other _____

Psychological & Psychiatric Disorders
☐ Depression
☐ Anxiety
☐ Bipolar Depression
☐ Schizophrenia
☐ Other _____
☐ Were you ever hospitalized for a psychiatric condition? ☐ Yes ☐ No Year admitted _____

Blood Disorders
☐ Anemia
☐ Bleeding or clotting problems
☐ Other _____

Musculoskeletal & Nervous System
☐ Gout
☐ Autoimmune Disease
-If yes, please explain (Eg., Lupus, Rheumatoid Arthritis) _____

Cancer
Ever diagnosed with Cancer? ☐ Yes ☐ No
Type of cancer _____
Year Diagnosed _____ Physician _____
Treatment _____

Other Medical Conditions not listed above
Condition _____
Year Diagnosed _____ Physician _____
Treatment _____

IV. OB/GYN HISTORY (If applicable)

Number of Pregnancies _____
Natural Deliveries _____
Cesarean sections _____
Are you ☐ Menstruating, or ☐ Post-menopausal
Have you had Tubal Ligation? ☐ Yes ☐ No
Have you had Hysterectomy? ☐ Yes ☐ No

V. SURGICAL HISTORY

Please list all of your previous surgical procedures
Surgery _____ Year _____
Surgery _____ Year _____
Surgery _____ Year _____

Have you ever had complication after surgery?
☐ Yes ☐ No If yes, describe _____
_____

VI. CURRENT MEDICATIONS

Please list all prescribed and over-the-counter medications, **including nutritional and herbal supplements** you are currently using.

	Medications	Dose	Frequency/day	Year Started	Purpose
1.					
2.					
3.					
4.					
5.					
6.					
7.					

Name, telephone, address of your pharmacy _____

VII. ALLERGY INFORMATION

Please list any known allergies to medications:
Medication _____ Allergic Reaction _____ Medication _____ Allergic Reaction _____
Medication _____ Allergic Reaction _____ Medication _____ Allergic Reaction _____

VIII. SOCIAL HISTORY

Tobacco: Do you currently smoke tobacco? ☐ Yes ☐ No
If a current smoker, you have smoked an average of ____ cigarettes/day for _____ years
If a past smoker, you smoked an average of ____ cigarettes/day for _____ years and quit _____ years ago

Alcohol: Do you currently drink alcohol? ☐ Yes ☐ No
If yes, indicate type of alcohol _____ and number of drinks/week _____
If a past consumer, type of alcohol _____ , number of drinks/week _____and quit _____ years ago

Drugs: Have you ever used recreational drugs? ☐ Yes ☐ No
If yes, please indicate which and how long ago? _____

Occupation: Occupation _____ Employer _____ Years at this job _____

IX. FAMILY HISTORY

Has anyone in your family reacted adversely to anesthesia? ☐ Yes ☐ No
If yes, please explain: _____

Has anyone in your family had excessive bleeding after a surgery? ☐ Yes ☐ No
If yes, please explain: _____

X. PREVIOUS DIAGNOSTIC PROCEDURES

Please indicate the date for any diagnostic procedures within the last two years.

Test	Date	Test	Date
☐ EKG	_____	☐ Upper GI	_____
☐ Chest X-Ray	_____	☐ Upper Endoscopy	_____
☐ Echocardiogram	_____	☐ Colonoscopy	_____
☐ Stress test	_____	☐ CT Scan	_____
☐ Cardiac Catheterization	_____	☐ Abdominal Ultrasound	_____
☐ Pulmonary Function Study	_____	☐ Gastric Emptying Study	_____
☐ Sleep Study	_____	☐ Other: _____	_____

How did you hear about us? _____

Which one of the choices best describes you?
☐ I am quite sure I want to have bariatric surgery soon, and I know what procedure: _____ (procedure)
☐ I am quite sure I want to have bariatric surgery soon, but not sure which procedure.
☐ I want to have bariatric surgery, but I am not sure when.
☐ I have not completely decided that I want bariatric surgery, but I am very eager to learn more.
☐ I am just not sure about bariatric surgery, and need some general information.

Has any family member or friend, or someone you know undergone Bariatric Surgery?
☐ Yes, Name type of surgery _____ ☐ No

Which of the following operations are you interested in?
☐ Laparoscopic Gastric Bypass ☐ Laparoscopic Sleeve Gastrectomy ☐ No preference ☐ Other ____

Please list any specific question or concern that you may have about your surgical procedure, so that we can address them during your consultation.

_____
_____
_____
_____

The information provided in this form is correct to the best of my knowledge.

_____	_____	_____
Patient Name (please print)	***Patient Signature***	***Date***

Information reviewed by Dr. Zaré on ___/___/_____ _____