Weight Loss Surgery Patient Questionaire

Office Use Only:
Date _____

Height_____ BP_____

Weight_____ HR_____

BMI:_____ % BF_____

Baptist Bariatric Center of Excellence

Please complete form in blue or black ink.

Personal

First Name:_____ MI:___ Last Name:_____

Age :____ ❑ Male ❑ Female Birthdate:_____ SS: _____

Address:_____ City:_____ State: ____ Zip:_____

Phone: _____ Cell: _____ Email: _____

❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Members in your household:

Name	Age	Relationship

Emergency contact person(s)	Relationship	Contact Phone Number

❑ Employed ❑ Disabled ❑ Not employed ❑ Student

Occupation: _____ Employer: _____

Employer address: _____

Employer phone: _____ How long with employer?_____

Health insurance name: _____

I acknowledge that I have received a copy of the organization's Notice of Privacy Practice that describes how my health information is used and shared.

Patient signature:_____ Date:_____

BAPTIST HEALTH CARE
Bariatric Center of Excellence
1717 N. "E" St., Tower III
Pensacola, FL 32501

4QUE
FM-0064 (8/10)
PRINT: BOOKLET

Experience & Passion
Hope & Health

Health History

Primary care physician (PCP): _____
PCP Address: _____
PCP Phone: _____ PCP Fax :_____ How long seen? _____

Current Medications: Please list or attach a copy

Medication	Dose/How often?	Medication	Dose/How often?

Current medical conditions: Please check all that apply:

Heart/Vascular

❑ Hypertension/ High Blood Pressure ❑ Coronary heart disease ❑ High triglycerides ❑ Congestive heart failure ❑ Heart attack ❑ Irregular heart beat ❑ Heart failure
❑ High cholesterol ❑ Pulmonary embolism ❑ Varicose veins ❑ Stroke
❑ Blood clots ❑ Thrombophlebitis ❑ Cellulitis ❑ Bleeding disorder
❑ Swelling in feet, ankles, or legs
❑ Previous stress test: When? _____ ❑ Previous cath: When?_____

Endocrine/Urinary/GI Related

❑ Diabetes ❑ Type 1 ❑ Type 2 Age of onset_____ ❑ High blood sugar ❑ Low blood sugar
❑ Heartburn: How often? ❑ weekly ❑ daily ❑ more than once daily
❑ Hypothyroidism ❑ GERD/reflux ❑ Hiatal hernia ❑ Rectal bleed
❑ Ulcers ❑ Gastritis ❑ IBS ❑ Crohn's
❑ Liver disease ❑ Fatty liver ❑ Cirrhosis ❑ Hep A, B, C
❑ Kidney stones ❑ Gallstones ❑ Anemia ❑ Iron def ❑ Other
❑ Urinary stress incontinence How often?_____ Wear pads?_____
❑ Previous colonoscopy: When? ❑ Blood in stool/urine ❑ Bruise easily

Muscular/Skeletal

❑ Arthritis ❑ Osteoarthritis ❑ Osteopenia ❑ Osteoporosis
❑ Lupus ❑ Chronic fatigue syndrome ❑ Chronic headache or migraines
❑ Chronic pain ❑ Fibromyalgia ❑ Rheum arthritis
❑ Previous Dexa scan: When?_____ Normal? ❑ yes ❑ no
❑ Pain of weight-bearing joints ❑ Back ❑ Hips ❑ Knees ❑ Feet ❑ Other_____

Lung Related

❑ Asthma ❑ Allergies/hay fever ❑ Lung disease ❑ Shortness of breath ❑ Emphysema or COPD
❑ Sleep apnea ❑ C-PAP ❑ Bi-PAP ❑ Pneumonia ❑ TB

Other

❑ Depression ❑ Anxiety ❑ Bipolar disorder ❑ Suicide attempt ❑ Other
❑ Cancer: If yes, type(s): _____
❑ Prostate problems
❑ Other medical conditions not addressed above:_____

Allergies

Medication_____
Food_____
Allergy to: ❑ bananas ❑ chestnuts ❑ avocados
Allergy to latex ? ❑ Yes ❑ No Sensitivity to rubber or bandaids? ❑ Yes ❑ No
Other _____

For Women Only

Age started menses_____ Date of last menses_____
Date of last PAP smear/pelvic exam_____ Results normal? ❑ Yes ❑ No
Date of last breast exam/mammogram_____ Results normal? ❑ Yes ❑ No
Number of pregnancies_____ Number of children _____
Have you had difficulty becoming pregnant? ❑ Yes ❑ No
What method of birth control do you use? _____
Do you plan on having more children? ❑ Yes ❑ No

Family Medical History (Check If Applies)

	Age	Height & Weight	Obesity	High blood pressure	Heart attack or other heart conditions	Diabetes	Other medical conditions	Check if deceased
Mother								
Father								
Siblings								
Spouse								
Children								

Physicians seen in the last 5 years (include specialty physicians)

Physician name	City/State	Phone	Fax

Previous Surgeries

Type of surgery	Date/Year	Surgeon	Hospital/City
Surgical Complications:			

❑ Bleeding ❑ Blood clots ❑ Anesthesia problems ❑ Blood transfusions ❑ Infections

❑ Other _____

Other Hospitalizations

Reason	Date/Year	Surgeon	Hospital/City

Sleep Study Assessment

A. Do you snore while sleeping? ❑ Yes ❑ No Does your bed partner say you snore? ❑ Yes ❑ No

Does your bed partner say that you stop breathing while sleeping? ❑ Yes ❑ No

B. THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose *the most appropriate number for each situation.*

0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing

Situation	Chance of Dozing
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. theater, meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
Total Score:	_____

For Office Use Only

Any "Yes" Section A?

(With BMI ≥ 35)

OR

Score ≥ 11 Section B?

(With BMI ≥ 35)

Refer for Pre-Op Sleep Study.

Date:_____

Name: _____

Psycho-Social History

Level of education_____ Occupation _____
Religious preference_____
Do you smoke? ❑ Yes ❑ No How much? _____ Recreational drugs? ❑ Yes ❑ No
Do you drink alcohol? ❑ Yes ❑ No ❑ Daily ❑ Once/week ❑ Once/month ❑ Once/year
What type of alcoholic beverages do you usually drink?_____ How much at a time? _____
Have drugs or alcohol ever been a problem for you? ❑ Yes ❑ No
What major stressors, if any, do you have in your life at this time? _____

_____

Describe briefly what you know about the:

Weight loss surgical procedure? _____

_____

Possible risks_____

Expected lifestyle changes_____

How did you obtain your information about the surgery?_____

What are your reasons for wanting weight loss surgery?_____

What would you expect to weigh after the surgery? _____

How long have you considered weight loss surgery and what events have led you to consider surgery at this time?

_____

How do expect your life will change if you have weight loss surgery? _____

_____

What are your major concerns if you have the surgery? _____

_____

How does your spouse, significant other, or family feel about you having weight loss surgery?

_____

Do you know anyone who has had this surgery (friends, family, coworkers, etc)? _____

Who will be your support system if you have weight loss surgery?_____

Nutrition/Activity/Weight History

Step 1: Please keep a 1-week food & beverage diary on separate sheets of paper. List when, what, and how much food or beverage was eaten daily for 1 week. Eat as you would normally – do not try to diet.

Step 2: Use the chart on the next page to identify all the weight loss attempts you have made in the past. Use additional paper, if needed.

Estimated height_____ Current or estimated weight _____ BMI, if known _____
Highest weight_____ When? _____ Lowest adult weight_____ When?_____
Age of first diet_____

How would you describe your weight during:

Childhood?	❑ Underweight	❑ Normal weight	❑ Overweight	❑ Obese
Middle school?	❑ Underweight	❑ Normal weight	❑ Overweight	❑ Obese
Teen years?	❑ Underweight	❑ Normal weight	❑ Overweight	❑ Obese

What was your estimated weight?
At birth_____ High school _____ 20's _____ 30's_____ 40's_____
50's _____ 60's _____

What significant life events have had a major impact on your weight, resulting in a weight loss or weight gain (move, job change, pregnancy, divorce, etc)?

Age	Event	Weight prior	Weight after

Do you feel you eat in response to:
❑ Anger ❑ Stress ❑ Frustration ❑ Boredom ❑ Loneliness ❑ Reward ❑ Other_____

Have you ever tried to lose weight by vomiting, fasting, or using laxatives excessively?
❑ Yes ❑ No If yes, when?_____

Would you say you have a problem with binging (eating large amounts of food, in a short period of time, feeling out of control)? ❑ Yes ❑ No If yes, explain_____
_____
Current exercise or physical activity_____
Describe any physical activity limitations you have_____
What physical activities do you enjoy?_____
List any vitamin, mineral, or herbal supplements you have been prescribed or take on a regular basis
_____

Please complete the charts below for any of weight loss attempts you have tried in the past.

PHYSICIAN-SUPERVISED PLANS	Age/year?	# of months on program	#lbs lost	How long before regain?
Optifast				
HMR				
Specific Diet plans per MD (list such as calorie-controlled, lowfat/low cholesterol, diabetic, etc.) List:				
RD/nutritionist referral				
Diabetic Program/classes				
Phen-fen (Redux)				
Diethylpropion (Tenuate, Dospane, etc.)				
Phentermine (Fastin, Adipex-P, Obenix, Ionamin, …)				
Sibutramine (Meridia)				
Orlistat (Xenical)				
Previous Weight Loss surgery—list type:				
Other MD-supervised programs or medications				

COMMERCIAL OR SELF-MONITORED	Age/year?	# of months on program	#lbs lost	How long before regain?
Weight Watchers				
Nutri-Systems				
Jenny Craig				
LA Weight Loss				
Overeaters Anonymous				
Tops				
Adkins/Southbeach/Sugarbusters				
YMCA or other physical activity program				
Curves				
Other diets or programs….(Slimfast, eDiet, etc.)				
Over-the-counter products (Dexatrim, Fat-blockers, etc.)				

BAPTIST
HEALTH CARE

Bariatric Center of Excellence
1717 N. "E" St., Tower 3
Pensacola, FL 32501

The Baptist Bariatric Center of Excellence is located on the ground floor of Baptist Medical Tower III. To learn more about weight loss surgery and the Bariatric Center,

call (850) 469-5816,

or visit our Web site:
www.eBaptistHealthCare.org/bariatrics