Beth Israel Deaconess Medical Center
Boston, MA 02215

PATIENT'S NAME _____

MED. REC. # _____

DOB _____

Patient Identification

NEW PATIENT QUESTIONNAIRE
Bariatric

I am interested in: ☐ Gastric Bypass ☐ Lap Band ☐ Gastric Sleeve ☐ Not Sure

MR2806

Medical Health Care Providers

Primary Care Physician: _____ Phone: (_____) _____ - _____

Therapist or Mental Health Counselor: _____ Phone: (____) _____ - _____

Psychopharmacologist: _____ Phone: (_____) _____ - _____

Do you have a history of any of the following conditions? (check all that apply)

☐ Diabetes	☐ Blood clots	☐ Gastro esophageal reflux (GERD)
☐ Hypoglycemia	☐ Leg swelling	☐ Colon (hemorrhoids, polyps)
☐ Hypothyroidism	☐ Peripheral vascular disease	☐ Celiac disease
☐ Thyroid disease	☐ Numbness or tingling in hands / feet	☐ Heartburn
☐ Kidney disease	☐ Migraines	☐ Crohn's disease
☐ Kidney stones	☐ Seizures	☐ Ulcerative colitis
☐ Liver disease (hepatitis, cirrhosis)	☐ Impaired mobility (e.g. trouble walking)	☐ Ulcers (Where: _____)
☐ Depression	☐ High blood pressure	☐ Infertility
☐ Panic attacks	☐ Chest pain / angina	☐ Polycystic Ovary Syndrome
☐ Past suicide attempts	☐ Coronary heart failure	☐ Anemia (iron deficiency)
☐ Schizophrenia	☐ Congestive heart failure	☐ Gout
☐ Bipolar disorder	☐ High cholesterol	☐ Prostate issues
☐ Borderline personality disorder	☐ Asthma	☐ Sleep apnea
☐ Binge eating	☐ Shortness of breath	☐ Stroke
☐ Vomiting / purging	☐ COPD	☐ Arthritis
☐ Anorexia	☐ Pulmonary embolism	☐ Other:

Do you have your gall bladder? ☐ Yes ☐ No
Are you currently breast feeding? ☐ Yes ☐ No

ALLERGIES: ☐ **No, I have no allergies, sensitivities or medication reactions that I know of.**
☐ **Yes (List below)**

Allergy / Sensitivity / Medication Reaction	Type of Reaction
Medications:	
Vaccinations:	
Contrast Dye:	
Latex:	
Food / Shellfish:	
Seasonal Allergies:	
Environmental Allergies:	
Insects / Venom (e.g., Bee Stings):	
Other:	
Other:	

Beth Israel Deaconess Medical Center
Boston, MA 02215

PATIENT'S NAME _____

MED. REC. # _____

DOB _____

Patient Identification

NEW PATIENT QUESTIONNAIRE
Bariatric

MR2806

Family History

Please indicate if your parents, siblings, and/or your children have had any of the following conditions and at what age they got the condition.

	Which Family Member?	At What Age?	Living or Deceased?
Heart Disease			
High Cholesterol / Lipids			
Diabetes			
Stroke			
Obesity			
Arthritis			
TB (Tuberculosis)			
Thyroid Disease			
Asthma			
Cancer			

Past Surgical History:
Have you ever had any operations or surgical procedures? ☐ No ☐ Yes If Yes, please list.

Date	Operation / Procedure
____/____/____	
____/____/____	
____/____/____	
____/____/____	

MEDICATIONS: List all the prescription and over–the–counter medicines that you take at home (such as cold medicine, herbals, vitamins and nutritional supplements). If you have received a printed Medication list, please add anything here that is not on your printed list.

☐ **I take no medications or supplements** ☐ **See attached list**

Medication / Supplement Name	Dose	How You Take It? (by mouth, injection, etc.)	Time of Day / How Often

Do you smoke? ☐ No ☐ Yes If Yes, how many packs per day? _____For how many years? _____

Do you drink? ☐ No ☐ Yes If Yes, how many drinks per week? _____For how many years? _____

Do you use Recreational Drugs? ☐ No ☐ Yes If Yes, What type? _____

Beth Israel Deaconess Medical Center
Boston, MA 02215

PATIENT'S NAME _____

MED. REC. # _____

DOB _____

Patient Identification

MR2806

NEW PATIENT QUESTIONNAIRE
Bariatric

Have you tried any of the following? (Check all that apply)

- ☐ Weight Watchers®
- ☐ Nutritionist / Dietitian
- ☐ Sibutramine (Meridia®)
- ☐ Acupuncture
- ☐ Orlistat (Xenical™)
- ☐ Fen-Phen
- ☐ LA Weight Loss®
- ☐ Phentermine(Fastin®, Adipex®)
- ☐ Other over the counter diet aids / herbs
- ☐ Medifast®
- ☐ Atkins®
- ☐ Ephedra
- ☐ The Zone
- ☐ Dexatrim
- ☐ Optifast®
- ☐ HMR
- ☐ South Beach
- ☐ Amphetamines
- ☐ Diet Workshop
- ☐ Topiramate (Topamax®)
- ☐ OA
- ☐ Hypnosis
- ☐ Trimspa®
- ☐ Laxatives
- ☐ Behavior Therapy
- ☐ Previous Gastric Surgery / Stomach stapling
- ☐ Slimfast
- ☐ Nutrisystem®
- ☐ Metabolife
- ☐ Pondimin
- ☐ TOPS
- ☐ Other Surgery
- ☐ Psychotherapy
- ☐ Jenny Craig

What food triggers do you feel contributed to your gaining weight?

_____

_____

In your opinion, what are the factors that contribute to your excess weight? (Check all that apply)

- ☐ Portion size
- ☐ Compulsive eating
- ☐ Eating too many fats and/or carb
- ☐ Emotional eating
- ☐ Genetics
- ☐ Lack of knowledge about healthy living
- ☐ Stress
- ☐ Lack of exercise

Who will be your Support Persons for after surgery?

Name: _____ **Relationship:** _____

_____ _____

Functional Health Status

- ☐ Independent – no help needed to complete activities of daily living
- ☐ Partially Dependent – some help needed
- ☐ Totally Dependent on others for self-care

Patient Certification: I have answered these questions to the best of my ability. I understand that this information will be used to guide my care.

X_____ _____ **OR**
Patient's Signature — Print Name

X_____ _____ **and** _____
Signature of Person completing form for Patient — Print Name — Relationship to Patient

Date: ____/____/____ **Time:** __ __ : __ __ ○ a.m. ○ p.m.

Physician Review: I have reviewed the above information with the patient

X_____ _____ ____/____/____ __ __ __ __
M.D. Signature — Print Name — Date — Time (24 hour)

Name of Interpreter (if applicable): _____