CHAPMAN
Center for Obesity

BARIATRIC PATIENT QUESTIONNAIRE

In order to better serve you, we need your assistance in obtaining all of the required documentation to submit a request for insurance approval. It is very important that you fill out all of the requested information below. Items in **bold** are *required*. When complete, you may FAX or mail this form to our office.

IMPORTANT: We also need copies of your insurance card, front and back.

Name ____ **Today's Date**____________________________

Phone (H) _____________________ **(W)**____________________ **(Cell)**____________________________

Email Address ____

Address____

City ___________________________ **State** _______________ **Zip** _________________________________

Sex _____ **Age** _____ **Height** _______ **Current Weight**___________ **Birth Date**______________________

Social Security # ______________________ **Driver's License:** State _____ #_________________________

Race (optional): ❑ Caucasian ❑ Black ❑ Asian ❑ Hispanic ❑ Other ______________________

Marital Status (optional): ❑ Single ❑ Married ❑ Separated
❑ Divorced ❑ Widowed

Maximum Weight: ___________ Age first became 75 lbs. or more overweight: _________________________

Number of weight loss methods tried pre-op (*Please provide a number even if unsure*): ___________________

How many times have you lost 20 or more pounds? (*Please answer even if it is only a guess*)________________

Main reason for wanting treatment for weight loss? ____

____

____

Please provide the full name, address and phone number of your primary care physician:

Physician Name ____

Address____

City _________________________ **State** ______ **Zip**___________ **Phone** (   ) ______________________

EMPLOYMENT INFORMATION

Are you employed? ❑ Yes ❑ No

Employer Name ________________________ Occupation ________________________

Employer Address ____

City ____________________ State ____________ Zip ____________________

INSURANCE VERIFICATION

Primary Insurance Company Name __________________ **Phone** __________________

Insurance Company Address ____

City ____________________ **State** ____________ **Zip** ____________________

IPA/Medical Group ____

Insured's Name ______________________ **Insured's SS #** ______________________

Relationship to Patient __________________ **Insured's Employer** ____________________

Insured's Policy Number ________________ **Insured's Group Number** ________________

Secondary Insurance Company Name __________________ Phone ____________________

Insurance Company Address ________________________ City ____________________

State ________ Zip __________ Insured's Name ______________________________

Relationship ________________ Insured's Employer ______________________________

Insured's Policy Number ______________ Insured's Group Number ______________________

CHOICE OF SURGERY (check one)

❑ Laparoscopic Gastric Banding ❑ Laparoscopic Gastric Bypass ❑ Laparoscopic Gastric Sleeve

CHOICE OF SURGEON (check one)

❑ David Oliak, M.D.–Medical Director ❑ Justin Braverman, M.D. ❑ Andrew Hajduczek, M.D.

❑ Doug Krahn, M.D. ❑ Milton Owens, M.D. ❑ Brian Quebbemann, M.D.

PATIENT INFORMATION SEMINAR

Have you attended a patient information seminar?

❑ Yes I have attended a seminar Date of seminar ______________________________

Location of seminar (check one) ❑ Chapman Medical Center
❑ Other

REFERRAL SOURCE

I heard about Chapman Center for Obesity from: (check one and/or write in the information)

❑ Online Search *(website address)* ______________________________

❑ Former Patient: Primary Care Physician ______________ Insurance Company ______________

❑ Newspaper Ad *(indicate name of paper)* ______________________________

❑ Other source ______________________________

Name and address *(if you selected Physician or Patient)*

Name______________________ Address ______________________________

City ____________________ State____________ Zip ______________________

MEDICAL HISTORY

LIST PRIOR WEIGHT LOSS OPERATIONS (IF ANY)

❑ J.I. Bypass When?______________ Hospital/Clinic Name: __________________________

❑ Vertical Band Gastroplasty When?______________ Hospital/Clinic Name: __________________________

❑ Vertical Ring Gastroplasty When?______________ Hospital/Clinic Name: __________________________

❑ Roux-en-Y Gastric Bypass When?______________ Hospital/Clinic Name: __________________________

LIST PREVIOUS OPERATIONS

Operation	Date	Type of Anesthesia	Problems (if any)

Has any blood relative ever had difficulty or problems with Anesthetics (e.g. malignant hyperthermia)
❑ Yes ❑ No

LIST MEDICAL ILLNESSES

____

____

____

____

____

____

____

____

Does anyone in the family have Diabetes, High Blood Pressure, Heart Disease or Gallstones?
❑ Yes ❑ No Describe: ____

MEDICATIONS

What medications are you taking? ***Be sure to include all your medications and the correct dosages.*** Attach another sheet if necessary. Do not forget such things as aspirin, cortisone, blood pressure medication, thyroid medication, tranquilizers, hormones, birth control pills, laxatives, vitamins etc.

Medicine	Dose	Frequency

Have you ever taken **Phen – fen**? .... ❑ No ❑ Yes

If so how long? ____

ALLERGIES

Are you allergic to any medications? .... ❑ No ❑ Yes

Medication ______________________ Reaction ______________________________

Medication ______________________ Reaction ______________________________

Medication ______________________ Reaction ______________________________

Medication ______________________ Reaction ______________________________

EATING HABITS

For the following 6 questions, answer "Yes" if they occur 3 or more days a week–otherwise answer "No"

Do you eat breakfast? .... ❑ No ❑ Yes

Do you snack at night? .... ❑ No ❑ Yes

Do you snack during the day? .... ❑ No ❑ Yes

Do you drink soda or other very sugary liquids?.. ❑ No ❑ Yes

Do you eat desserts and fried foods? .... ❑ No ❑ Yes

Are the meals that you eat small, medium, or large as compared to normal weight people eating the same meal?

❑ Small ❑ Med. ❑ Large

SMOKING AND DRINKING

How many cigarettes (packs) do you smoke a day? ______________________________

Do you drink alcohol?
❑ Never ❑ Rarely (2 times per month of less) ❑ Occasionally (once a week or so) ❑ Daily

SLEEPING

Has anyone told you that you sometimes hold your breath for a long time while asleep? ... ❑ No ❑ Yes

For the following questions, answer "Yes" if they occur 2 or more days a week – otherwise answer "No"

Do you have restless sleep or frequent awakening? .... ❑ No ❑ Yes

Do you have night sweats? .... ❑ No ❑ Yes

Do you snore? .... ❑ No ❑ Yes

Do you have daytime sleepiness? .... ❑ No ❑ Yes

Do you have morning headaches? .... ❑ No ❑ Yes

Do you wake at night with a snort or gasp? .... ❑ No ❑ Yes

RESPIRATORY

Shortness of breath at rest .... ❑ Never ❑ Past ❑ Now

Pneumonia .... ❑ No ❑ Yes

Bronchitis .... ❑ No ❑ Yes

Emphysema/COPD .... ❑ No ❑ Yes

Have you been diagnosed or treated for asthma? .... ❑ No ❑ Yes

Year of last chest X-ray? .... __________

Normal? .... ❑ No ❑ Yes

CARDIOVASCULAR

Chest pain or angina pectoris? .... ❑ Never ❑ Past ❑ Now

Heart murmur? .... ❑ Never ❑ Past ❑ Now

Have you ever had palpitations/arrhythmia? .... ❑ No ❑ Yes

Have you had a heart attack? .... ❑ No ❑ Yes

Have you been diagnosed or treated for high blood pressure? .... ❑ No ❑ Yes

If yes, were you prescribed medication?

❑ None ❑ 1 medication ❑ 2 medications ❑ 3 or more medications

Varicose veins? .... ❑ Never ❑ Past ❑ Now

Have you had blood clots or phlebitis (inflammation in the leg vein)? .... ❑ No ❑ Yes

Year of last EKG?__________ Normal? .... ❑ No ❑ Yes

Do you have shortness of breath after climbing on flight of stairs? .... ❑ No ❑ Yes

How many blocks can you walk without having to stop for breath?______________________________

How many days a week do you exercise on average?______________________________

GASTROINTESTINAL

Have you been told that you have Gallstones? ❑ No ❑ Yes

Do you have heartburn or acid indigestion? ❑ No ❑ Yes

Tarry black stool or blood in bowel movements? ❑ Never ❑ Past ❑ Now

Trouble swallowing or persistent abdominal pain? ❑ Never ❑ Past ❑ Now

Do you frequently regurgitate (burp up) your food? ❑ Never ❑ Past ❑ Now

Crampy abdominal pain? ❑ Never ❑ Past ❑ Now

Chronic constipation? ❑ Never ❑ Past ❑ Now

Frequent diarrhea? ❑ Never ❑ Past ❑ Now

Change in bowel habits? ❑ Never ❑ Past ❑ Now

Hemorrhoids or piles? ❑ Never ❑ Past ❑ Now

Have you been diagnosed as having stomach or intestinal ulcers or other disorders of the gastrointestinal system? ❑ Never ❑ Past ❑ Now

Have you pain or difficulty swallowing? ❑ Never ❑ Past ❑ Now

Have you had hepatitis or liver problems? ❑ Never ❑ Past ❑ Now

Ever vomit blood? ❑ Never ❑ Past ❑ Now

GENITOURINARY

Menstrual difficulties? ❑ None ❑ Irregular periods ❑ Heavy period ❑ Painful period

Have you had gynecologic (female) problems? ❑ Never ❑ Past ❑ Now

Are you or might you be pregnant? ❑ Never ❑ Past ❑ Now

Do you lose small amounts of urine with coughing or straining? ❑ No ❑ Yes

Have you had kidney problems? ❑ Never ❑ Past ❑ Now

Burning or pain urination? ❑ Never ❑ Past ❑ Now

Frequent urination? ❑ Never ❑ Past ❑ Now

Feeling you must go immediately? ❑ Never ❑ Past ❑ Now

Blood in urine? ❑ Never ❑ Past ❑ Now

Kidney Stones? ❑ Never ❑ Past ❑ Now

MUSCULOSKELETAL

Arthritis, swollen or painful joints? ❑ Never ❑ Past ❑ Now

Pain in calves or buttocks when walking, relieved by rest? ❑ Never ❑ Past ❑ Now

Do you have swelling of ankles? ❑ No ❑ Yes

Do you have joint pain – back? ❑ No ❑ Yes

Do you have joint pain – hip? ❑ No ❑ Yes

Do you have joint pain – knee? ❑ No ❑ Yes

Do you have joint pain – ankle? ❑ No ❑ Yes

Do you have joint pain – foot? ❑ No ❑ Yes

SKIN

Frequent infections? ❑ Never ❑ Past ❑ Now

Unusual moles or lumps? ❑ Never ❑ Past ❑ Now

Describe ____________________

NEUROLOGICAL

Eye disease or injury? ❑ Never ❑ Past ❑ Now

Double vision? ❑ Never ❑ Past ❑ Now

Headaches? (also, check one box in each group below) ❑ Never ❑ Past ❑ Now

❑ rarely ❑ occasionally ❑ frequently
❑ minimal ❑ moderate ❑ severe

Epilepsy or Seizures? ❑ Never ❑ Past ❑ Now

Brain disease or Strokes? ❑ Never ❑ Past ❑ Now

EMOTIONAL

Are you satisfied with your social life? ❑ No ❑ Yes

Were you ever severely, **emotionally, physically** and/or **sexually** abused? ❑ No ❑ Yes

Are you satisfied with your sex life? ❑ No ❑ Yes

How would you rate your self esteem level? ❑ Low ❑ Med ❑ High

How would you rate your energy level? ❑ Low ❑ Med ❑ High

Do you have trouble sleeping? ❑ Never ❑ Past ❑ Now

Are you usually tired? ❑ Never ❑ Past ❑ Now

Are you often depressed? ❑ Never ❑ Past ❑ Now

Are you often anxious or nervous? ❑ Never ❑ Past ❑ Now

Do you ever wish you were dead and away from it all? ❑ Never ❑ Past ❑ Now

Have you ever seen a psychiatrist? ❑ No ❑ Yes

If seen by a Psychiatrist, please provide their name, address and phone number:

Psychiatrist Name ____________________

Address ____________________

City __________ State ______ Zip ______ Phone (   ) __________

Have you ever been hospitalized for psychiatric reasons? ❑ No ❑ Yes

HEMATOLOGICAL

Anemia? ❑ Never ❑ Past ❑ Now

Excessive bleeding or abnormal bruising? ❑ Never ❑ Past ❑ Now

Have you ever received a blood transfusion? ❑ Never ❑ Past ❑ Now

If yes, when? ______________________________

ENDOCRINE

Hormone therapy? ❑ Never ❑ Past ❑ Now

Thyroid problems? ❑ Never ❑ Past ❑ Now

Have you been diagnosed or treated for Diabetes? ❑ No ❑ Yes

If yes, were you prescribed medication? ❑ None ❑ Oral Medication ❑ Insulin

METHODS OF WEIGHT CONTROL USED IN THE PAST

Doctor Supervised Programs

❑ Rader Institute ... When? _______ Program: ______________________

❑ Lindora ... When? _______ Program: ______________________

❑ Fasting ... When? _______ Program: ______________________

❑ B-6 ... When? _______ Program: ______________________

❑ Amphetamines ... When? _______ Program: ______________________

❑ Opti-Fast ... When? _______ Program: ______________________

❑ Schick Center ... When? _______ Program: ______________________

❑ Medifast ... When? _______ Program: ______________________

❑ HCG Shots ... When? _______ Program: ______________________

❑ B-12 ... When? _______ Program: ______________________

❑ Other weight loss pills ... When? _______ Program: ______________________

❑ Other ... When? _______ Program: ______________________

Traditional Weight Loss Programs:

❑ Jenny Craig ... When? _______ Program: ______________________

❑ Over Eater's Anonymous ... When? _______ Program: ______________________

❑ Weight Watchers ... When? _______ Program: ______________________

❑ Nutri System ... When? _______ Program: ______________________

❑ "Fat Farms" ... When? _______ Program: ______________________

❑ Exercise program ... When? _______ Program: ______________________

❑ Other ... When? _______ Program: ______________________

Non-traditional Weight Loss Programs

❑ Gastric Bubble .... When? _______ Program: ____________________

❑ Acupuncture .... When? _______ Program: ____________________

❑ Jaw wiring .... When? _______ Program: ____________________

❑ Hypnosis .... When? _______ Program: ____________________

❑ Other .... When? _______ Program: ____________________

Self Diets

❑ Slim Fast .... When? _______ Program: ____________________

❑ Dieter's tea .... When? _______ Program: ____________________

❑ Xenadrine .... When? _______ Program: ____________________

❑ Metabolife .... When? _______ Program: ____________________

❑ Accutrim .... When? _______ Program: ____________________

❑ Dexatrim .... When? _______ Program: ____________________

❑ Cal Ban 3000 .... When? _______ Program: ____________________

❑ Fasting .... When? _______ Program: ____________________

❑ Other .... When? _______ Program: ____________________

Popular Diet Programs

❑ Atkins Diet .... When? _______ Program: ____________________

❑ Bahamian Diet .... When? _______ Program: ____________________

❑ Beverly Hills Diet .... When? _______ Program: ____________________

❑ Cambridge Diet .... When? _______ Program: ____________________

❑ Herbal Life .... When? _______ Program: ____________________

❑ Hollywood Diet .... When? _______ Program: ____________________

❑ Pritikin Diet .... When? _______ Program: ____________________

❑ Scarsdale Diet .... When? _______ Program: ____________________

❑ R. Simmons' Deal-A-Meal .... When? _______ Program: ____________________

❑ South Beach Diet .... When? _______ Program: ____________________

❑ Other .... When? _______ Program: ____________________

NUTRITIONAL PROGRAMS

❑ In-Hospital .... When? _______ Program: ____________________

Hospital/Clinic Name: ____

❑ Out-Patient .... When? _______ Program: ____________________

Hospital/Clinic Name: ____