Please complete this questionnaire. Do not leave any questions blank. You may enter N/A if a question is not applicable.

DATE: _____

NAME: _____ AGE: _____ DATE OF BIRTH: _____

GENDER: _____ CURRENT HEIGHT: _____ CURRENT WEIGHT: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE NUMBER: (home) _____ (work) _____

OCCUPATION: _____

EMPLOYER'S ADDRESS: _____

INSURANCE COMPANY: _____ POLICY NUMBER: _____

SPOUSE NAME: _____

SPOUSE EMPLOYEE ADDRESS: _____

PRIMARY CARE PHYSICIAN: _____

ADDRESS OF PRIMARY PHYSICIAN: _____

OTHER PHYSICIANS SEEN RECENTLY: _____

LIST ALL PREVIOUS HOSPITALIZATIONS:

| | Date | Reason | Hospital |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |

LIST ALL MEDICAL PROBLEMS:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

LIST ALL MEDICATIONS THAT YOU TAKE (even occasionally):

Name Dose Frequency

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

MEDICATION ALLERGIES: _____

How much alcohol do you drink in one week? _____

Have you ever smoked cigarettes? _____ When did you stop smoking? _____

How many cigarettes do you smoke in a day? _____

Have you ever been addicted to drugs? _____

FATHER'S age _____ OR age at death _____

Cause of Death: _____

Other Health problems: _____

MOTHER'S age _____ OR age at death _____

Cause of Death: _____

Other Health problems: _____

Names, ages, and health problems of brothers and sisters.

1. _____
2. _____
3. _____
4. _____

DIRECTIONS:

The following questions are intended to find out what you already know about surgery for clinically severe obesity. These questions are NOT intended to provide you with new information about the surgery. After you have completed this questionnaire, we will personally answer any questions that you may have. Additionally, we will provide additional information about the surgery and our program.

1. After surgery, how much food will you be able to eat at one time? _____

2. How much weight do you expect to lose within one year of surgery? _____

3. Can any person who is overweight have obesity surgery? _____

4. What are the risks of obesity surgery? _____

5. After losing a sufficient amount of weight, do you need to have a second surgery to "undo" the obesity procedure? _____

6. Approximately how long does obesity surgery take to perform? _____

7. Approximately how long will you be hospitalized after the procedure? _____

8. Is it possible to "out-eat" the effects of obesity surgery? _____

9. Must you continue to see a doctor regularly after the surgery? _____

10. Will you need to make lifestyle changes after the surgery? _____

11. At what age did you develop a weight problem? _____

12. What is the most that you have weighed? _____

13. How much weight do you think you should lose? _____

14. How does your weight influence your LIFESTYLE?_____

_____

15. How does your weight influence your HEALTH? _____

_____

16. Do you suffer from depression? If so, how do you think surgery and its resulting weight loss would affect your depression? _____

_____

17. Do you participate in any exercise activity? If so, what type of exercise do you do? How long do you exercise? How often do you exercise? _____

_____

This weight loss sheet must be fully completed with all weight loss attempts you have made within the past 5 years, the approximate date you started the diet, the weight you began at, the

amount lost, and the time you spent trying to lose the weight. **Most insurance's now require that you complete at least one 6-month doctor or dietitian supervised weight lost program within 2 to 3 years of your application for weight loss surgery. Records of this or any other 6 month supervised diet must be forwarded to our office.**
Thanks for your cooperation.

| PROGRAM | DATE | WEIGHT | AMT LOST | TIME SPENT ON EACH ATTEMPT |
|---|---|---|---|---|
| Weight Watchers | | | | |
| Diet Center | | | | |
| Nutri-System | | | | |
| Physician's weight loss | | | | |
| TOPS | | | | |
| Dietician Counseling | | | | |
| Fad diets (specify) | | | | |
| Diet Pills | | | | |
| Low Calorie Diets | | | | |
| Liquid Diets | | | | |
| Hypnosis | | | | |
| Optifast | | | | |
| Jaw Wiring | | | | |
| Acupuncture | | | | |
| Other (specify) | | | | |