HCA Va
MultiSpecialty Health Group at Spotsylvania Regional
An HCA affiliate

WEIGHT LOSS SURGERY HEALTH/WEIGHT HISTORY QUESTIONNAIRE

Surgical Weight Loss Center
Spotsylvania Regional Medical Center
Pogonia Medical Arts Building
4604 Spotsylvania Parkway
Suite 200
Fredericksburg, VA 22408.

Phone: (540) 423-6600
Fax: (540) 423-6655
Website: www.fredericksburgweightloss.com

Mohammad Jamal, MD, FACS
Medical Director.

Vonzie Niehoff, BSN RN, CBN, CCM
Bariatric Nurse Coordinator
(540) 498-4759.

Ashley Hand, LPN
Bariatric Surgery Nurse
(540) 735-9242.

Alison McGrail, RD
Bariatric dietitian
(540) 498-4138.

Thank you for contacting the Surgical Weight Loss Center at Spotsylvania Regional Medical Center!

Please follow the instructions provided in order to process your application.

- **Complete the attached questionnaire in its entirety.**
- A copy of the front and back of your insurance card(s) is required in order to process your application.
- Bring the completed questionnaire and copy of your insurance card(s) to the seminar or clinic consultation.

PATIENT INFORMATION:

Name: _____ **Date:** _____

Age: _____ **Date of Birth:** _____/_____/_____ **Sex:** ☐ M ☐ F

Address: _____

City: _____ **State:** _____ **Zip code:** _____

Phone: (list all)

Home: (_____) _____-_____ **Work:** (_____) _____-_____ **Cell:** (_____) _____-_____

Can we use email as a way to contact you? ☐ No ☐ Yes: Email _____

Ethnicity (for demographic purpose only):

☐ African/American ☐ Caucasian (white) ☐ Hispanic ☐ Native American ☐ Asian

☐ Other _____

I am interested in the following procedures: (✓ all that apply)

☐ **Laparoscopic sleeve gastrectomy**

☐ **Laparoscopic Roux-en-Y gastric bypass**

☐ **Laparoscopic adjustable gastric band**

☐ **Revision of previous bariatric surgery**

For revision evaluation you must bring, along with this questionnaire:

1. Initial bariatric surgery operative report

2. All recent tests showing complication or failure.

How did you hear about our program? (Please ✓ all that apply):

☐ Internet ☐ TV ☐ Radio ☐ News Paper ☐ Seminar ☐ HCA Employee

☐ Family/Friend ☐ From bariatric surgery patient (Name) _____

☐ I had bariatric surgery elsewhere ☐ Insurance Company ☐ Self Referred

☐ **Referring physician name/practice:** _____

Phone (_____) _____-_____

☐ **Primary Care Physician name/practice:** _____

Phone (_____) _____-_____

OBESITY HISTORY:

Current height: _____ feet ____ inches

Current weight: _____ lbs

Highest weight since age 18: _____ lbs

Lowest weight since age 18: _____ lbs

Age at onset of obesity: _____ years

For office use only:

BMI: _____

IBW: _____ lbs

EW: _____ lbs

RESPONSIBLE PARTY INFORMATION:

Name: _____ **Date:** _____

Relationship to patient: _____

Age: _____ **Date of Birth:** _____/_____/_____ **Sex:** ☐ M ☐ F

Address: _____

City: _____ **State:** _____ **Zip code:** _____

Phone: (list all)

Home: (_____) _____-_____ **Work:** (_____) _____-_____ **Cell:** (_____) _____-_____

INSURANCE INFORMATION:

A copy of your insurance card(s) front and back is required:

Insurance company name: _____

Policy #: _____ Group #: _____

Policy holder & DOB: _____ Phone #: _____

Insurance company name: _____

Policy #: _____ Group #: _____

Policy holder & DOB: _____ Phone #: _____

OBESITY RELATED COMPLAINTS:

Please ✓ all that apply. Have **you ever had…**

Past / Now	Condition	Medication/Treatment needed (name and dosage)	Notes (office use)
☐ ☐	High blood pressure		
☐ ☐	Diabetes		
☐ ☐	Sleep Apnea		
☐ ☐	Daytime Sleepiness		
☐ ☐	Snoring		
☐ ☐	Reflux (heartburn)		
☐ ☐	Heart disease		
☐ ☐	High Cholesterol		
☐ ☐	High Triglycerides		
☐ ☐	Joint pain		
☐ ☐	Back pain		
☐ ☐	Hip pain		
☐ ☐	Knee pain		
☐ ☐	Ankle & foot pain		
☐ ☐	Limited range of motion		
☐ ☐	Limited strength of limbs		
☐ ☐	Swelling of feet		
☐ ☐	Urinary stress incontinence		
☐ ☐	Blood clots		
☐ ☐	Pulmonary embolism		
☐ ☐	Stroke		
☐ ☐	Shortness of breath		
☐ ☐	Asthma		
☐ ☐	Emphysema		
☐ ☐	Headaches		
☐ ☐	Migraines		
☐ ☐	Kidney disease		
☐ ☐	Seizures		
☐ ☐	Rashes		

☐ ☐	Arthritis		
☐ ☐	Cancer		
☐ ☐	Irregular periods		
☐ ☐	Thyroid disease		
☐ ☐	Marfans Syndrome		
☐ ☐	Ehlers Danlos Syndrome		
☐ ☐	Others (please specify)		

Past / Now	Psychiatric History	Medications	Hospitalized*	Dates	Explain
☐ ☐	☐Anorexia / ☐Bulimia		☐No ☐Yes		
☐ ☐	Depression		☐No ☐Yes		
☐ ☐	Schizophrenia		☐No ☐Yes		
☐ ☐	Bipolar		☐No ☐Yes		
☐ ☐	Anxiety		☐No ☐Yes		

Do you see a psychologist, psychiatrist or counselor for mental health issues? ☐No ☐Yes*

***If yes, please include a recent psychiatric evaluation including history, diagnosis and treatment.**

PSYCHIATRIC HISTORY (explanation)*:

_____

_____

MEDICAL HISTORY: (list any other conditions not addressed on previous page)

Condition: _____ Medication: _____ Dosage: _____

Condition: _____ Medication: _____ Dosage: _____

Condition: _____ Medication: _____ Dosage: _____

MEDICATION LOG:

Medication	Dosage	Frequency	Date treatment started

DRUG ALLERGIES:

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

SURGICAL HISTORY:

(If you have had bariatric surgery provide initial operative report and test results/complications)

Type: _____ Reason _____ Year _____

Type: _____ Reason _____ Year _____

Type: _____ Reason _____ Year _____

Type: _____ Reason _____ Year _____

Type: _____ Reason _____ Year _____

Type: _____ Reason _____ Year _____

FAMILY HISTORY:

Please ✓ all appropriate boxes

	Obesity	Cancer	Hypertension	Diabetes	Heart Disease	Lung Disease	Kidney Disease	Bleeding disorder	Bariatric Surgery
Father									
Paternal Grandfather									
Paternal Grandmother									
Mother									
Maternal Grandfather									
Maternal Grandmother									
Your brothers									
Your sisters									
Your sons									
Your daughters									

PROGRESSION OF WEIGHT GAIN PATTERN (AGE 18 TO CURRENT):

☐ No pattern

☐ Steady, gradual increase of weight over the years

☐ Sudden increases of weight with pregnancies

☐ Variable weight gain/loss due to intermittent diet and exercise (regained weight when stopped program)

DIETARY HISTORY:

What do you consider to be your daily eating pattern? **(✓ all that apply)**

☐ Less than normal ☐ Normal ☐ Overeat ☐ Binge ☐ Serious eating disorder ☐ Excessive snacking

Do you eat/snack just before bedtime? ☐ No ☐ Yes

Which meals do you eat each day? ☐ Breakfast ☐ Lunch ☐ Supper ☐ Snacks

What and how much do you usually eat for breakfast?

_____

What and how much do you usually eat for lunch?

_____

What and how much do you usually eat for supper?

_____

What are your favorite snacks?

_____

How much of them do you eat per sitting?

_____

Do you drink pop? ☐ No ☐ Yes How many 12 oz servings per day? DIET ____ REGULAR ____

Do you drink juice? ☐ No ☐ Yes What kind? _____ How much per day? _____

EXERCISE HISTORY:

What is your exercise program? _____

☐ I am unable to exercise due to - ☐ severe joint pain ☐ shortness of breath ☐ wheelchair bound

☐ I am able to exercise but I do not have a regular routine

☐ I walk / run ___ times per week for ____ minutes

☐ I swim ____ times per week for _____ minutes

☐ I lift weights ____ times per week for ____ minutes

☐ Other – (please explain) _____

SOCIAL AND PERSONAL HISTORY:

Highest level of education: _____

Occupation: _____ ☐ Part time ☐ Full time

Employer name: (for our records only) _____

Do you have children? ☐ No ☐ Yes - how many? _____

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient lives: ☐ Alone ☐ With family ☐ Other _____

How does your support person (family) feel about you having this type of surgery?

_____

Have you **ever** smoked tobacco (cigarettes, cigars, pipes, etc)? ☐ No ☐ Yes

If YES, do you currently smoke?

☐ No - When did you quit? _____ How many packs per day _____

☐ Yes – Year you started? _____ How many packs per day _____

Have you **ever** used chewing tobacco? ☐ No ☐ Yes

If YES, do you currently "chew"?

☐ No - When did you quit? _____ How many times/cans per day _____

☐ Yes – Year you started? _____ How many times/cans per day _____

Do you consume alcoholic beverages? ☐ No ☐ Yes - If yes, how many drinks per week? _____

Have you used recreational/illegal drugs in the past? ☐ No ☐ Yes

If YES, do you currently use drugs?

☐ No. What drug(s) did you use? _____ When did you quit? _____

☐ Yes. What type of drug(s) are you using? _____

FEMALE REPRODUCTIVE HISTORY:

Current method of birth control: _____

Number of: Pregnancies: _____ Normal vaginal deliveries: _____ C-Sections: _____

1st pregnancy: _____ (year) _____ pounds gained

2nd pregnancy:_____ (year) _____ pounds gained

3rd pregnancy: _____ (year) _____ pounds gained

OTHER RELEVANT INFORMATION PERTINENT TO YOUR HISTORY OF OBESITY:

_____

_____

_____

_____

_____

_____

SUMMARY DOCUMENT OF PATIENTS WEIGHT LOSS ATTEMPTS

PATIENT NAME: ____

In chronological order (most recent first), list ALL diet attempts over the past 5 years:

1. List SUPERVISED diets first (Physician, dietitian, Weight Watchers, Nutri-System, Jenny Craig, etc)
2. Then add SELF-MONITORED diet attempts

Name/type of diet attempt: ____

Dates on diet (**month/year**): _____/______ to _____/______ (# of months_________)

Beginning weight: ___________ pounds lost: ___________ pounds gained: ___________

Supervised by a physician, dietician or weight management program ☐ Yes ☐ No

Name/type of diet attempt: ____

Dates on diet (**month/year**): _____/______ to _____/______ (# of months_________)

Beginning weight: ___________ pounds lost: ___________ pounds gained: ___________

Supervised by a physician, dietician or weight management program ☐ Yes ☐ No

Name/type of diet attempt: ____

Dates on diet (**month/year**): _____/______ to _____/______ (# of months_________)

Beginning weight: ___________ pounds lost: ___________ pounds gained: ___________

Supervised by a physician, dietician or weight management program ☐ Yes ☐ No

Name/type of diet attempt: ____

Dates on diet (**month/year**): _____/______ to _____/______ (# of months_________)

Beginning weight: ___________ pounds lost: ___________ pounds gained: ___________

Supervised by a physician, dietician or weight management program ☐ Yes ☐ No

Name/type of diet attempt: ____

Dates on diet (**month/year**): _____/______ to _____/______ (# of months_________)

Beginning weight: ___________ pounds lost: ___________ pounds gained: ___________

Supervised by a physician, dietician or weight management program ☐ Yes ☐ No

- **I authorize treatment by Surgical Weight Loss Center at Spotsylvania Regional Medical Center physicians and personnel.**

- I authorize the release and disclosure of any or my entire medical and treatment records or reports to any other health care provider who may be of assistance, and/or for assisting in any reimbursement or medical benefits to which patient may be entitled. I allow fax transmittal of my medical records, if necessary.

- I further authorize and request that insurance payments be made directly to MultiSpecialty Health Group should they elect to receive such payment. **This is a direct assignment of my rights and benefits under this policy.** A photocopy of this assignment shall be considered as effective and valid as the original.

- I acknowledge full financial responsibility for services rendered by Surgical Weight Loss Center at Spotsylvania Regional Medical Center. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of a default of payment of my charges.

- We would like to inform you that education regarding bariatric surgery is done in a group setting format due to the number of people requesting bariatric surgery. Please know that all personal information is kept private during these classes. It will be your decision to share personal information or ask individual questions during the group sessions. Our staff will be available to answer individual questions following these group sessions.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

_____ _____

Patient's signature **Date**

Please sign and return with your questionnaire.

Surgical Weight Loss Center at Spotsylvania Regional Medical Center
4604 Spotsylvania Parkway, Suite 200, Fredericksburg, VA 22408.
Phone: (540) 423-6600 Fax: (540) 423-6655
www.fredericksburgweightloss.com