General & Bariatric Surgery

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BARIATRIC SURGERY HEALTH QUESTIONNAIRE

Patient Name: ______________________ DOB: ______________ Age: ______________

Gender: ☐ Male ☐ Female Primary Care Physician: ______________________

DIETARY AND WEIGHT LOSS HISTORY

The information requested in this questionnaire is very important. To give you the best care, and to obtain your insurance approval, we must have complete answers:

(PLEASE DO NOT FILL THESE NUMBERS. FOR OFFICE USE ONLY)

Height	Weight	BMI	Excess Body Weight	Ideal Body Weight

Please check the appropriate boxes and add notes as needed:

My obesity started: ☐In childhood ☐at puberty ☐as an adult ☐after pregnancy ☐after a traumatic event

Family History of Obesity: Yes ☐ No ☐ If YES, who: ______________________

How long have you been around the present weight for: _______ Years

Highest Adult Weight: ________ Date: _______ Lowest Adult Weight: ________ Date: __________

Most weight lost on any program: ____ Program? ________________ Weight loss sustained for: __________

Taste preferences (please check all that apply) ☐ Sweets ☐ Salty ☐ Fast food ☐ Comfort foods ☐ _______

Eating Habits (please check all that apply) ☐Binge eater ☐Stress ☐Boredom ☐Loneliness ☐ ______________

Weight Loss Programs/Diets/Medications attempted in the past:

Program	Dates	Duration	Max Wt Lost	MD Supervised
Jenny Craig				
Nutri-system				
Weight Watchers				
Opti-fast, Medi Fast				
O.A. or TOPS				
Fen/Phen Redux				
Meridia				
Xenical				
Over the counter diet aids				
Atkins Diet				
Other:				
Other:				
Other:				
Other:				

Personal Medical History (Do you have or have you ever had? Check all that apply)

Cardiovascular	**Yes**	**No**	**Don't know**	**Genitourinary**	**Yes**	**No**	**Don't know**
Chest Pain (Angina)				Frequent Bladder Infections?			
MI (Heart Attack)				Difficulty with Urination?			
High Blood Pressure				Kidney Stones			
Irregular Heart Beat				Kidney Failure			
Heart Failure				Leakage of Urine			
Palpitations				Other:			
Leg/Ankle Swelling				**Gynecological**			
Varicose Veins				Irregular Periods			
Mitral Valve Prolapse				Excessively Heavy Periods			
High Cholesterol				Excessively Painful Periods			
Pulmonary Hypertension				Infertility			
Other:				Excess Body Hair or Acne			
Respiratory				Polycystic Ovary Disease			
Asthma				Last Mammogram:			
Emphysema				Was it normal?			
Chronic Chough				Last pap smear:			
Wheezing				Was it normal?			
Sleep Apnea				Taking hormones? BCP/HRT			
Shortness of Breath?							
Other:				**Hematological**			
Endocrine				Bleeding Tendency			
Hypothyroidism				AIDS/HIV			
Hyperthyroidism				Blood Clots			
Diabetes				Pulmonary Embolism			
Insulin Resistance				Anemia			
Metabolic Syndrome				Previous Blood Transfusion			
Other:				Other:			
Head and Neck				**Neurological**			
Ringing in Ears				Seizures			
Hearing Loss				Epilepsy			
Dizziness				Pseudo Tumor Cerebri			
Cataracts				Weakness in Hands or Feet			
Migraine Headache				Other:			
Glaucoma				**Psychological**			
Other:				Depression			
Gastrointestinal				Panic Attacks			
Heartburn/GERD				Anxiety			
Ulcers				Bipolar Disease			
Ulcerative Colitis/				Schizophrenia			
Crohns Disease				Other:			
Gallbladder Disease							

Cancer history:

Have you ever been diagnosed with cancer: Yes: ☐ No: ☐

Have you ever been diagnosed with cancer: Yes: ☐ No: ☐

When were you diagnosed with cancer: ________________ Cancer free since: _____________

What treatment have you received since diagnosis: Chemotherapy:☐ Surgery:☐ Radiation Therapy:☐ Other:☐

Past Surgical History:

Type of Surgery	Year of surgery. Open or Laparoscopic?

Have you had weight loss surgery before like gastric bypass, gastric stapling, etc. If so, give details:

Please list all **Previous Hospitalizations:**

Reason for Hospitalization	Date and Year	Name of Hospital

Please list any **medications (prescription and over the counter, eye drops, creams), vitamins and/or herbal supplements** you are presently taking:

Name of Medication	Dosage / Frequency	Reason for taking the medicine

List any allergies you have to food and medications. Please list the nature of your allergic reaction:

Do you have an allergy to any latex products? Yes: ☐ No: ☐

Social Profile:

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

Do you have a support person? Yes: ☐ No: ☐

Does the support person live with you? Yes: ☐ No: ☐

Employment Status: Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐

Are you a smoker? Yes: ☐ No: ☐ Packs/day: ____________________

Have you smoked in the past? Yes: ☐ No: ☐ Age started:_________ Age Quit:______

Do you consume alcohol: Yes: ☐ No: ☐ Drinks/day: ___________________

Do you use recreational drugs? Yes: ☐ No: ☐ Type/frequency: ______________

Education: 8th Grade or less ☐ High school graduate: ☐ College Graduate: ☐ Any Postgraduate Work: ☐

Screening for Sleep Apnea:

Have you ever been diagnosed with Sleep Apnea: Yes ☐ No ☐
Do you use a C-Pap: Yes ☐ No ☐
Do you use a Bi-Pap: Yes ☐ No ☐
Please complete the following even if you have sleep apnea:

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 (i.e. a theater)	
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 lunch without alcohol	
TOTAL SCORE	

Review of systems (Please indicate any personal history below):

• ***CONSTITUTIONAL SYMPTOMS***			• ***GENITOURINARY***		
Fever	No	Yes	Painful Urination:	No	Yes
Chills	No	Yes	Frequent Urination:	No	Yes
Fatigue	No	Yes	Blood in Urine:	No	Yes
Lightheadedness	No	Yes	Urinary Infections:	No	Yes
• ***EYES***			• ***MUSCULOSKELETAL***		
Eye Glasses	No	Yes	Muscle Cramps:	No	Yes
Eye Discharge	No	Yes	Joint Swelling:	No	Yes
Eye Pain	No	Yes	Joint Pain:	No	Yes
Blurred Vision	No	Yes	Back Pains	No	Yes
• ***EARS/NOSE/MOUTH/THROAT***			• ***INTEGUMENTARY (skin, breast)***		
Nose Discharge	No	Yes	Rash:	No	Yes
Hoarseness of voice	No	Yes	Dry Skin:	No	Yes
Decreased hearing	No	Yes	Breast Mass:	No	Yes
Ringing in ears	No	Yes	Nipple Discharge:	No	Yes
Bleeding from nose	No	Yes			
			• ***NEUROLOGICAL***		
• ***CARDIOVASCULAR***			Dizziness:	No	Yes
Chest Pain:	No	Yes	Headache:	No	Yes
Palpitations:	No	Yes	Strokes:	No	Yes
Edema:	No	Yes	Seizures	No	Yes
Shortness of Breath:	No	Yes			
Coronary Artery Disease:	No	Yes	• ***HEMATOLOGIC/LYMPHATIC***		
			Easy Bruising:	No	Yes
• ***RESPIRATORY***			Prolonged Bleeding:	No	Yes
Asthma:	No	Yes	Enlarged Lymph Nodes:	No	Yes
Cough:	No	Yes	Deep Vein Thrombosis:	No	Yes
Spitting up blood:	No	Yes			
Shortness of breath:	No	Yes	• ***OTHERS***		
• ***GASTROINTESTINAL***					
Change in Bowel habit:	No	Yes			
Nausea/ Vomiting:	No	Yes			
Rectal Bleeding:	No	Yes			
Constipation:	No	Yes			
Diarrhea:	No	Yes			
Heartburn:	No	Yes			

Please list the names of all the physicians you see:

Primary Care Physician:

Name: ______________________________
Address: ______________________________
____

Office Tel: ______________ Office Fax: ______________

Cardiologist:

Name: ______________________________
Address: ______________________________
____

Office Tel: Office Fax:

Psychiatrist / Psychologist:

Name: ______________________________
Address: ______________________________
____

Office Tel: ______________ Office Fax: ______________

Pulmonary / Sleep Study Specialist:

Name: ______________________________
Address: ______________________________
____

Office Tel: ______________ Office Fax: ______________

Gastroenterologist:

Name: ______________________________
Address: ______________________________
____

Office Tel: Office Fax:

Other Physician:

Name: ______________________________
Address: ______________________________
____

Office Tel: Office Fax:

Research and Support System

How long have you been contemplating bariatric surgery? ____________________

Have you done any research about bariatric surgery? YES ☐ NO ☐

If YES, What type of research was done: ____________________

Do you have a friend or family member who has had bariatric surgery? ☐ YES ☐ NO

If YES, who? ____________________

Describe your present life stressors: ____________________

Describe the present support system you rely upon during and after surgery: ____________________

What are your goals expected from surgery: ____________________

What do you think is your greatest hope about the surgery: ____________________

What is your greatest fear about weight loss surgery: ____________________

What is the motivating factor making you seek this surgical intervention for weight loss: ____________________

Please write any other concerns that you have regarding your health or bariatric surgery:

I attended the public patient information seminar on: ____________

Signature of the Patient

Date of Signature

Please return the completed form along with a copy of your driving license and the front and back of insurance card to:

Ravindra V Mailapur, MD. FACS.
Attention: Office Manager
201 Sivley Road
Suite 540
Huntsville, AL 35801

EXTREMELY IMPORTANT

Failure to fill this form completely may result in undue delay in having your information reviewed. Please take some time to fill this form as completely as possible to avoid delays in processing insurance approvals.