Stony Brook Medicine

# Bariatric and Metabolic Weight Loss Center

**Weight Loss Surgery Program Questionnaire:** ***Please complete this questionnaire and bring it with you to your appointment with the doctor. This information will assist us in your care plan. Thank you.***

**Full Name:** _____ **Date of Birth:** _____

**Personal Information**

Gender: Female Male

Address: _____

City, State, Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Date Attended Seminar: _____

Race: (please circle all that apply)

African-American Caucasian Hispanic Pacific Islander/Hawaiian
Asian Native American Other

**How did you hear about our program?**

☐ Newspaper ☐ Brochure ☐ A friend ☐ My physician ☐ Other _____

**Operation Requested:**

☐ Roux-en-Y Gastric Bypass

☐ Adjustable Gastric Banding

☐ Sleeve Gastrectomy

☐ Other _____

☐ Undecided

**Surgeon Requested:** ☐ **Dr. Aurora Pryor** ☐ **Dr. Dana Telem** ☐ **First Available**

☐ **Not interested in surgery; seeking supervised medical weight loss program.**

# Insurance Information

**Primary Insurance Information (First Insurance Company Claims are Filed With)**

Insurance Company: _____ State: ____
Policy Holder's Name: _____
Policy Holder's DOB: _____
Policy Number: _____
Group Number: _____
Ins. Co. Phone Number: _____

**Secondary Insurance Information (Second Insurance Company Claims are Filed With)**

Insurance Company: _____ State: ____
Policy Holder's Name: _____
Policy Holder's DOB: _____
Policy Number: _____
Group Number: _____
Ins. Co. Phone Number: _____

**Tertiary Insurance Information (Third Insurance Company Claims are Filed With)**

Insurance Company: _____ State: ____
Policy Holder's Name: _____
Policy Holder's DOB: _____
Policy Number: _____
Group Number: _____
Ins. Co. Phone Number: _____

# Physician Information

**Primary Care/Family Physician Information**

Primary Care/Family Physician: _____
Practice Name: _____
Address: _____
City, State, Zip: _____
Office Phone: _____
Office Fax: _____

If different from above,
Referring Physician: _____
Specialty: _____
Practice Name: _____
Address: _____
City, State, Zip: _____
Office Phone: _____
Office Fax: _____

**Miscellaneous Doctor**

Referring Physician: _____
Specialty: _____
Practice Name: _____
Address: _____
City, State, Zip: _____
Office Phone: _____
Office Fax: _____

**Have you ever been seen by a psychiatrist? If yes, then**

Psychiatrist Name: _____
Practice Name: _____
Address: _____
City, State, Zip: _____
Office Phone: _____
Office Fax: _____
Date Last Seen: _____

## Weight History

Current Weight:_____lbs; kg  Current Height:_____in; cm

| | |
|---|---|
| BMI: | _____ |
| Number of yrs overweight: | _____ |
| Highest Adult Weight: | _____ |
| When was your highest weight?: | _____ |
| Lowest Adult Weight: | _____ |
| When was your lowest Weight? | _____ |
| Birth Weight | _____ |
| As best you can recall, what was your body weight at each of the following points of your life? | Grade School ____ High School ____<br>Ages 20-29 ____ 30-39 ____ 40-49 ____<br>50-59 ____ 60-69 ____ |
| What is the most weight you lost? | _____ |
| When did you lose this weight? | _____ |
| How long did you keep this weight off? | _____ |
| Method used for this weight loss | _____ |
| Have you had previous bariatric surgery? | _____ |
| Weight History Comments | _____ |

## Medical History

| Have you ever had: | | | |
|---|---|---|---|
| Hypertension | Yes | No | |
| Heart Attack | Yes | No | |
| Lung Disease | Yes | No | |
| Stroke | Yes | No | |
| Seizures | Yes | No | |
| Cancer | Yes | No | If yes, type of cancer:_____ |
| Transfusions | Yes | No | |
| Hepatitis | Yes | No | |
| HIV/AIDS | Yes | No | |
| Ulcers | Yes | No | |
| Reflux | Yes | No | |
| Diabetes | Yes | No | |
| High Cholesterol | Yes | No | |
| Other Diagnosis | _____ | | |

## Previous Operations

| | |
|---|---|
| Previous Bariatric Surgery? | _____ |
| If yes, year, surgeon and location of surgery: | _____ |
| Did you have complications from surgery? | _____ |
| Gallbladder | _____ |
| Joint | _____ |
| Hernia | _____ |
| Endoscopy | _____ |
| Other Operations | _____ |
| | _____ |

## Medications and Supplements

| Medication/Supplement | Dosage & Frequency | Reason |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Allergies

| Medication/Food | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |
| **Other Allergies** | |
| | |

## Current Medical Conditions

*General*

| | | |
|---|---|---|
| Fever | No | Yes |
| Fatigue | No | Yes |
| Recent Weight Change | No | Yes |
| Insomnia | No | Yes |
| Stress | No | Yes |
| Comments? | _____ | |

*ENT*

| | | |
|---|---|---|
| Glasses/Contacts | No | Yes |
| Eye/Vision Problems | No | Yes |
| Hearing Loss/Ringing | No | Yes |
| Ear Aches | No | Yes |
| Nose Bleeds | No | Yes |
| Sinus Problems | No | Yes |
| Frequent Colds | No | Yes |
| Dental Problems | No | Yes |
| Sore Throat/Hoarseness | No | Yes |
| Swollen Glands | No | Yes |
| Comments? | _____ | |

*Cardiac*

| | | |
|---|---|---|
| Chest Pain (Angina) | No | Yes |
| Irregular/Fast Heartbeat (Arrhythmia) | No | Yes |
| High Blood Pressure (Hypertension) | No | Yes |
| CHF (Cardiac Heart Failure) | No | Yes |
| Swelling of Feet/Ankles (Edema) | No | Yes |
| MI (Myocardial infarction) | No | Yes |
| Valvular Disease | No | Yes |
| Comments? | _____ | |

*Pulmonary*

| | | |
|---|---|---|
| Sleep Apnea | No | Yes |
| Chronic Bronchitis | No | Yes |
| Asthma | No | Yes |
| Shortness of Breath with 1 flight of stairs | No | Yes |
| Comments? | _____ | |

*Vascular*

| | | | |
|---|---|---|---|
| Varicose Veins | No | Yes | |
| Phlebitis | No | Yes | |
| Swelling | No | Yes | Location:_____ |
| Diagnosis of Lymphedema | No | Yes | Location:_____ |
| Cellulitis (skin infection) | No | Yes | Location:_____ |
| Comments? | _____ | | |

*Bleeding Disorders*

| | | |
|---|---|---|
| Slow to heal after cuts | No | Yes |
| Comments? | _____ | |

## Current Medical Conditions (continued)

*Gastrointestinal*

| | | |
|---|---|---|
| Loss of Appetite | No | Yes |
| Nausea / Vomiting | No | Yes |
| Throwing Up Blood | No | Yes |
| Blood in Stool | No | Yes |
| Diarrhea | No | Yes |
| Constipation | No | Yes |
| Reflux Disease/Symptoms (Heartburn) | No | Yes |
| Peptic Ulcer Disease | No | Yes |
| Stomach Ulcers requiring meds | No | Yes |
| Inflammatory Bowel Disease | No | Yes |
| Colitis | No | Yes |
| Crohn's Disease | No | Yes |
| Hemorrhoids | No | Yes |
| GI Cancer | No | Yes |
| Liver Disease | No | Yes |
| Gall Bladder Problems/Stones | No | Yes |
| Colon Cancer/Problems | No | Yes |
| Do you regularly use laxatives or stool softeners | No | Yes Type/Frequency:_____ |
| Number of Bowel Movements per day: | _____ | |
| Comments? | _____ | |

*Musculoskeletal*

| | | |
|---|---|---|
| Joint Pain | No | Yes |
| Muscle/Joint Weakness | No | Yes |
| Back Pain | No | Yes |
| Arthritis | No | Yes |
| Pain when walking | No | Yes |
| Cold Extremities | No | Yes |
| Numbness or Tingling Arms/Legs | No | Yes |

*Neurologic*

| | | |
|---|---|---|
| Frequent Headaches | No | Yes |
| Light Headed/Dizzy | No | Yes |
| History of Falling | No | Yes |
| Paralysis | No | Yes |
| Seizures | No | Yes |
| Visual problems | No | Yes |
| History of Stroke or TIA | No | Yes |
| Comments? | _____ | |

*Diabetes/Endocrine*

| | | |
|---|---|---|
| Diabetes Type I/II requiring medication | No | Yes |
| Pre-Diabetic | No | Yes |
| History of Gestational Diabetes | No | Yes |
| Glandular Hormone Problem | No | Yes |
| Excessive Thirst or Urination | No | Yes |
| Heat/Cold Intolerance | No | Yes |
| Thyroid Problems | No | Yes |
| Hypoglycemia | No | Yes |
| Comments? | _____ | |

## Current Medical Conditions (continued)

*Skin*

| | | |
|---|---|---|
| Rash/Itching | No | Yes |
| Bleeding/Bruising | No | Yes |
| Change in Skin/Hair/Nails | No | Yes |
| Latex Allergy | No | Yes |
| Comments? | _____ | |

*Psychological*

| | | |
|---|---|---|
| Memory Loss/Confusion | No | Yes |
| Anxiety | No | Yes |
| Nervousness | No | Yes |
| Depression | No | Yes |
| Bipolar Disorder | No | Yes |
| Personality Disorder | No | Yes |
| Schizophrenia | No | Yes |
| Hallucinations | No | Yes |
| Suicide Attempts | No | Yes |
| Homicidal Ideations | No | Yes |
| Have you ever been in counseling? | No | Yes |
| Psychological Hospitalizations | No | Yes |
| Alcohol Abuse | No | Yes |
| Substance Abuse | No | Yes |
| Eating Disorder: Bulimia/Anorexia Nervosa | No | Yes |
| Have you ever received disability benefits (short-term or long-term) for any reason? | No | Yes |
| Are you currently on, or applying for disability? | No | Yes |
| Is all or part of your disability status related to a psychological, psychiatric, emotional, or cognitive issue? | No | Yes |
| What conditions(s), disorders(s), diagnosis, or disease(s) led to your disability? | _____ | |
| | _____ | |

*Genitourinary*

| | | |
|---|---|---|
| Frequent Urination | No | Yes |
| Painful/Burning Urination | No | Yes |
| Bladder Control Problems (Stress Incontinence) | No | Yes |
| Kidney Stones | No | Yes |
| Change in Force or Stream | No | Yes |
| Venereal Disease | No | Yes |
| Comments? | _____ | |

*Males Only*

| | | |
|---|---|---|
| Testicle Pain | No | Yes |
| Prostate Problems | No | Yes |
| Comments? | _____ | |

*Breast (Female Only)*

| | | |
|---|---|---|
| Breast Pain | No | Yes |
| Breast Lump | No | Yes |
| Nipple Discharge/Bleeding | No | Yes |
| Family History of Breast Cancer | No | Yes |
| Last Mammogram | _____ | |
| Comments? | _____ | |

## Current Medical Conditions (continued)

*Females Only*

| | |
|---|---|
| Painful/Irregular Periods | No Yes |
| Last Pap Smear | _____ |
| Last Menstrual Period | _____ |
| Age at First Menstrual Period | _____ |
| Menstrual Frequency | _____ |
| Age at first Pregnancy | _____ |
| Number of Pregnancies | _____ |
| Number of Full Term Pregnancies | _____ |
| Number of Miscarriages | _____ |
| Did you breast feed? | No Yes |
| Infertility | No Yes or in the past |
| Plans for Future Pregnancy | Yes No If so, when:_____ |
| Comments? | _____ |

## Family History

| | | |
|---|---|---|
| Overweight Family Members | _____ | |
| Family History of Heart Disease | _____ | |
| Family History of Diabetes/Endocrine Disease | _____ | |
| Family History of High Blood Pressure | _____ | |
| Family History of Cancer | _____ | Type:_____ |
| Family History of Arthritis | _____ | |
| Family History of Early Death | _____ | |
| Family History of Asthma | _____ | |
| Family History of Stroke | _____ | |
| Family History of Depression | _____ | |
| Other Family Disease History | _____ | |

## Social History

| | | | |
|---|---|---|---|
| Employment Status | Full Time | Part Time | Self Employed |
| | Homemaker | Student | Retired |
| | Disabled | Unemployed | Not specified |
| Employer | _____ | | |
| Occupation | _____ | | |
| Marital Status (please circle one) | Single | Married | Separated |
| | Divorced | Widowed | Partnered |
| Children | _____ | | |
| Tobacco use? | _____ | | |
| Alcohol use? | _____ | | |
| Drug use? | _____ | | |
| Comment | _____ | | |

## Activity/Exercise

| | |
|---|---|
| Do you exercise regularly? | No Yes |
| If no, what prevents you from exercising? | Time Work Health Other_____ |
| If yes, types of exercise? | _____ |
| How often? | _____ times/week _____times/month |
| How much time do you spend exercising each time? | 15 min 30 min 45 min 60 min 90 min Other |
| What is your exercise routine? | _____ |
| | _____ |

**Nutrition: Much of the following information will be sent to your insurance company to obtain authorization for any surgical procedures. Please fill out this part of the form with as much detail as possible!**

| Program | Weight Loss | Weight Regained | Month/Year<br>How long on the program(s).<br>Why did you stop the program(s)? |
|---|---|---|---|
| Weight Watchers | | | |
| Tops | | | |
| Overeaters Anonymous | | | |
| Other Diet Centers (Jenny Craig, LA weight loss, The Diet Center, form U#, NutriSystem, etc.) | | | |
| OTC Diet Pills | | | |
| Counseling: Specify RD, psychologist, etc. | | | |
| Prescription Weight Loss Medications: (Fen Phen, Phentremine, Redux, Meredia, Xenical, etc.) | | | |
| Weight Loss Shots/Injections | | | |
| Hypnosis | | | |
| Exercise | | | |
| Acupuncture | | | |
| Low Carbohydrate Diets: specify plan | | | |
| Physician Sponsored Diets: | | | |
| Diet Books, fad diets: | | | |
| Liquid diets (Medifast, Optifast, Slimfast, etc) | | | |

| **Do any of the following environmental issues listed below affect your weight? If so, please explain.** |
|---|
| Occupation-related eating issues: □ Yes □ No |
| Travel: □ Yes □ No |
| Household issues (family/obligations/schedule): □ Yes □ No |
| Shopping/cooking/etc: □ Yes □ No |
| Financial Issues: □ Yes □ No |
| Meals eaten away from home (frequency/location): □ Yes □ No |
| Sleep: □ Yes □ No |

| **Do any of the following eating behaviors listed below affect your weight? If so, please explain.** | | |
|---|---|---|
| □ Binge Eating | Current Problem □ Yes □ No | Past Problem □ Yes □ No |
| □ Anorexia | Past Problem □ Yes □ No | |
| □ Bulimia | Current Problem □ Yes □ No | Past Problem □ Yes □ No |
| □ Emotional Eating | Current Problem □ Yes □ No | Past Problem □ Yes □ No |
| □ Frequent Cravings | Current Problem □ Yes □ No | Past Problem □ Yes □ No |
| □ Lack of Awareness of Hunger | Current Problem □ Yes □ No | Past Problem □ Yes □ No |
| □ Lack of Awareness of Fullness | Current Problem □ Yes □ No | Past Problem □ Yes □ No |

| **Please answer the questions below to the best of your ability:** |
|---|
| Do you have any food allergies? □ Yes □ No If yes, what are they? |
| Do you have any food intolerances? □ Yes □ No If yes, what are they? |
| What would you like to achieve from visiting with the dietitian? |
| Do you see any barriers to achieving this goal? |
| How often do you eat fast food? Where? What do you typically eat when you order fast food? |
| How often do you eat at restaurants? What do you typically eat when you order from a restaurant? |
| How often do you eat fried foods? What fried foods do you typically eat? |
| How often do you eat sweets? What sweets do you typically eat? |
| Place a check in the box if you use:<br>□ Butter □ Margarine □ Salad Dressing □ Oil □ Mayonnaise □ Ketchup □ Marinades<br>□ Sauces □ Gravy |
| Place a check in the box if you drink:<br>□ Regular Soda □ Diet Soda □ Water □ Juice □ Juice Drink □ Iced Tea □ Coffee □ Tea<br>□ Energy Drinks □ Milk □ Other: |
| How often do you consume alcoholic beverages? What type? |
| What types of food do you crave? |
| Do you eat fruits and vegetables daily? What types of fruits and vegetables do you eat? |
| Place a check in the box if you eat daily:<br><br>Cheese □ Yes □ No If yes, is it □ Regular full fat □ 2% reduced fat □ 1% low fat □ 0% skim/fat free<br>Yogurt □ Yes □ No If yes, is it □ Regular full fat □ 2% reduced fat □ 1% low fat □ 0% skim/fat free<br>Milk □ Yes □ No If yes, is it □ Regular full fat □ 2% reduced fat □ 1% low fat □ 0% skim/fat free |
| Put a check in the box if you eat:<br>□ Meat □ Poultry □ Beans □ Tofu □ Nuts □ Eggs |

| | | |
|---|---|---|
| **Please provide a typical day's meal plan with estimation of portion sizes in the space provided below.**<br>**Example: Breakfast at 8:30 am: 2 scrambled eggs, 1 slice white toast with 1 tablespoon natural peanut butter with 8 fluid ounces of 1% milk.** | | |
| **1st Meal**<br>**(Breakfast)**<br>**Time:** | | |
| **2nd Meal**<br>**(Lunch)**<br>**Time:** | | |
| **3rd Meal**<br>**(Dinner)**<br>**Time:** | | |
| **Snack 1**<br>**Time:** | **Snack 2**<br>**Time:** | **Snack 3**<br>**Time:** |
| | | |

## Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling 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 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** | **Chances of Dozing** |
|---|---|
| Sitting and reading | _____ |
| Watching TV | _____ |
| Sitting, inactive in a public place (e.g. a theater or meeting) | _____ |
| 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 a lunch without alcohol | _____ |
| In a car, while stopped for a few minutes in traffic | _____ |

## CPAP:

Do you use a CPAP machine? No Yes

What is the setting? _____

**Thank you for your cooperation**

The information provided in this questionnaire is, to the best of my knowledge, true and complete.

_____
(Patient Print Name)

_____ _____
(Patient Signature) (Date)

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Questionnaire was reviewed with patient for accuracy and completeness.

_____ ID_____ Date_____
Provider Signature