

Your Name _____ Your Date of Birth _____

Medical Information Questionnaire

Your height (inches) _____ Your weight (pounds) _____

What problems is obesity causing for you? _____

What began your interest in bariatric surgery, and how did you learn about our group?

What makes you think seriously about bariatric surgery **now**? _____

Please list the names of any physicians or other healthcare professionals who have talked to you about how to manage or treat your obesity _____

What was your weight at the following times in your life?

6th grade _____ At your wedding _____

High School Graduation _____ Birth of 1st child _____

Age 21 _____ Age 40 _____

Age 30 _____ Age 50 _____

What has been your maximum weight? _____

What has been your lowest weight (not due to illness) after age 21, which you have maintained for at least 1 year? _____ lbs at _____ yrs old, maintained for _____ yrs.

Was this weight reached after a weight loss effort? (circle one)yes/no

Check the statement that best describes you: "During the past 6 months my weight has ..."

- decreased more than 10 lbs
- decreased 5-10 lbs
- stayed about the same
- increased 5-10 lbs
- increased more than 10 lbs

Please list your medical problems and year diagnosed.

1		8	
2		9	
3		10	
4		11	
5		12	
6		13	
7		14	

A list of common medical diagnoses is provided as a reminder for you:

- | | |
|------------------------------------|---|
| Diabetes | Venous thrombosis (DVT) or PE
<i>(Blood clot in legs or lungs)</i> |
| High Blood pressure (Hypertension) | Urinary incontinence |
| Sleep Apnea (do you use CPAP?) | Menstrual irregularity, infertility |
| Asthma, Reactive Airway Disease | Hirsutism |
| Heart Failure | Depression |
| Angina, Coronary Artery Disease | High cholesterol, high lipids |
| Gallstones | Hypothyroidism |
| GE Reflux disease ("GERD") | Other Endocrine/hormone problem |
| Arthritis | Other?? |
| Back pain | |
| Cancer (type?) | |

Have you been treated at a hospital (inpatient or outpatient) within the last year? _____

If yes, please provide further information: _____

Please list the physicians who participate in your care:

Primary MD: _____

Other physicians and their role for you: _____

Have you ever undergone colonoscopy (lower scope?) _____

If yes, when was it done, and who was the GI doctor? _____

Please list your past surgical history and year surgery performed.

1		6	
2		7	
3		8	
4		9	
5		10	

Have you undergone any surgical procedure for obesity in the past? _____ *If so:*

Name of Procedure: _____ When performed: _____

Name of Surgeon: _____ Office location: _____

Your weight prior to that procedure _____

Maximum weight lost, or lowest weight after surgery: _____

Reason you are seeking another surgical evaluation: _____

More than one prior surgical procedure for weight loss? _____

Have any of your family members or close friends undergone weight loss surgery? If yes, please describe:

Are you **allergic** to any medications? Yes No

If yes, please list: *please describe your reaction to the medications listed*

Please list all medications that you are currently taking:

	Medication	Strength	How many at one time	Schedule for dosing
	Example: TYLENOL	250 mg	2	Each morning, twice a day, etc.
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

Do you take birth control pills, or any hormone related medications? _____

Do you use any non-prescription (over-the-counter) drugs, vitamins, or herbal remedies?
Please describe:

Family History:

Has anyone in your immediate family had any of the following diseases?

(use: M = mother, F = father, S = sister, B = brother, G = grandparent)

Diabetes _____ Cancer (what type?) _____
Hypertension _____ Blood Clotting _____
Severe Obesity _____ _____

Social History:

Are you married? Yes/No/Divorced _____ If married, how long? _____

If you have children, please list their names and ages below.

Where do you work? What does your job involve? How long have you had this job?

Do you smoke now? _____ How much? _____ How many years? _____

Did you ever smoke? _____ *If yes:*

How many packs/day? _____ How many years? _____

When did you quit? _____

Do you drink alcohol? _____ If so, how much? _____

Do you use drugs like marijuana, cocaine, etc? _____

What do you aim for your weight to be, five years from now? _____

Please use this space to provide any other information that you think is important to understanding your medical situation, or how we may help you be most successful with the program.

General Symptom Review:

Circle a number that corresponds with your general energy level:

(1 = lowest, 5 = highest)

1 2 3 4 5

Have you experienced more than one week of fever in the last year? yes/no

Do you have severe headaches? yes/no

Have you experienced any visual changes in the last year? yes/no

Do you fall asleep unexpectedly? yes/no

Do you snore loudly? yes/no

Do you wake frequently at night? yes/no

How many times? _____

Do you experience shortness of breath with exercise? yes/no

Do you experience chest pain with exercise? yes/no

How many flights of stairs can you climb without stopping? _____

How many times per week do you have heartburn? _____

Do you experience abdominal pain or nausea after eating fatty foods? yes/no

Do you have difficulty swallowing, or feel a “catching” sensation
when eating thick or bulky foods? yes/no

Do you have difficulty with leaking of urine when you cough or laugh? yes/no

Have you had more than one urinary infection in the last year? yes/no

Do you have persistent skin irritation, rash, ulcers? yes/no
Where? _____

Do you have severe joint pain? yes/no
What joints are worst? _____

Do you have persistent ankle or foot pain? yes/no

Have you noticed any changes in your hair in the last year? yes/no

Have you noticed any changes in your energy level in the past year? yes/no

Has your thyroid function been checked by your physician in the past? yes/no

Do you feel depressed or hopeless? yes/no

Have you ever had a blood clot in your legs or lungs? yes/no