

Bariatric Patient Questionnaire

Personal details

Name: _____ Today's Date: / /

Social Security Number: _____ Date of Birth: / /

E-mail address: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone (home): _____ (business): _____ (mobile): _____

Occupation: _____ Employer: _____

Mother's Maiden Name: _____

Members of household: _____

Health Insurance Fund: _____ Membership Number: _____

Please put a star (*) beside your preferred method of contact

Contact persons

This information often is vital to us if we need to contact you urgently. Occasionally people move or have new phone numbers and do not let us know.

Next of kin - Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone (home): _____ (business): _____ (mobile): _____

Learning Needs Assessment

Spoken language English Other interpreter needed? Yes No interpreter notified Yes N/A

Do you need glasses to read? Yes No

Do you need a hearing aid to hear? Yes No

Do you have any difficulty with reading? Yes No

Do you have any difficulty with writing? Yes No

Special communication needs? Yes No If yes, please note here _____

Highest educational level achieved: Elementary School Middle School High School Technical School Associates

Bachelors Masters >Masters

Easiest way to learn: Reading Listening Pictures Demo

Surgical Weight Loss program

Please indicate your surgeon of choice:..... Eric Smith, D.O. Roderick Tompkins, M.D. Timothy Wheeler, M.D.

How did you first learn about our program? yourhealthylife.org/kdmc.com Other Internet source Newspaper Radio
 Television Physician Brochure Telephone book Word of mouth Other: _____

Which procedure would you like to pursue? Laparoscopic Roux-En-Y Gastric Bypass Laparoscopic-assisted Gastric Banding
 Laparoscopic Sleeve Gastrectomy

Height: _____ Weight: _____ Body Mass Index (BMI): _____

Please state your goals for Surgical Weight Loss:

At what age did you become 100 pounds overweight?

Please list your last 3 diet attempts.

Date(s) that this weight loss occurred?

Personal medical history

Do you experience any of the following health issues:	Yes	No	Details
• Recent weight change	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Have you ever had a blood clot in your leg or lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye-related Issues			
• Eye disease or injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Glasses or contacts	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear, Nose and Throat Issues			
• Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Chronic sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Sore throat/voice change	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Swollen neck glands	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular Issues			
• Chest pain or angina	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Swelling feet, hands and/or legs	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____
• High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
• High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory Issues			
• Chronic/frequent cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Respiratory/breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal			
• Dysphagia/loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Diarrhea/constipation	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Rectal bleeding/tar-like stool	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Reflux or heartburn	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Gastric or duodenal ulcer	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Hepatitis or liver disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

Genitourinary Issues

- Frequent urination _____
- Burning/pain with urine. _____
- Blood urine. _____
- History of kidney or urinary disorder _____

Skin Issues

- Rash or itch _____
- Varicose veins _____
- Breast lump you can feel _____
- Breast discharge _____
- Breast biopsy/surgery _____

Psychiatric

- Anxiety/panic attacks _____
- Confusion _____
- Depression _____
- Insomnia _____

Musculoskeletal

- Arthritis _____
- Joint pain _____
- Back pain _____

Endocrine

- Thyroid _____
- Diabetes _____
- Gestational diabetes _____

For Females Only

- Could you be pregnant? Last period: _____
- Are you nursing? _____
- Birth control pill use _____
- Number of pregnancies: _____ Number of children: _____

Please list your current medications (including prescriptions, over-the-counter medicines and herbal supplements):

Please list your allergies (including food, medication and latex sensitivity):

Please give dates and details of any major illnesses/problems:

Surgical History

Please give dates and details of any past operations:

If you have ever had hernia repair surgery, please list what type:

Yes No Problems

- Have you even been sedated/received spinal anesthesia? _____
- Have any family members had problems with anesthesia?..... _____

Family medical history

If you have a family history of any of the following, please indicate:

	Parent	Sibling/Child	Other Relatives (cousins, aunts, grandparents, etc.)	No Family History	Don't Know
• Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Snoring/sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Dermatitis/eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Hip fractures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Alcohol

- Do you drink alcohol? NeverRarelyRegularly
- If you drink: how many standard glasses do you drink a day? _____
- If you drink: how many days a week do you drink? _____

Tobacco Use

- Do you smoke? YesNoNever
- If yes: how many packs a day? _____
- Do you use smokeless tobacco? YesNoNever
- How often _____

Cough and shortness of breath

- Do you usually have a cough?YesNo
- Do you usually bring up phlegm from your chest when you cough?YesNo
- Do you get short of breath on exertion?YesNo
- Do you get short of breath walking on flat surfaces?YesNo
- Do you get short of breath walking uphill or doing housework?YesNo
- In the last 12 months, have you had an attack of shortness of breath that came on when you were not exercising and without obvious cause?YesNo

Wheezing

(A whistling noise that comes from the chest and may cause breathlessness or difficulty in breathing.)

- In the last 12 months, have you had wheezing in your chest?YesNo
- In the last 12 months, have you had an attack of wheezing that came on after you stopped exercising?YesNo
- In the last 12 months, have you had a feeling of tightness in your chest on waking in the morning?YesNo

Activity level

What exercise do you do on a regular basis?

- How many sessions of exercise (walking, sports, etc.) do you do a week for more than 30 minutes at a time? _____
- What sort of activities: _____

• How do you feel when exercising? Please mark level on scale:

Awful		Average		Excellent					
1	2	3	4	5	6	7	8	9	10

Gastroesophageal reflux/indigestion

- | | | | |
|--|------------|-----------|----------------|
| | Yes | No | Details |
|--|------------|-----------|----------------|
- Do you have a history of heartburn or indigestion? _____
- If yes, how often do you have reflux during the day? ...Many timesDailyMost daysMost weeks ...Occasionally
 - Do you suffer from heart burn/indigestion during the night?
- If so how often:Many timesNightly ...Most nightsMost weeks ...Occasionally
 - What aggravates or causes your reflux? _____
 - Do you have difficulty swallowing? _____
 - Does food ever get stuck? _____
 - Does food or fluid reflux into the mouth? _____
 - Do you vomit with reflux? _____
 - Do you suffer from recurrent sore throats? _____
 - Do you suffer from a hoarse voice? _____
 - Do you suffer from a regular cough at night? _____

Please list any treatments you may use for reflux/heartburn or indigestion:

Insurance Information

Name:

Primary Insurance Company:

Telephone:

Insurance ID Number:

Name of Subscriber:

Subscriber's Social Security Number:

Subscribers Date of Birth:

Secondary Insurance Company:

Telephone:

Insurance ID Number:

Name of Subscriber:

Subscriber's Social Security Number:

Subscribers Date of Birth:
