Bariatric Questionnaire - Angott Surgical Associates

Name: _____ _____ Date:_____
(Last) (First)

Address:_____

Telephone: Day (____)_____

Occupation:_____

Primary Care Doctor & Office Number: _____

Your Age: _____ Height: ____ft. _____in. Weight: _____ pounds BMI:_____

List any medications, vitamins, minerals, herbs and nutritional supplements that you take:

Medication	***Dosage***	***Frequency***	***Reason for Med***

Comprehensive Medical History

Medical Conditions:

Do you have any beliefs that prohibit the use of blood or blood products?

If yes please explain: _____

Do you now have or have you had in the past? *Please circle answer:*

Cirrhosis: Yes☐ No☐ **Diabetes Mellitus** ☐ **Insulin** ☐ **non-insulin**: Yes☐ No☐ **Kidney Disease**: Yes☐ No☐

Hepatitis A, B or C: Yes☐ No☐ **Coronary artery disease:** Yes☐ No☐ **Arrhythmia/A-Fib:** Yes☐ No☐

Sarcoid/Lupus: Yes☐ No☐ **High Cholesterol:** Yes☐ No☐ **Blood Clots/DVT**: Yes☐ No☐ **Gallstones:** Yes☐ No☐

COPD/Emphysema: Yes☐ No☐ **High Blood Pressure:** Yes☐ No☐ **Asthma:** Yes☐ No☐ **Heart Attack:** Yes☐ No☐

Chronic Bronchitis: Yes☐No☐ **Stroke:** Yes☐ No☐ **Hypothyroid:** Yes☐ No☐ **Mitral Valve Prolapse:** Yes☐ No☐

HIV: Yes☐ No☐ **Bleeding Abnormality:** Yes☐ No☐ **Gout:** Yes☐ No☐ **Gastric Reflux/Heartburn:** Yes☐ No☐

Prostate Problems/BPH: Yes☐ No☐ **Cancer-Type** _____**:** Yes☐ No☐

Sleep Apnea: Yes☐ No☐ **Use of C-Pap/Bi-Pap:** Yes☐ No☐

Other: _____

_____

_____

Previous Surgeries:

Date	***Surgery***	***Reason***

Allergies (drugs & food) and Reaction: _____
_____
_____
_____
_____

Latex Allergy? Yes☐ No☐

Psychosocial History

Are you: single☐ married☐ separated☐ divorced☐ widowed☐

Who do you live with? _____

Are you: student☐ employed☐ unemployed☐ disabled☐ retired☐

Have you had depression/anxiety or other mental illness? Yes☐ No☐

If yes, what was the date and diagnosis when first treated? _____

What are your current symptoms?

_____

Have you had any psychiatric hospitalizations? Yes☐ No☐

If yes, list date(s) and reason: _____

Please list any past and current psychiatric medications and side effects:

_____
_____
_____
_____
_____

Have you been in therapy? Yes☐ No☐ **Have you had any suicide attempts?** Yes☑ No☐

Have you had any self-cutting or other self-harm behavior? Yes☐ No☐

Have you ever had a problem with alcohol/substance use? Yes☐ No☐

Is there a family history of (please circle): obesity__ eating disorders__ depression/bipolar__ anxiety☐ suicide attempts☐ schizophrenia☐ alcohol/substance abuse☐?

How many siblings do you have? ____ brother(s) ____ sister(s)

Did you have any childhood abuse? Yes☐ No☐

Highest education level completed: _____

If employed, what is your occupation and for how long? _____

How many times have you been married? _____

How many children do you have? ____ daughter(s) ____ son(s)

Do you currently smoke? Yes☐ No☐ **Quit date if applicable:** _____

If yes, how much/how long? _____

Have you used street drugs in the past year? Yes☐ No☐

List any major life stressors (ie. deaths, relationships, job changes, moves): _____

_____

Who do you turn to for support and help? _____

_____

General History

Please list any physical activities/exercises that you do:

Activity or Exercise	Times per Week	Minutes per Activity

Physical Limitations? _____

How long have you been overweight? _____years **Onset of Obesity(age)?** _____

At what age did you begin your first diet? _____ age

Highest adult weight and date: _____ **Lowest adult weight and date:** _____

What is your average weight over the past 3 years? _____

What was your greatest single weight loss? _____ lbs

How long did you sustain that weight loss? _____

How was this weight loss obtained? (be specific) _____

_____

_____

Have you ever had any weight loss surgery? yes☐ no☐

If yes, name of MD: _____

Type of surgery:_____ Date: _____

Why do you want to lose weight? _____

_____

_____

_____

What methods have you tried to lose weight?

Method, Diets, Medication, Exercise plans	Doctor or Dietician Supervised?	Number of Attempts	Longest Length of Time	Amount of Weight Lost

How have you gathered information about the surgery? _____

_____

Do you have a close relative or friend who has had the surgery? _____

_____

Have you attended the Pre-Op Educational Session with the Nurse & Dietitian? Yes☐ No☐

Do you Binge eat? Yes☐ No☐ **Do you wake up and eat in the middle of the night?** Yes☐ No☐

Have you ever tried vomiting to lose weight? Yes☐ No☐

Have you ever used laxatives to lose weight? Yes☐ No☐

How many meals do you eat daily? _____ **How many snacks do you eat daily?**_____

How many minutes does it take you to eat a meal? _____

What causes you to gain weight? _____

_____

How confident are you that you can lose 10% of your weight before bariatric surgery?_____

_____

Who will assist you at home following the surgery?_____

_____

What is your plan for exercise after you have recovered from surgery?_____

_____

_____

Will it be difficult for you to give up drinking alcohol? Yes☐ No☐

If you are a woman, do you plan to become pregnant? Yes☐ No☐

Note: Even for those who have a history of infertility, becoming pregnant may be easier with weight loss. However, pregnancy should be avoided until you have maintained a stable body weight for 12 to 18 months or more. Women who wish to become pregnant in the future may benefit from a consult with an obstetrician/gynecologist.

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