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Diplomate American Board of Surgery
General and Laparoscopic Surgery
Bariatric Surgery

PATIENT QUESTIONNAIRE FOR BARIATRIC SURGERY

Today's Date _____

Name _____ Age _____ Birthdate _____

Current Weight _____ Current Height _____ BMI _____

WEIGHT HISTORY

What are your most significant problems related to obesity? _____

At what age were you first significantly overweight? _____

How much did you weigh at that time? _____

How long have you been overweight? _____ Age began first diet? _____

Most weight you ever lost? _____ lbs Last 5 years: Lowest weight _____

Highest weight _____

How was weight loss obtained? _____

How many meals per day do you eat? _____

Are you a snacker? Yes No Favorite foods: _____

Do you eat a lot of sweets: Yes No How often do you eat sweets? _____

Are you a binge eater? Yes No

Are you currently under a physicians care for weight loss? Yes No

If yes, physician name and address _____

Have you had any previous weight loss surgery? Yes No (please indicate below)

Surgery Type	Date	Surgeon	Weight Loss

Diet Programs and Supplements (please indicate which of the following diets or plans you have attempted)

Program	Dates	Duration	MD Supervised	Weight Loss
Atkins Diet				
Grapefruit Diet				
Herbalife				
Jenny Craig				
Liquid Diets				
Medifast				
Metabolife				
Nutri-Systems				
Optifast				
Pritikin Diet				
Slim Fast				
TOPS				
Weight Watchers				
Other				

Weight Loss Medication History (please indicate which of the following medications you have taken)

Medication	Dates	Dosage	MD Supervised	Weight Loss
Amphetamines				
Phentermine (Adipex, Fastin, Pondimin)				
Phen-Fen				
Redux (Dexafenafouramine)				
Xenical (Orlistat)				
Meridia (Sibutramine)				
Accutrim/Dexatrim				
Xenadrine				
Lasix (diuretic)				
Other Diet Medication				

Non-Dietary Therapies (please indicate if you have attempted any of the following weight loss treatments)

Therapy	Dates	Duration	MD Supervised	Weight Loss
Regular Exercise (Health club)				
Hypnosis				
Subliminal Types				
Behavior Modification				
Psychotherapy				
Acupuncture				

Obesity Related Medical History

Do you have, or have you ever had, any of the following illnesses or symptoms?

Cardiovascular

Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Angina (Chest Pains)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Palpitations (Abnormal Heartbeat)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
MI (Heart Attack)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Coronary Bypass Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Angioplasty/Stent	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congestive Heart Failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Elevated Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Elevated Triglycerides	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Thyroid Disease

Hyperthyroid	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hypothyroid	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Gastrointestinal

Nausea/Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Constipation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diverticulitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Colitis/Crohn's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heartburn/Acid Reflux	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stomach Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hiatal Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gallstones	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cirrhosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Abdominal Wall Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ventral	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Incisional	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Umbilical	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of hernia Repairs _____		

Respiratory

Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sleep Apnea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Loud snoring	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Awakening at Night	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Daytime Drowsiness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Observed Apnea Episodes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ever been to a sleep lab?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you use a CPAP/BiPAP machine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of Breath:		
at rest	<input type="checkbox"/> Yes	<input type="checkbox"/> No
while walking/exercise	<input type="checkbox"/> Yes	<input type="checkbox"/> No
You can walk _____ blocks		
You can climb _____ flights of stairs		

Circulation

Venous Stasis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Varicose Veins	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Leg or Ankle Edema (swelling)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Leg Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Leg Blood Clots, DVT	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pulmonary embolism	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Musculoskeletal

Pain of Arthritis/Joint Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
In Ankles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
In Knees	<input type="checkbox"/> Yes	<input type="checkbox"/> No
In Hips	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lowerback	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Limits Ability to Walk	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Limits Ability to Exercise	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Low Back Pain/Sciatica	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Limits Ability to Walk	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Limits Ability to Exercise	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Diabetes Mellitus

Juvenile Onset	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gestational (Pregnancy)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Adult Onset	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diet Controlled	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Oral Medications	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Insulin Dependent	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Kidney/Bladder/Other

Urinary Tract Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Stones	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Leaking Urine with Coughing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Leaking Urine with Sneezing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Leaking Urine with Straining	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Menstrual Irregularity	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Infertility	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Polycystic Ovaries	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prostate	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Blood/Other:

Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood transfusions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood clotting problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Exposure to HIV/AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
List type: _____		

Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Scleroderma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Problems with anesthesia/surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Neuro-Psychiatric:

Black-outs/Fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seizures/Convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pseudotumor Cerebri	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Migraine Frequency _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Abused Intravenous Drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcohol abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been treated for:		
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Suicidal thoughts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Suicidal attempts	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Are you currently in treatment? Yes No

If yes, please indicate the name and phone number of your physician or therapist.

Have you ever been hospitalized for mental illness? Yes No

I verify the content and accuracy of the above information.

Date	Signature	Print Name
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initial I hereby authorize Louis Fox, M.D. and/or his associates and staff to release any information in my chart that will assist with my care, obtain insurance approval/certification and help obtain payment from my health plan.

initial I authorize the release of all medical records, documents and associated information to Dr. Louis Fox or his authorized agent.

initial All charges are due at the time of service. If hospitalization or surgery is indicated, this office will file your claim directly to your insurance company. Please remember that most insurance companies do not pay the full amount, and therefore you are responsible for the balance. If there is a problem paying your balance in full, please let us know and we will establish a payment arrangement with you. For certain elective procedures, we require payment in full before providing service. I understand that if I have not secured the appropriate referrals and authorizations and otherwise followed the terms of my health plan contract, there may be a decrease in my insurance coverage or no coverage at all for some or all of the services which I will receive. I will be financially responsible for all remaining balances, including co-payments and co-insurance. If I have no insurance, I understand that I am financially responsible for all services provided.

initial I request that payment of authorized benefits - including Medicare and any other government sponsored program, private insurance and any other health benefit plans - be made directly to Louis Fox, M.D. for any services furnished.

These authorizations will remain in effect until revoked by me in writing.

initial A photocopy or fax of these assignments, authorizations and releases is to be considered as valid as the original.

initial

Date	Signature	Print Name
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