Sentara Comprehensive Weight Loss Solutions

Bariatric Patient Questionnaire

Last Name: _____ First Name: _____

Birth Date: ____/____/____ Age: _____ Phone: _____

Primary Care Physician: _____

Address: _____

Phone: _____

Specialty Physicians (i.e.: Endocrine, Cardiologist,Pulmonologist, Etc):

1) _____ Phone: _____

Specialty: _____

2) _____ Phone: _____

Specialty: _____

Height: _____ Weight: _____ BMI: _____

Highest Weight: _____ Age Obesity First Noted: _____

Weight At Age: 25: _____ 35: _____ 45: _____ 55: _____

Medication Allergies & Reactions? _____

_____

Latex Allergy? _____

Current Medications And Doses:

1) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

7) _____ 8) _____

Do You Take?

Coumadin? ❑ Yes ❑ No

Plavix? ❑ Yes ❑ No

Aspirin? ❑ Yes ❑ No

Do You Smoke? ❑ Yes ❑ No

Check One: ❑ Never

❑ Quit Date Quit:

❑ Yes Packs per day: _____ Years: _____

Do You Drink Alcohol?

Check One: ❑ No

❑ Yes How Many Per Week?

CO-MORBID CONDITIONS

❑ High Blood Pressure? Number of Years _____

❑ Heart Attack Chest Pain With Exercise? ❑ Yes ❑ No

❑ Congestive Heart Failure

❑ Diabetes Number of Years _____ Insulin? ❑ Yes ❑ No

❑ Sleep Apnea

❑ Snoring? ❑ Waking? ❑ CPAP?

Do You Have Your Own CPAP Machine? ❑ Yes ❑ No Pressure Setting? _____

❑ Severe Heartburn or Reflux (GERD)

History Of Ulcers? ❑ Yes ❑ No

❑ Blood Clot (DVT)

Pulmonary Embolism (Blood Clot In Lung) ❑ Yes ❑ No What Year? _____

Pain In Weight Bearing Joints? ❑ Yes ❑ No

❑ Back ❑ Hips ❑ Knees/Feet

❑ Limitations With Exercise ❑ Mild ❑ Moderate ❑ Severe

❑ Arthritis

❑ Shortness Of Breath

❑ Asthma ❑ Emphysema ❑ COPD

❑ Urinary Stress Incontinence

❑ Ankle Swelling

❑ Varicose Veins

❑ Fatty Liver ❑ Cirrhosis/Liver Disease

❑ High Cholesterol/Triglycerides

❑ Gallstones

❑ Anemia

Bleeding Disorder? ❑ Yes ❑ No Name Of Disorder? _____

❑ Hypothyroidism

❑ Polycystic Ovary Syndrome (PCOS)

❑ Chronic Headaches ❑ Migraines ❑ Blurred Vision

❑ Depression

❑ Suicide Attempts

❑ Bipolar Disorder

OTHER MEDICAL HISTORY

(Please Give Dates If Possible)

- ❑ Glaucoma _____
- ❑ Pneumonia _____
- ❑ Sarcoidosis _____
- ❑ Hepatitis (A, B, or C) _____
- ❑ HIV/AIDS _____
- ❑ Rectal Bleeding _____
- ❑ Prostate Problems Or Cancer (Men Only) _____
- ❑ Cancer (Skin, Breast, Lung, Colon, Other) _____
- ❑ Other (Please Explain) _____

_____

FOR WOMEN ONLY:

Age Started Menses: _____ Last Period: _____

Date Of Last Pap/Pelvic Exam: _____ Normal? ❑ Yes ❑ No

Date Of Last Breast Exam: _____

Date Of Last Mammmogram: _____ Normal? ❑ Yes ❑ No

Number Of Pregnancies: _____ Number Of Children: _____

Do You Plan To Have More Children? ❑ Yes ❑ No

PAST SURGICAL HISTORY:

- ❑ Gallbladder Surgery Laparoscopic? ❑ Yes ❑ No
- ❑ Hernia Surgery ❑ Umbilical? ❑ Groin?

  Previous Surgery Site Hernia? _____
- ❑ C-Sections What Years? _____
- ❑ Reflux Surgery _____
- ❑ Other Please List: _____

_____

SURGICAL COMPLICATIONS:

- ❑ Bleeding
- ❑ Problems With Anesthesia
- ❑ Blood Transfusions
- ❑ Blood Clot
- ❑ Infections

SOCIAL HISTORY:

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Level of Education: ❑ High School ❑ College ❑ Advanced Degree

Religious Preference: _____

FAMILY HISTORY:

	Age	Weight	Medical Conditions
Mother	_____	_____	_____
Father	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

PSYCHOLOGICAL HISTORY:

Do You Have Problems With Self-esteem? ❑ Yes ❑ No

Have You Been Sexually Or Physically Abused? ❑ Yes ❑ No

Have You Ever Been Down or Depressed Every Day For 2 Weeks? ❑ Yes ❑ No

Have You Ever Had A Suicide Attempt? ❑ Yes ❑ No

Have You Ever Had A Problem With Alcohol or Drugs? ❑ Yes ❑ No

Have You Ever Been Hospitalized for Psychiatric Reasons? ❑ Yes ❑ No

Have You Used Vomiting, Excessive Exercise or Laxatives to Lose Weight? ❑ Yes ❑ No

Do You Eat for Comfort? ❑ Yes ❑ No

Does Your Spouse/Family Support Your Decision for Gastric Bypass? ❑ Yes ❑ No

Describe Your Support System:

_____

_____

_____

_____

_____

WEIGHT LOSS HISTORY

PROGRAM	YEAR	# OF MONTHS	# WGT LOSS
MD Supervised			
Medifast			
Optifast			
Primary Care			
Other_____			
Dietitian or Nutritionist			
Name: _____			
Non-MD Supervised			
Weight Watchers			
Nutri-Systems			
Jenny Craig			
TOPS			
Overeater's Anonymous			
Medication Assisted			
Phen-Phen			
Xenical (Orlistat)			
Sibutramine (Meridia)			
Redux			
Other _____			
Other Treatments			
Hypnosis			
Acupuncture			
Self-Monitored Diets (i.e., Atkins, South Beach, Zone, etc.)			

Eating Habits:

Number of Meals per Day: _____

Number of Sodas per Day: _____

Caffeinated Drinks/Coffee per Day: _____

Preferences:

❑ Sweets (candy, chocolates, cakes)

❑ Starches (pasta, bread, pizza)

❑ Snacks (chips)

Name: _____ SSN: _____ Date: _____

REVIEW OF SYSTEMS

Please Circle Symptoms You Currently Have or Have Had in the past year:

Constitutional
Chills
Sweating
Fever
Malaise/fatigue
Night sweats
Weakness
Weight gain
Weight loss

Respiratory
Cough
Coughing up blood
Shortness of breath
Sputum production
Wheezing

Integument/Breast
Patchy hair loss
Itching
Rash
Skin changes on breast
Nipple Discharge

Behavioral/Psych
Depression
Hallucinations
Trouble sleeping
Memory Loss
Nervous/Anxious
Substance Abuse
Suicidal Ideas

Eyes
Blurred vision
Double vision
Eye discharge
Eye pain
Eye redness
Light sensitivity

Cardiovascular
Chest Pain
Pain with Walking
Leg swelling
Trouble laying flat
Palpitations

Hematol/Lymphatic
Easy bruising/bleed
Environ Allergies
Swollen Glands

Endocrine
Frequent Urination
Frequent Drinking
Poor Wound Healing
Excessive eating
Skin Dryness
Itching

ENT, Mouth, Face
Congestion
Ear discharge
Ear pain
Headaches
Hearing Loss
Nose Bleeds
Sore Throat
Ringing in the ears

Gastrointestinal
Abdominal pain
Blood in Stool
Constipation
Diarrhea
Heartburn
Black Stools
Nausea
Vomiting

Neurological
Dizziness
Focal weakness
Loss of Conscious
Seizures
Sensory change
Speech change
Tingling
Shakiness

Allergy/Immunologic
Severe allergic reaction
Swelling
Hay fever
Hives

Genitourinary
Pain with urinating
Flank pain
Frequency
Blood in urine
Urgency
Urinary infection
Urinary retention
Decline in erection

Musculoskeletal
Back Pain
Falls
Joint Pain
Muscle Pain
Neck Pain

Other
_____
_____
_____
_____
_____
_____
_____

STOP-BANG Sleep Apnea Questionnaire

Chung F et al Anesthesiology 2008 and BJA 2012

STOP

Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors)?

Yes No

Do you often feel **T**IRED, fatigued, or sleepy during daytime?

Yes No

Has anyone **O**BSERVED you stop breathing during your sleep?

Yes No

Do you have or are you being treated for high blood **P**RESSURE?

Yes No

BANG

BMI more than 35kg/m2? Yes No

AGE over 50 years old? Yes No

NECK circumference > 16 inches (40cm)? Yes No

GENDER: Male? Yes No

TOTAL SCORE

Stop

High risk OSA: Yes 2 or more

Low risk OSA: Yes < 2

Stop Bang

High risk of OSA: Yes 5 - 8

Intermediate risk of OSA: Yes 3 - 4

Low risk of OSA: Yes 0 - 2

OSA SCREENING SURVEY

please CHECK best answer

1. Do you snore regularly? ❑ Yes ❑ No
2. Have you ever been told that you stop breathing while asleep? ❑ Yes ❑ No
3. Do you frequently urinate at night? ❑ Yes ❑ No
4. Are you tired during the day? ❑ Yes ❑ No
5. Do you fall asleep unintentionally or nap? ❑ Yes ❑ No
6. Have you nodded off or fallen asleep during driving? ❑ Yes ❑ No
7. While driving over the past year, have you run off the road or had an accident due to sleepiness? ❑ Yes ❑ No
8. Do you have high blood pressure? ❑ Yes ❑ No
9. Has a doctor ever told you that you have sleep apnea? ❑ Yes ❑ No
10. Do you awaken with headaches in the morning? ❑ Yes ❑ No

If you have answered YES to 2 or more of these questions,
you may have a sleeping disorder and should be referred to a sleep specialist

Authorization for Release of Information

Date: _____

Patient Name: _____

Date of Birth: _____ Soc. See # _____

To: _____

Phone # _____ Fax # _____

I hereby authorize the release of my complete medical records to:

Sentara Comprehensive Weight Loss Solutions
633 Center Drive
Norfolk, Virginia 23502

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Signature of Witness Date

Name: _____
(Please put your first and last name on each page.)

Release for Use of Photograph

I, _____ do hereby authorize the staff of Sentara Comprehensive Weight Loss Solutions absolute permission to utilize any photographs taken of me pre-operatively, intra-operatively or post-operatively in reference to my roux en-Y Gastric Bypass or laparoscopic adjustable Gastric Band, to use, re-use, publish or republish in whole or in part, individually or in conjunction with others, in any medium and for any purpose whatsoever, including (not limited to) illustration, promotion, and/or advertising and trade.

I also release and discharge Sentara Comprehensive Weight Loss Solutions from any and all claims and demands arising from or in connection with the use of my photographs, including claims for libel.

I have read and fully understand the intent and purpose of this release and am signing it without reservation.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Signature of Witness Date

Name: _____

(Please put your first and last name on each page.)