MEDICAL and SURGICAL CLINIC of IRVING

Bariatric Patient Questionnaire

Name: _____ Sex: ☐ Male ☐ Female Age: _____

Street Address: _____

City/State/ZIP: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell/Other: ( ) _____

Weight: _____ Height: _____ Date of Birth: _____

Previous attempts at weight reduction:

How many years have you been overweight? _____

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

Program	**Dates**	**Duration**	**MD Supervised?**	**Weight loss**
Weight Watchers				
Jenny Craig				
Metabolife				
Medifast				
Nutri/System				
Atkins Diet				
Herbalife				
Slim Fast				
Other				

Weight-Loss Medication History: Please indicate if you have taken any of the following medications

Medication:	Dates	Duration	MD Supervised?	Weight Loss
Amphetamines				
Phentermine (Adipex, Fastin, Pondimen)				
Phen-Fen				
Dexfenfluramine (Redux)				
Xenical (Orlistat)				
Other Diet Medications:				

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List any other weight loss methods you have tried: _____

Previous Weight Loss Surgery: ☐ **Yes** ☐ **No**

Type of Weight Loss Surgery	Date	Surgeon	Weight Loss

Obesity Related Medical History:

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

Heart Disease ☐ **No** ☐ **Yes**

If yes, year of diagnosis: _____

Do you have, or have you had:

- ☐ Angina
- ☐ M.I. (heart attack, myrocardial infraction)
- ☐ Coronary Bypass Surgary
- ☐ Coronary Angioplasty
- ☐ Palpitations (abnormal heart beat)

Congestive Heart Failure: ☐ **No** ☐ **Yes**

If yes, year of diagnosis: _____

High Blood Pressure ☐ **No** ☐ **Yes**

If yes, year of diagnosis: _____

Elevated Cholesterol ☐ **No** ☐ **Yes** **Elevated Triglycerides** ☐ **No** ☐ **Yes**

If yes, year of diagnosis: _____

Diabetes ☐ **No** ☐ **Yes**

If yes, year of diagnosis: _____

☐ Juvenile onset
☐ Gestational (Pregnancy)
☐ Adult onset

Diet Controlled ☐ **No** ☐ **Yes**
Oral Medications ☐ **No** ☐ **Yes**
Insulin ☐ **No** ☐ **Yes**

Ashtma ☐ **No** ☐ **Yes**

If yes, year of diagnosis: _____

Shortness of Breath ☐ **No** ☐ **Yes**

If yes, can you: walk _____ blocks
climb _____ flights of stairs

Sleep Apnea ☐ **No** ☐ **Yes**

If yes, do you use a CPAP or BiPAP machine? ☐ **No** ☐ **Yes**

Sleep Dificulties:

snoring	☐ **No**	☐ **Yes**
awakenings at night	☐ **No**	☐ **Yes**
daytime drowsiness	☐ **No**	☐ **Yes**
observed apnea spells	☐ **No**	☐ **Yes**
morning headaches	☐ **No**	☐ **Yes**

Reflux/Heartburn/Esophagitis/Hiatal Hernia ☐ **No** ☐ **Yes**

If yes, year of diagnosis: _____
Prescription medications: ☐ **No** ☐ **Yes**
Over the counter meds: ☐ **No** ☐ **Yes**
Frequency of use: _____
Endoscopy: ☐ **No** ☐ **Yes**

Venous Stasis ☐ **No** ☐ **Yes**

Leg or ankle swelling/edema ☐ **No** ☐ **Yes**
Leg ulceration ☐ **No** ☐ **Yes**
Leg skin color change or thickening ☐ **No** ☐ **Yes**

Pain or Arthritis of Ankles/Knees/Hips ☐ **No** ☐ **Yes**

Limits ability to walf or exercise ☐ **No** ☐ **Yes**
Prescription medications ☐ **No** ☐ **Yes**
Over the counter medications ☐ **No** ☐ **Yes**

Low Back Pain/Sciatica	☐ **No**	☐ **Yes**	
Limits ability to walf or exercise	☐ **No**	☐ **Yes**	
Prescription medications	☐ **No**	☐ **Yes**	
Over the counter medications	☐ **No**	☐ **Yes**	
Urinary Incontinence (leakage of urine)	☐ **No**	☐ **Yes**	
With coughing/sneezing/straining	☐ **No**	☐ **Yes**	
Number of times per week: _____			
Migraine Headaches	☐ **No**	☐ **Yes**	
Frequency: _____			
Prescription medications	☐ **No**	☐ **Yes**	
Over the counter medications	☐ **No**	☐ **Yes**	
Deep Venous Thrombosis (Blood Clots in Legs)	☐ **No**	☐ **Yes**	
If yes, year of diagnosis: _____			
Pulmonary embolism	☐ **No**	☐ **Yes**	
Blood thinning medication	☐ **No**	☐ **Yes**	
Abdominal Wall Hernia	☐ **No**	☐ **Yes**	
Incisional	☐ **No**	☐ **Yes**	
Umbilical (belly button)	☐ **No**	☐ **Yes**	
Number of hernia repairs and dates: _____			
Hernia currently present	☐ **No**	☐ **Yes**	
Menstrual Irregularities	☐ **No**	☐ **Yes**	
Infertility	☐ **No**	☐ **Yes**	☐ **N/A**

Past Medical History:

Please list all other medical conditions or illnesses not previously mentioned:

_____

_____

_____

_____

Past Surgical History:

Please list all surgical procedures or operations:

Procedure	Indication	Hospital	Date

Do you have allergies to any medications? ☐ **No** ☐ **Yes**

If yes, please list medications and reactions (e.g., rash, breathing difficulty, shock, etc):

Medications: List or attach a medication list

Name	Dosage	Frequency

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Family History: (Please indicate if family members have any of the following illnesses)

☐ Obesity	☐ Lung disease or emphysema	☐ Kidney Disease
☐ High blood pressure	☐ High Cholesterol	☐ Diabetes
☐ Heart Disease	☐ Breast cancer	☐ Blood Disorder
☐ Stroke	☐ Other cancers	☐ Bleeding Tendency

Social History:

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced**

Children: ☐ **No** ☐ **Yes** **Number:** _____

Occupation: _____

Do you smoke tobacco? ☐ **No** ☐ **Yes**

If yes, number of packs per day: _____ Years of tobacco use: _____

Do you use alcohol? ☐ **No** ☐ **Yes**

If yes, amount and frequency: _____

Do you use drugs? ☐ **No** ☐ **Yes**

If yes, type and frequency:

I am interested in the gastric: ☐ Gastric Bypass ☐ Gastric sleeve ☐ Lap Band

Physician Attestion: I have reviewed and verified the above information with:

Patient Signature: _____ Date _____

Bariatric Physician Signature: _____ Date _____

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