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4QUESTI

Record below major diets that resulted in a weight loss of 10 pounds or more (use page 6 as needed)

Year	Length of Diet	Starting Wt.	# of Lbs Lost	Length of time weight stayed off	Type of diet program

At what age did you develop a significant weight problem? _____

In your opinion, what contributes to your excess weight? (Check all that apply.)

❒ Portion sizes ❒ Eating too much fat/sugar ❒ Nervous eating ❒ Lack of exercise ❒ Emotional eating ❒ Stress

❒ Compulsive eating ❒ Lack of knowledge about healthful eating and exercise ❒ Other _____

Have you or one of your relatives/spouse ever had bariatric (weight reduction) surgery? ❒ Yes ❒ No

a. If yes, what relationship are they to you?

❒ Self ❒ Mother ❒ Father ❒ Spouse ❒ Brother ❒ Sister ❒ Other _____

b. If yes, what type of procedure was performed?

❒ Gastric Banding ❒ Roux-en-Y Gastric Bypass ❒ Distal Bypass ❒ Don't know ❒ Other _____

Medical Information

Please list all prescribed and over-the-counter medications that you are currently using:

	Medication	Dose	Times per day	Year started	Purpose
1					
2					
3					
4					
5					

(please add additional medications on page 6.)

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

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Surgical Information

Part I. Please list any surgical procedure, reason and year. If relevant, please specify if the surgery was performed laparoscopic or open (*i.e.* hysterectomy, tubal ligation, hernia repair, gallbladder or appendix removal).

Type of Surgery _____ Reason _____ Year _____

Type of Surgery _____ Reason _____ Year _____

Type of Surgery _____ Reason _____ Year _____

Type of Surgery _____ Reason _____ Year _____

Have you or a family member ever have any trouble with anesthesia? ❒ Yes ❒ No

If yes, please explain: _____

Medical Health Information

Please indicate if any of the following conditions have ever been significant problems for you. Please specify the year diagnosed and the physician who currently manages the problem.

Cardiac:

Coronary Artery Disease ❒ Yes ❒ No Year diagnosed _____ Physician _____

Heart Attack ❒ Yes ❒ No Year diagnosed _____ Physician _____

If yes, treatment _____

High Cholesterol/Triglyceride ❒ Yes ❒ No Year diagnosed _____ Physician _____

Chest Pain ❒ Yes ❒ No Year diagnosed _____ Physician _____

Congestive Heart Failure ❒ Yes ❒ No Year diagnosed _____ Physician _____

Valvular Heart Disease ❒ Yes ❒ No Year diagnosed _____ Physician _____

(mitral valve prolapse, mitral valve regurgitation, etc.)

Heart Murmur ❒ Yes ❒ No Year diagnosed _____ Physician _____

Irregular Heart Beat ❒ Yes ❒ No Year diagnosed _____ Physician _____

High Blood Pressure ❒ Yes ❒ No Year diagnosed _____ Physician _____

Pulmonary:

Asthma ❒ Yes ❒ No Year diagnosed _____ Physician _____

Pneumonia ❒ Yes ❒ No Year diagnosed _____ Physician _____

Bronchitis ❒ Yes ❒ No Year diagnosed _____ Physician _____

COPD (Emphysema) ❒ Yes ❒ No Year diagnosed _____ Physician _____

Diagnosed Sleep Apnea ❒ Yes ❒ No Year diagnosed _____ Physician _____

If yes, treatment _____

Stop Breathing While Sleeping ❒ Yes ❒ No

Loud Snoring ❒ Yes ❒ No

Gasping for Breath at Night ❒ Yes ❒ No

Family History of Sleep Apnea ❒ Yes ❒ No Family member _____

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Endocrine:

Diabetes Mellitus ❒ Yes ❒ No Year diagnosed _____ Physician _____

Currently on Insulin ❒ Yes ❒ No

Hyperthyroid/Hypothyroid ❒ Yes ❒ No Year diagnosed _____ Physician _____

Gastrointestinal:

Reflux Disease (Heartburn) ❒ Yes ❒ No Year diagnosed _____ Physician _____

Gallbladder Disease ❒ Yes ❒ No Year diagnosed _____ Physician _____

Liver Disease ❒ Yes ❒ No Year diagnosed _____ Physician _____

If yes, describe condition _____

Inflammatory Bowel Disease ❒ Yes ❒ No Year diagnosed _____ Physician _____

(ex. Crohn's, ulcer colitis, etc.)

Hiatal Hernia ❒ Yes ❒ No Year diagnosed _____ Physician _____

If yes, describe condition _____

Other _____ ❒ Yes ❒ No Year diagnosed _____ Physician _____

Cancer:

Type/Organ(s) Affected:_____Treatment_____

History of Breast Cancer? ❒ Yes ❒ No Year diagnosed_____

Peripheral Vascular Disease:

Arterial Vascular Disease ❒ Yes ❒ No Year diagnosed _____ Physician _____

Pulmonary Embolism ❒ Yes ❒ No Year diagnosed _____ Physician _____

DVT (Phlebitis) ❒ Yes ❒ No Year diagnosed _____ Physician _____

Superficial Phlebitis ❒ Yes ❒ No Year diagnosed _____ Physician _____

Swelling Legs, Ankles ❒ Yes ❒ No Year diagnosed _____ Physician _____

Leg Ulcers ❒ Yes ❒ No Year diagnosed _____ Physician _____

Ulcers Currently ❒ Yes ❒ No

Varicose Veins ❒ Yes ❒ No Year diagnosed _____ Physician _____

Renal:

Kidney Disease ❒ Yes ❒ No Year diagnosed _____ Physician _____

Urinary Stress Incontinence ❒ Yes ❒ No Year diagnosed _____ Physician _____

Kidney Stones ❒ Yes ❒ No Year diagnosed _____ Physician _____

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Obstetrical/Gynecological:

1. Have you ever been pregnant? ❒ Yes ❒ No
   a. Please indicate the number of pregnancies to term _____
   b. Please indicate the number of deliveries _____
   c. Please indicate whether you are ❒ Pre Menopausal ❒ Post Menopausal
2. Menstrual Cycles ❒ Regular ❒ Irregular ❒ None
3. Polycystic Ovarian Syndrome or History ❒ Yes ❒ No

Musculoskeletal:

Lower Back Pain ❒ Yes ❒ No Year diagnosed _____ Physician _____

Osteoarthritis/Joint Disease ❒ Yes ❒ No Year diagnosed _____ Physician _____

If yes, joints involved: ❒ Neck ❒ Shoulders ❒ Back ❒ Hips ❒ Hands/Wrist ❒ Knees ❒ Ankles ❒ Feet ❒ Heels

Painful Joints (without osteoarthritis/joint disease) ❒ Yes ❒ No

If yes, joints involved: ❒ Neck ❒ Shoulders ❒ Back ❒ Hips ❒ Hands/Wrist ❒ Knees ❒ Ankles ❒ Feet ❒ Heels

Central Nervous System:

❒ Seizures ❒ Migraines ❒ Visual Disturbances

❒ Hearing Impairments ❒ Numbness of Extremities ❒ Frequent Headaches

Autoimmune Disease ❒ Yes ❒ No Year diagnosed _____ Physician _____

(ex. Lupus, Rheumatoid Arthritis, Connective Tissue, etc.)

Gout ❒ Yes ❒ No Year diagnosed _____ Physician _____

If yes, list joints involved: _____

Have you ever had any broken bones of the face? _____

Have you ever had broken bones of the back/neck? _____

Blood Disorders:

Anemia ❒ Yes ❒ No Year diagnosed _____ Physician _____

If yes, type if known: _____

Do you have or have you had any abnormalities with bleeding or clotting? ❒ Yes ❒ No

If yes, explain: _____

Psychiatric Disorders:

Depression ❒ Yes ❒ No Bipolar Disorder ❒ Yes ❒ No Anxiety ❒ Yes ❒ No

Schizophrenia ❒ Yes ❒ No Eating Disorder ❒ Yes ❒ No Other _____

If yes, to any of the above, please explain: _____

Are you currently receiving therapy or medications? ❒ Yes ❒ No

Have you ever been hospitalized for the above conditions? ❒ Yes ❒ No

Other Medical Disorders:

_____

_____

_____

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Gender: ❑ Male ❑ Female

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Family History:
In this section, please complete this chart to the best of your knowledge. If adopted and have no history of your biological family, please place an "X" in the box. ❒ Adopted

Family History	
Check (√) if any blood relatives have had:	Medical information about your biological family (i.e. ages, medical conditions, types of cancer, etc.):
❒ Colon Cancer/Polyps ❒ Crohns Disease, Ulcerative Colitis ❒ Liver Disease or hepatitis ❒ Pancreatic cancer ❒ Gall Bladder Disease ❒ Stomach or Esophagus Cancer ❒ Diabetes ❒ Coronary Artery Disease	Father: Mother: Siblings: Children: Paternal grandparents: Maternal grandparents:

Please list any specific question(s) you may have about your surgical procedures in order that our doctors may become aware of your concerns prior to your appointment.

PATIENT IDENTIFICATION

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Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Male ❑ Female

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Additional Information:

Completed by (signature): _____ Date: _____ Time: _____

Completed by (printed name): _____

This information is very important. It helps us to give you the best possible medical/surgical care. Thank you for taking the time and energy to complete this worksheet for your bariatric surgery.

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

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