

Bariatric Patient History Questionnaire

Demographics: Please fill out completely

First Name: _____ Middle Name: _____

Last Name: _____

Nickname/ preferred name: _____

Maiden Name: _____

Date of Birth: _____

Gender: Male Female

Marital Status: Single Married Divorced Separated Partnered Widowed

Social Security Number: _____ - _____ - _____

Ethnicity: African American Arabic Asian Caucasian Hispanic Native American Other

Religious Affiliation: _____

Patient Level of Education: _____

Employment Status: Full-time Part-time Retired Disabled Housewife Student Unemployed

If disabled, specify the year and the cause: Year: _____ Cause: _____

Patient Occupation (indicate if student): _____

Patient Employer: _____

Years Employed: _____

Patient Employers Address: _____

Reason for Visit (i.e. why are you seeking weight loss surgery?): _____

List your preferred procedure: _____

Referral Information: Please circle how you heard about TLC Surgery

Internet/Facebook Magazine Newspaper Other Patient Our Website Television Yellow Pages

Physician Referral: _____ Hospital Referral: _____
(name of physician) (name of hospital)

Do you like to use Facebook? Yes No If yes, may we send you a friend request?
(We hold monthly Support Groups via Facebook and also post valuable information for patients)

Address Information: Please fill out all information completely

Street Address: _____

City: _____ State: _____ Zip Code: _____ Country: _____

E-Mail: _____

Phone (home): _____ - _____ - _____ Is it ok to leave a message on this number? Y N

Phone (work): _____ - _____ - _____ Is it ok to leave a message on this number? Y N

Phone (mobile): _____ - _____ - _____ Is it ok to leave a message on this number? Y N

Spouse Information: Please fill out all information completely

Spouse name: _____

Spouse employment status: Full-time Part-time Retired Disabled Housewife Student Unemployed

Spouse's occupation (indicate if student): _____

Spouse's SSN: _____ - _____ - _____

Spouse's date of Birth: ____ / ____ / ____

Spouse's Employer: _____

Years Employed: _____

Emergency Contact #1:

First Name: _____

Last Name: _____

Relation to you: _____

Phone: _____ - _____ - _____

Emergency Contact #2:

First Name: _____

Last Name: _____

Relation to you: _____

Phone: _____ - _____ - _____

Insurance Information: Please fill out all information

Insurance Company: _____

Policy Number: _____

Payment Type: _____

Group Number: _____

Full Name of Insured: _____

Effective Date: ____ / ____ / ____

Insured DOB: ____ / ____ / ____

Terminated Date: ____ / ____ / ____

Relationship to Insured: _____

Insured Employer: _____

SS# of Insured: _____ - _____ - _____

Insured ID: _____

Notes: _____

Insurance Phone#: _____ - _____ - _____

Weight-Loss History: Please fill out all information

What is your height? _____ Ft _____ In How much do you weigh? _____ Lbs

From what age have you been obese? _____ Years

For how many years have you been at your current weight? _____ Years

What was your maximum adult weight? _____ Lbs

What was your minimum adult weight? _____ Lbs

What was the most weight you ever lost on a single diet? _____ Lbs

How many months did you keep it off? _____

What was your weight at the following ages (estimate)?

Age 10 _____ Age 18 _____ Age 25 _____ Age 30 _____ Age 35 _____

Age 40 _____ Age 45 _____ Age 50 _____ Age 60+ _____

Please list all weight loss medication you have taken:

Comorbidities: Please only select ONLY ONE per category for each system

****Please note that if you are not familiar with a listed condition, then it may not pertain to you!*

Cardiovascular System

Hypertension:

- No history
- Borderline, no medication
- Diagnosis of hypertension, no medication
- Treatment with single medication
- Treatment with multiple medications

Congestive Heart Failure:

- No history or symptoms of congestive heart failure
- Class I: Symptoms with more than ordinary activity
- Class II: Symptoms with ordinary activity
- Class III: Symptoms with minimal activity
- Class IV: Symptoms at rest

Ischemic Heart Disease:

- No history of ischemic heart disease
- Abnormal EKG, no active ischemia
- PCI, CABG
- Active ischemia

Peripheral Vascular Disease:

- No symptoms of peripheral vascular disease
- Asymptomatic with bruit
- Claudication, anti-ischemic medication
- Transient ischemic attack, rest pain
- Procedure for peripheral vascular disease

Lower Extremity Edema:

- No symptoms of lower extremity edema
- Intermittent lower extremity edema, does not require treatment
- Symptoms requiring treatment, diuretics, elevation, or hose
- Stasis ulcers
- Disability, decreased function, hospitalization

Angina Assessment:

- No chest pain symptoms/angina
- Anginal chest pain with extreme exertion, such as running, swimming, etc...
- Anginal chest pain occurs with moderate activity or exertion
- Anginal chest pain with minimal exertion, such as walking across a room
- Unstable angina

Metabolic System

Glucose Metabolism:

- No symptoms of diabetes
- Elevated fasting glucose
- Diabetes, controlled with oral medication
- Diabetes, controlled with insulin
- Diabetes, controlled with insulin and oral medication
- Diabetes, with severe complications, such as retinopathy, neuropathy, renal failure, or blindness

Gout/Hyperuricemia:

- No symptoms of gout/hyperuricemia
- Hyperuricemia, no symptoms
- Hyperuricemia, medications
- Arthropathy
- Destructive joints
- Disability, unable to walk

Pulmonary

Obstructive Sleep Apnea Syndrome:

- No symptoms or evidence of obstructive sleep apnea syndrome
- Sleep apnea symptoms (negative sleep study or not done)
- Sleep apnea diagnosis by sleep study (no oral appliance)
- Sleep apnea requiring oral appliance such as CPAP
- Sleep apnea with significant hypoxia or oxygen dependent
- Sleep apnea with complications (pulmonary HTN, etc.)

DVT/PE:

- No history of DVT/PE
- History of DVT resolved with anticoagulation
- Recurrent DVT long term anticoagulation medication
- Previous PE
- Recurrent PE, decreased function, hospitalization
- Vena Cava filter

Lipids:

- Not present
- Present, no treatment required
- Controlled with lifestyle change, including Step 1 or Step 2 diet
- Controlled with single medication
- Controlled with multiple medications
- Not controlled

Pulmonary Hypertension:

- No symptoms or indication of pulmonary hypertension
- Symptoms associated with PH (tiredness, SOB, dizziness, fainting)
- Confirmed PH diagnosis
- Well controlled on anticoagulants and/or calcium channel blockers
- Stronger medications and/or oxygen
- Patient needs or has had lung transplant

Obesity Hypoventilation Syndrome:

- No symptoms of obesity hypoventilation
- Hypoxemia/hypercarbia on room air
- Severe hypoxemia or hypercarbia
- Pulmonary hypertension
- Right heart failure
- Right heart failure – left ventricular dysfunction

Asthma:

- No symptoms of asthma
- Intermittent mild symptoms, no medication
- Symptoms controlled with oral inhaler (such as albuterol)
- Well controlled with ongoing daily medication
- Symptoms not well controlled, steroids, or anticholinergics
- Hospitalized within last 2 years, history of intubation

Gastrointestinal System

GERD:

- No history of GERD
- Intermittent or variable symptoms of GERD
- Intermittent medication
- H2 blockers or low dose PPI
- High dose PPI
- Meet criteria for anti-reflux surgery, or prior surgery for GERD
-

Cholelithiasis:

- No history of gallstones
- Gallstones with no symptoms
- Gallstones with intermittent symptoms
- Gallstones with severe symptoms or h/o cholecystectomy
- Gallstones with complications requiring immediate surgery prior to this
- Cholecystectomy, with unresolved complications

Liver Disease:

- No history of liver disease
- Hepatomegaly modest, normal LFT's, fatty change Category 1
- Modest or greater hepatomegaly, LFT alteration, fatty change Category 2
- Moderate to marked hepatomegaly, fatty change Category 3, mild inflammation, mild fibrosis
- Definite NASH, cirrhosis, hepatic dysfunction by LFT's
- Hepatic failure, transplant indicated or done

Musculoskeletal System

Musculoskeletal Disease:

- No symptoms of musculoskeletal disease
- Pain with community ambulation
- Non narcotic analgesia required
- Pain with household ambulation
- Surgical intervention required (arthroscopy)
- Awaiting or past joint replacement or other disability

Fibromyalgia:

- No history of fibromyalgia
- Treatment with exercise
- Treatment with non-narcotic medications
- Treatment with narcotics
- Treatment with narcotics, surgical intervention done or recommended
- Disabling, treatment ineffective

Reproductive System

Polycystic Ovarian Syndrome (PCOS):

- No history of PCOS
- Symptoms of PCOS, no treatment
- OCP's or anti-androgen medications
- Metformin or TZD
- Combination Therapy
- Infertility

Psychosocial

Psychosocial Impairment:

- No impairment
- Mild impairment in psychosocial functions, but able to perform primary tasks
- Moderate impairment in psychosocial functions, but able to perform most primary tasks
- Moderate impairment in psychosocial functioning and unable to perform some primary tasks
- Severe impairment in psychosocial functioning and unable to perform most primary tasks

Back Pain:

- No symptoms of back pain
- Intermittent symptoms not requiring medical treatment
- Degenerative changes or positive objective findings, symptoms requiring narcotic treatment
- Surgical intervention done or recommended pending weight loss
- Failed previous surgical intervention with existing symptoms

Menstrual Irregularities (not PCOS):

- No history
- Irregular periods or oligomenorrhea
- Menorrhagia
- Amenorrhea
- Prior total abdominal hysterectomy

Confirmed Mental Health Diagnosis:

- None
- Bipolar Disorder
- Anxiety/Panic Disorder
- Personality Disorder
- Psychosis

Depression:

- No symptoms of depression
- Mild and episodic not requiring treatment
- Moderate, accompanied by some impairment, may require treatment
- Moderate with significant impairment, treatment indicated
- Severe, definitely requiring intensive treatment
- Severe, requiring hospitalization

General

Stress Urinary Incontinence:

- No history of stress urinary incontinence
- Minimal and intermittent
- Frequent but not severe
- Daily occurrence, requires sanitary pad
- Disabling
- Operating ineffective

Pseudotumor Cerebri:

- No symptoms of pseudotumor cerebri
- Headaches with dizziness, nausea, and or pain behind the eyes
- Headaches with visual symptoms and or controlled with diuretics
- Had MRI to confirm PTC, is well controlled with oral diuretics
- Patient is well controlled with stronger medications
- Patient requires narcotics or has had, or needs surgical intervention

Abdominal Hernia:

- No hernia
- Asymptomatic hernia, no prior operation
- Symptomatic hernia with or without incarceration
- Successful repair
- Recurrent hernia or size > 15 cm
- Chronic evisceration through large hernia with associated complications or multiple failed hernia repairs

Functional Status:

- No impairment of functional status
- Able to walk 200 ft with assistance device, such as cane or crutch
- Cannot walk 200 ft with assistance device, such as cane or crutch
- Requires a wheelchair
- Bedridden

Abdominal Skin/Pannus:

- No symptoms
- Intertriginous irritation
- Pannus so large it interferes with ambulation
- Recurrent cellulitis, ulceration
- Surgical treatment required

Surgical/ Hospitalization History: Please check all surgeries you have ever had in your life time

		Month	Year
Gallbladder (Open):	<input type="checkbox"/>	_____	_____
Gallbladder (Laparoscopic)	<input type="checkbox"/>	_____	_____
Appendectomy:	<input type="checkbox"/>	_____	_____
Hysterectomy (Uterus removed- vaginal):	<input type="checkbox"/>	_____	_____
Hysterectomy (Uterus removed- abdominal):	<input type="checkbox"/>	_____	_____
Ovary Surgery:	<input type="checkbox"/>	_____	_____
Cesarean Section:	<input type="checkbox"/>	_____	_____
Back:	<input type="checkbox"/>	_____	_____
Right Knee:	<input type="checkbox"/>	_____	_____
Left Knee:	<input type="checkbox"/>	_____	_____
Right Breast Biopsy:	<input type="checkbox"/>	_____	_____
Left Breast Biopsy:	<input type="checkbox"/>	_____	_____
Tonsillectomy:	<input type="checkbox"/>	_____	_____
Hernia:	<input type="checkbox"/>	_____	_____
Tubal Ligation:	<input type="checkbox"/>	_____	_____
Kidney Transplant:	<input type="checkbox"/>	_____	_____
Liver Transplant:	<input type="checkbox"/>	_____	_____
Pancreas Transplant:	<input type="checkbox"/>	_____	_____
Previous Weight Loss Surgery	<input type="checkbox"/>	_____	_____

Type of Surgery: _____ **Performing Surgeon or Dr.** _____

Weight before Weight Loss Surgery: _____ **Lowest weight achieved:** _____

Other Surgery 1: _____

Other Surgery 2: _____

Social History: Please select all that apply

Alcohol Use:	Tobacco Use:	Substance Abuse (Rx or Illegal)
<input type="radio"/> None	<input type="radio"/> None	<input type="radio"/> None
<input type="radio"/> Rare	<input type="radio"/> Rare	<input type="radio"/> Rare
<input type="radio"/> Occasional	<input type="radio"/> Occasional	<input type="radio"/> Occasional
<input type="radio"/> Frequent	<input type="radio"/> Frequent	<input type="radio"/> Frequent
<i>Drinks per week:</i> _____	<i>Packs per week:</i> _____	<i>Usage per week:</i> _____

Family history: Please circle all that apply

Obesity	Y	N	# of family deaths related to obesity_____
Kidney Disease	Y	N	
Heart Disease	Y	N	
Diabetes Mellitus	Y	N	
High blood pressure	Y	N	
Alcoholism	Y	N	
Liver problems	Y	N	
Lung problems	Y	N	
Bleeding disorder	Y	N	
Gallstones	Y	N	
Mental Illness	Y	N	
Cancer	Y	N	Type:_____
			If another please specify type:_____
Malignant hyperthermia	Y	N	
Adopted?	Y	N	

Drug Allergies: please list all DRUG allergies

<i>Name of Medication</i>	<i>Reaction it Causes</i>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Skin Allergies: please circle all SKIN allergies

<i>Circle all that apply</i>	<i>Reaction it Causes</i>
1. Latex	_____
2. Iodine	_____
3. Band-Aid Bandages or Adhesive	_____
4. Other:	_____

Medications/Vitamins & Minerals: Please list all medication that you currently use

<i>Name</i>	<i>Dosage</i>	<i>Frequency*</i>	<i>Indication</i>
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

*Frequency: QD: 1x daily BID: 2x daily TID: 3x daily QID: 4x daily QOD: 1x daily, every other day

****IMPORTANT** Information for e-Prescribe****

Name of your pharmacy: _____ **Phone #:** _____

Pharmacy address: _____

Blood Analysis:

- | | | |
|---|---|---|
| Have you ever received a blood transfusion? | Y | N |
| Would you accept a blood transfusion? | Y | N |
| Have you ever had hepatitis? | Y | N |
| Have you ever been exposed to HIV/ AIDS? | Y | N |
| Have you ever abused intravenous drugs? | Y | N |

Review of Systems: Check all the health problems you have had or are currently experiencing

****Please note that if you are not familiar with a listed condition, then it may not pertain to you!*

Cardiovascular:

Heart Attack	<input type="checkbox"/>	Angina (chest pain with activity)	<input type="checkbox"/>
Rhythm disturbance/ palpitations	<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Ankle Swelling	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	Ankle/ leg ulcers	<input type="checkbox"/>
Heart bypass/valve replacement	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>
Clogged Heart Arteries	<input type="checkbox"/>	Rheumatic fever/ valve damage	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	Irregular heart beat	<input type="checkbox"/>
Cramping in legs when walking	<input type="checkbox"/>	Other Symptoms	<input type="checkbox"/>

Respiratory:

Asthma	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	Short of Breath	<input type="checkbox"/>
Use of CPAP or oxygen supplement	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Pulmonary Embolism	<input type="checkbox"/>	Hypoventilation Syndrome	<input type="checkbox"/>
Cough up blood	<input type="checkbox"/>	Snoring	<input type="checkbox"/>
Awaken at Night	<input type="checkbox"/>	Daytime Drowsiness	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	Lung Surgery	<input type="checkbox"/>
Lung Cancer	<input type="checkbox"/>		

Endocrine:

Hypothyroid (low)	<input type="checkbox"/>	Hyperthyroid (high/ overactive)	<input type="checkbox"/>
Goiter	<input type="checkbox"/>	Parathyroid	<input type="checkbox"/>
Elevated Cholesterol	<input type="checkbox"/>	Elevated Triglycerides	<input type="checkbox"/>
Low Blood Sugar	<input type="checkbox"/>	Diabetes (Managed by diet pills)	<input type="checkbox"/>
Diabetes (Needing insulin shots)	<input type="checkbox"/>	“Prediabetes” w/ elevated blood sugar	<input type="checkbox"/>
Gout	<input type="checkbox"/>	Endocrine gland tumor	<input type="checkbox"/>
Cancer of endocrine gland	<input type="checkbox"/>	High Calcium level	<input type="checkbox"/>
Abnormal facial hair	<input type="checkbox"/>		

Gastrointestinal:

Heartburn	<input type="checkbox"/>	Hiatal Hernia	<input type="checkbox"/>
Abdominal Hernia	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	Blood in Stool	<input type="checkbox"/>
Change in bowel habit	<input type="checkbox"/>	Constipation	<input type="checkbox"/>
Irritable Bowel	<input type="checkbox"/>	Colitis	<input type="checkbox"/>
Crohn's	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>
Fissure	<input type="checkbox"/>	Rectal Bleeding	<input type="checkbox"/>
Black, tarry stool	<input type="checkbox"/>	Polyps	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	Enlarged Liver	<input type="checkbox"/>
Cirrhosis/ hepatitis	<input type="checkbox"/>	Gallbladder problems	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	Pancreatic disease	<input type="checkbox"/>
Unusual vomiting	<input type="checkbox"/>	Surgery	<input type="checkbox"/>
Cancer	<input type="checkbox"/>		

Bladder/ Kidney:

Kidney Stones	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>
Prostate Problems	<input type="checkbox"/>	Kidney Failure	<input type="checkbox"/>
Leaking Urine	<input type="checkbox"/>	For men: PSA in last year?	<input type="checkbox"/>
Burning on Urine	<input type="checkbox"/>	Loss of bladder control (leakage)	<input type="checkbox"/>
Wear panty liner for leakage?	<input type="checkbox"/>	Trouble starting urine	<input type="checkbox"/>
Surgery	<input type="checkbox"/>	Cancer	<input type="checkbox"/>

Gynecologic (for women only):

Problems conceiving (infertility)	<input type="checkbox"/>	Are you pregnant?	<input type="checkbox"/>
Uterine/ Ovarian Cancer	<input type="checkbox"/>	Surgery	<input type="checkbox"/>
Menstrual irregularity	<input type="checkbox"/>	Menstrual pain	<input type="checkbox"/>
Excessively heavy periods	<input type="checkbox"/>	Do you plan to have more children?	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>		

Date of menopause onset _____

How many pregnancies have you had? _____

Date of last pap-smear _____

How many children do you have? _____

Date of last Menstrual period _____

Age started menses _____

How many miscarriages or abortions have you had? _____

Musculoskeletal:

Arthritis
Shoulder Pain
Back Pain
Knee Pain
Foot Pain
Ball of foot/toe pain
Carpal tunnel syndrome
Scleroderma
Autoimmune disease
Fibromyalgia
Joint replacement
Muscular dystrophy
Cancer

Neck Pain
Wrist Pain
Hip Pain
Ankle Pain
Heel Pain
Plantar fasciitis
Lupus
Sciatica
Muscle pain/spasm
Broken Bones
Nerve injury
Surgery

Head And Neck:

Wear Contacts/ Glasses
Hearing Problems
Neck Lumps
Dentures/ Partial
Hoarseness
Cancer

Vision Problems
Sinus Drainage
Swallowing Difficulty
Oral Sores
Head/ Neck Surgery

Neurologic:

Migraine Headaches
Seizure or Convulsions
Stroke
Pseudotumor cerebri
Frequent severe headaches
Surgery

Balance Disturbance
Weakness
Alzheimer's
Multiple Sclerosis
Knocked Unconscious
Cancer

Breast:

Lumps
Fibrocystic disease
Surgery

Pain
Nipple discharge
Cancer

Skin:

Rashes under skin folds

Keloids (excessively raised scars)

Poor wound healing

Frequent skin infections

Surgery

Cancer

Blood:

Anemia (iron deficient)

Anemia (vitamin B12 deficient)

HIV

Low platelets (thrombocytopenia)

Lymphoma

Swollen lymph nodes

Superficial blood clot in leg

Deep blood clot in leg

Blood clot in lungs

Bleeding disorder

Blood transfusion

Blood and thinning medicine use

Psychiatric:

Anxiety

Depression

Anorexia

Bulimia

Bipolar disorder

Alcoholism

Drug dependency

Schizophrenia

Other psychiatric problems

Hospitalization for psychiatric problems

Have you ever been in a psychiatric hospital?

Have you ever attempted suicide?

Have you ever been physically abused?

Have you ever seen a psychiatrist or counselor?

Are you currently seeing a psychiatrist or counselor?

Have you ever taken medications for psychiatric problems or for depression?

Have you ever been in a chemical dependency program?

Constitutional:

Fevers

Night Sweats

Anemia

Weight Loss

Chronic Fatigue

Hair Loss

Thank you for filling out the questionnaire honestly and completely.