

PROGRAM FOR SURGICAL WEIGHT LOSS



*PATIENT INFORMATION PROFILE
& MEDICAL QUESTIONNAIRE*

PERSONAL DETAILS

Last Name: _____ First Name: _____ Age: _____

Education Level : Grade School _____ High School _____ College _____ Post Graduate _____

Occupation: _____ Employer: _____

Email Address: _____

REFERRAL INFORMATION

Primary Doctor: _____

Address: _____

Telephone: _____

Referring Doctor: _____

Address: _____

Telephone Contact: _____

Psychologist/Psychiatrist, if any: _____

Address: _____

Telephone Contact: _____

Other Doctors/Specialist: _____

Address: _____

Telephone Contact: _____

How did you hear about our program? MD _____ TV _____ Radio _____

Word of Mouth _____ Newspaper _____ Internet (If so, which site?) _____ Other (please specify) _____

SOCIAL PROFILE

FAMILY STRUCTURE:

Married: _____ Single: _____ Divorced: _____ Widowed: _____ Partnered: _____

Children/Ages: _____

Support persons/friends: _____

Do you have a pet? If so, give details: _____

WEIGHT HISTORY

Please indicate your weight at the following times. Please indicate whether you consider your weight was below average, average, above average or very heavy in the relevant boxes..

	Below Average	Average Weight	Above Average	Very Heavy
Birth Weight				
Weight at starting school (5-6 years)				
Weight at beginning of high school (10-12 yrs)				
Weight at end of high school (15-18 years)				
Weight at time of commencing work (21 years)				
Weight at time of marriage (if applicable)				

WEIGHT LOSS HISTORY

PAST ATTEMPTS

Weight Watchers: _____ Duration: _____ Amount Lost: _____

Jenny Craig: _____ Duration: _____ Amount Lost: _____

Nutrisystem: _____ Duration: _____ Amount Lost: _____

Optifast: _____ Duration: _____ Amount Lost: _____

Atkins Diet: _____ Duration: _____ Amount Lost: _____

Zone Diet: _____ Duration: _____ Amount Lost: _____

LA Diet: _____ Duration: _____ Amount Lost: _____

Scarsdale Diet: _____ Duration: _____ Amount Lost: _____

Medically Supervised Diet: _____ Duration: _____ Amount Lost: _____

Nutritionist: _____ Duration: _____ Amount Lost: _____

Overeaters Anonymous: _____ Duration: _____ Amount Lost: _____

Hypnosis: _____ Duration: _____ Amount Lost: _____

Jaw Wiring: _____ Duration: _____ Amount Lost: _____

Fad diets: _____ Duration: _____ Amount Lost: _____

Self Diets: _____ Duration: _____ Amount Lost: _____

Appetite suppressants: _____ Duration: _____ Amount Lost: _____

Any other drug treatment (please specify):

Type: _____ Duration: _____ Amount Lost: _____

Type: _____ Duration: _____ Amount Lost: _____

Did you take Phen-Fen? Yes ___ No ___ If yes, did you have an echocardiogram? Yes ___ No ___

Inpatient Rehab Programs (please specify) _____

Duration:

Amount Lost:

Has a physician ever supervised your attempts to lose weight? Yes No

If yes, please list:

Doctor/Clinic: _____ City: _____ Treatment Dates: _____ Type of Treatment: _____

Details of any other weight loss measures (including surgical):

Was there any particular event that lead to significant weight gain:

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following and if so, please indicate:

	PARENT	SIBLING / CHILD	OTHER RELATIVES cousins, aunts, grandparents etc)	NO FAMILY HISTORY	DON'T KNOW
Diabetes					
Heart Disease					
Hypertension					
Gout					
Gallstones					
Obesity					
Snoring / sleep apnea					
Asthma					
Cancer					
Depression					
Dermatitis / Eczema					
High Cholesterol					
Osteoporosis					
Hip fractures					

ALLERGIES (including foods, medications, latex): Yes No

If yes, please give details: _____

ALCOHOL:

Do you drink alcohol (circle): Never · Rarely · Regularly ·

How many standard glasses do you drink per day _____

How many days do you drink per week _____

Do you drink (circle): Beer · Wine · Spirits ·

SMOKING:

Do you smoke? (circle) · Yes · No · Never If yes: how many per day? _____

Have you smoked in the past? (circle) · Yes · No If so, how many per day? _____

For how many years _____ When did you stop smoking? _____

There is increasing evidence that alcohol consumption may help some of the risk factors that lead to heart disease and stroke. Indeed it may even decrease the mortality associated with these serious conditions.

We wish to look at these risk factors in people who are obese. To assist us we would like you to answer these few simple questions about your alcohol consumption and a few questions about any folate or multivitamins you may take.

Please circle your answers where appropriate.

Part A

Do you drink any alcohol? Yes · No · (go to part B)

How often do you have a drink containing alcohol?

Every Day · Most days · Most weeks · Most months · Rarely (once or twice a year) ·

What is the main type of beverage you drink? Please circle one only.

Beer · Wine · Liquor ·

From the list below please **circle** the **main** alcoholic beverage you drink and **circle** any others you would drink at times.

Beer light beer red wine white wine sparkling wine fortified wine

spirits (specify) _____

When do you usually drink? Please circle the main one. Check off any others that are relevant.

Social occasions Parties With meals Before/after meals Weekends

If you indicated above that you drank every day, most days or most weeks, please circle how many standard drinks you would have in a **typical week**. (1 standard drink = 1 small glass of wine, 1 glass of full strength beer or a shot of liquor).

1-2

3-10

11-20

21-40

40+

Part B- for non-drinkers only.

Is there a reason you don't drink any alcohol?

Part C

1. Do you take multivitamin tablets or other dietary supplements? Yes No (go to 2)

If yes, how often do you take them? Rarely Monthly Weekly Most days Every day

Please name the multivitamin or other dietary supplements you usually take :

2. Do you take folate tablets? Yes No

If yes, how often do you take them? Rarely Monthly Weekly Most days Every day

What dose do you take? 200mg 400mg

QUESTIONS FOR THE LADIES:

Do you have a regular Menstrual Cycle? (26 - 33 days) Yes No

If not, please describe _____

Do you have problems with excessively heavy Menstrual Cycle? Yes No

If Yes, please described _____

Have you had difficulty in conceiving in the past? Yes No

Do you currently have problems with infertility? Yes No

Have you suffered from excess body hair or acne? Yes No

Have you every been told by a doctor that you have polycystic ovaries? Yes No

Have you had problems with pregnancy and/or childbirth? Yes No

If so, in what way _____

Have you had a caesarean section? Yes No

If so, why? _____

SURGICAL HISTORY

Please give details of any past operations:

PERSONAL MEDICAL HISTORY

Have you ever suffered with any of the following health problems:

Diabetes:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Diabetes while pregnant:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Asthma:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Respiratory/Breathing problems:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Arthritis or joint pain:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Back pain:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Kidney or urinary disorder:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Neurological:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Psychological/nervous disorder:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Gallstones:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Reflux or heartburn:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Gastric or duodenal ulcer:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Hepatitis or liver disease:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
High blood pressure:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Heart disease:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
High cholesterol:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Anemia or bleeding disorder	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Thrombosis or clotting disorder:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Varicose veins or leg swelling	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Eczema or skin condition	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Hayfever or Rhinitis	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____
Easy bruising	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Details: _____

Please give details of any major illnesses/problems: _____

SLEEP HISTORY

How many hours sleep do you get a night? _____

Is there any thing else that keeps you awake at night? (circle) Yes · No ·

Details: _____

Would you consider the quality of your sleep is (circle) Good · Fair · Poor ·

If your sleep is a major problem to you or your partner, Yes · No ·
would you be prepared to have a sleep study performed now and after you lose weight?

SYMPTOMS OF SLEEP APNEA

To answer each question, mark the horizontal line with a | in the position that best indicates your answer.

1. How often do you snore?
NEVER ←————→ ALWAYS
2. Do you wake during the night with a choking feeling?
NEVER ←————→ ALWAYS
3. How often would you sleep more than 8 hours in total in a 24 hour period?
NEVER ←————→ ALWAYS
4. How often do you wake up more than once during the night?
NEVER ←————→ ALWAYS
5. Do you have a headache when you wake up in the morning?
NEVER ←————→ ALWAYS
6. Have you noticed a reduction in your libido or sex drive?
NEVER ←————→ ALWAYS
7. Do you feel sleepy during the day?
NEVER ←————→ ALWAYS
8. Has anyone noticed that you momentarily stop breathing during your sleep?
NEVER ←————→ ALWAYS
9. Do you fall asleep while reading?
NEVER ←————→ ALWAYS
10. Do you wake up in the morning feeling confused?
NEVER ←————→ ALWAYS
11. How often do you have a nap during the day?
NEVER ←————→ ALWAYS
12. Do you feel sleepy in the evenings?
NEVER ←————→ ALWAYS
13. Have you or anyone else noticed a change in your personality recently?
NEVER ←————→ ALWAYS
14. How often do you doze off or fall asleep while driving?
NEVER ←————→ ALWAYS

How likely are you to **doze off or fall asleep** in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you.

Use the following table to choose the **most appropriate option** for each situation by placing a check in the boxes below:

Situation	[0] Never doze	[1] Slight chance of dozing	[2] Moderate chance of dozing	[3] High chance of dozing
Sitting and reading				
Watching TV				
Sitting, inactive in a public place (e.g. a theatre or a meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a lunch without alcohol				
In a car, while stopped for a few minutes in the traffic				

EMPLOYMENT

Current Employment:

Are you currently employed? _____

Are you full-time, part-time or volunteer? _____

If you are unemployed, what is the reason? _____

Are you actively looking for work? _____

Has your weight made it difficult to find employment? _____

If employed, please state what level of activity your job involves:

Little (sedentary job) · Moderately active · Very active (Laboring, etc.) ·

MEDICATIONS

Please indicate whether you are now or have previously taken any of the following medications (circle).

*If yes, please state the name of the medication and how long you have been or were taking it.

Medication for psychiatric disorder Yes · No · Details _____

Migraine medication Yes · No · Details _____

Medications to assist weight loss Yes · No · Details _____

Drugs for epilepsy Yes · No · Details _____

Drugs for asthma or breathing Yes · No · Details _____

Hormones, e.g. The Pill Yes · No · Details _____

Estrogen Yes · No · Details _____

Cortisone Yes · No · Details _____

Please list in detail all medications that you have used in the last 12 months. Please include any dietary supplements, cremes, eye drops, etc.

BREATHING HISTORY

Does being at work ever make your chest tight or wheezy?

Yes [2] No [1] details: _____

Have you ever had to change your job because it affected your breathing?

Yes [2] No [1] details: _____

Have you ever worked in a job, which exposed you to vapors, gas dust or fumes?

Yes [2] No [1] details: _____

ASTHMA

Have you ever had asthma? (check one) Never Current In the past Don't know

Have you ever had to spend a night in hospital because of asthma/breathing problems? Yes No

If yes was it in the last 12 months Yes No

In the last 12 months, have you visited an Emergency Room or seen a doctor urgently because you had asthma or breathing problems? Yes No Details: _____

In the last 12 months, have you taken a course or prednisone because of asthma or breathing problems? Yes No Details: _____

In the last 12 months, have you missed work or school because of asthma or breathing problems? Yes No Details: _____

COUGH AND SHORTNESS OF BREATH:

Do you usually have a cough? Yes No

Do you usually bring up phlegm from your chest when you cough? Yes No

Do you get short of breath on exertion? Yes No

Do you get short of breath walking? Yes No

Does food ever get stuck? Yes No Details: _____

Does food or fluid reflux into the mouth? Yes No Details: _____

Do you vomit with reflux? Yes No Details: _____

Do you suffer from recurrent sore throats? Yes No Details: _____

Do you suffer from a hoarse voice? Yes No Details: _____

Do you suffer from a regular cough at night? Yes No Details: _____

Please list any treatments you may use for reflux / heartburn or indigestion :
