



PeaceHealth  
Southwest Medical Center

Weight Loss Surgery Department  
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**For Office Use Only**

Received: \_\_\_\_\_  
Scheduled: \_\_\_\_\_  
MRN: \_\_\_\_\_  
BMI: \_\_\_\_\_  
Referral #: \_\_\_\_\_  
Acct. Balance: \$ \_\_\_\_\_  
How heard: \_\_\_\_\_  
 Spreadsheet

**Patient Questionnaire**

Information Session Attendance Date:

In-Person: \_\_\_\_/\_\_\_\_/\_\_\_\_

On-Line: \_\_\_\_/\_\_\_\_/\_\_\_\_

Surgery of Interest:  Gastric Bypass

Gastric Sleeve

Revision

Contact Preference:  Home phone

Cell phone

E-mail

***Please Print***

Patient Full Legal Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
City State Zip

E-mail Address: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female Race: \_\_\_\_\_

Employer: \_\_\_\_\_

Primary Care Physician (PCP): \_\_\_\_\_

Insurance Information – ***please attach a copy of your insurance card***

Name of Insurance Company: \_\_\_\_\_

Phone #: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Current Medications** – list all prescription and over the counter medications, vitamins, herbs and supplements

| Drug Name | Dosage | Frequency | # years taking |
|-----------|--------|-----------|----------------|
|           |        |           |                |
|           |        |           |                |
|           |        |           |                |
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|           |        |           |                |
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|           |        |           |                |
|           |        |           |                |

**Allergies** – list all medication allergies

| Medication | Reaction |
|------------|----------|
|            |          |
|            |          |
|            |          |
|            |          |

| Medication | Reaction |
|------------|----------|
|            |          |
|            |          |
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|            |          |

**Operations** – list all past surgeries

| Surgery | Year |
|---------|------|
|         |      |
|         |      |
|         |      |
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|         |      |
|         |      |
|         |      |

Did you experience any problems with anesthesia?  Yes  No

If yes, please describe:

\_\_\_\_\_

Most recent mammogram: \_\_\_\_\_

Contraceptive method: \_\_\_\_\_

Most recent tetanus vaccination: \_\_\_\_\_

Most recent colonoscopy: \_\_\_\_\_

**Medical History** – If yes to any medical conditions, please explain as needed

| Medical Condition   | Mark Yes or No   | Please explain as needed                              |
|---|--|---|
| <b>Cardiac:</b><br>a. Angina or chest pain<br>b. Bleeding problems<br>c. Congestive Heart Failure (CHF)<br>d. Deep Venous Thrombosis (DVT-clot in leg)<br>e. Edema or water retention<br>f. Heart attack<br>g. High Blood Pressure<br>h. High Cholesterol<br>i. Irregular heartbeat<br>j. Pacemaker<br>k. Peripheral Vascular disease<br>l. Pulmonary Embolism (PE-clot in lung)<br>m. Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |
| <b>Endocrine:</b><br>a. Diabetes - Type 1<br>b. Diabetes - Type 2<br>c. Thyroid problems<br>d. Polycystic Ovarian Syndrome (PCOS)   | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | If yes for Diabetes, please write year of onset below |
| <b>Pulmonary:</b><br>a. Asthma<br>b. COPD or Emphysema<br>c. Sleep Apnea<br>If yes, do you use a CPAP/BiPAP machine   | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |
| <b>GI:</b><br>a. Colon or intestinal problems<br>b. Gallbladder problems<br>c. GERD/ reflux<br>d. Hernia (if yes, what type?)<br>e. Stomach ulcers<br>f. Swallowing problems  | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |
| <b>Musculoskeletal:</b><br>a. Arthritis<br>b. Back pain<br>c. Degenerative Joint Disease<br>d. Fibromyalgia<br>e. Gout<br>f. Joint replacement  | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |
| <b>Mental Health:</b><br>a. Depression<br>b. Psychiatric condition (bipolar disorder, etc.)<br>c. Eating disorder   | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |
| <b>Cancer (If yes, what type?)</b>  | <input type="checkbox"/> Yes <input type="checkbox"/> No   |   |
| <b>Kidney problems</b>  | <input type="checkbox"/> Yes <input type="checkbox"/> No   |   |
| <b>Liver problems</b>   | <input type="checkbox"/> Yes <input type="checkbox"/> No   |   |

## Family History

| Relationship    | Mother | Father | Sister | Brother | Daughter | Son | Grandmother, maternal | Grandfather, maternal | Grandmother, paternal | Grandfather, paternal | Auth, maternal | Uncle, maternal | Aunt, paternal | Uncle, paternal |
|-----------------|--------|--------|--------|---------|----------|-----|-----------------------|-----------------------|-----------------------|-----------------------|----------------|-----------------|----------------|-----------------|
| Diabetes        |        |        |        |         |          |     |                       |                       |                       |                       |                |                 |                |                 |
| Heart Disease   |        |        |        |         |          |     |                       |                       |                       |                       |                |                 |                |                 |
| Hyperlipidemia  |        |        |        |         |          |     |                       |                       |                       |                       |                |                 |                |                 |
| Hypertension    |        |        |        |         |          |     |                       |                       |                       |                       |                |                 |                |                 |
| Osteoporosis    |        |        |        |         |          |     |                       |                       |                       |                       |                |                 |                |                 |
| Thyroid Cancer  |        |        |        |         |          |     |                       |                       |                       |                       |                |                 |                |                 |
| Thyroid Disease |        |        |        |         |          |     |                       |                       |                       |                       |                |                 |                |                 |

## Social History

Work information:     Full Time     Part Time     Self-Employed     Homemaker  
 Student     Retired     Disabled     Unemployed

Occupation: \_\_\_\_\_

Marital Status:     Single     Married     Partnered     Divorced     Widowed

Number of children: \_\_\_\_\_    Ages of children: \_\_\_\_\_

## Social Habits

Do you drink alcohol?     Yes     No    If yes, how often? \_\_\_\_\_

Do you currently smoke or chew tobacco?     Yes     No

If yes, what type?     Cigarettes     Pipe     Cigars     Chew

Have you ever smoked or chewed tobacco?     Yes     No    If yes, when did you quit? \_\_\_\_\_

Do you use recreational drugs?     Yes     No

If yes, what type?     Cocaine     Opioids     PCP     Marijuana

**Review of Symptoms:** Check yes if you experience any of the following symptoms:

Please check any symptoms you currently have. If you don't have any of these symptoms check here

**General:**

- Chills
- Fatigue
- Fever
- Night sweats
- Sleep disturbance
- Weight gain
- Weight loss

**Psychological:**

- Anxiety
- Concentration difficulties
- Depression
- Memory difficulties

**Ophthalmic:**

- Blurry vision
- Decreased vision
- Double vision
- Eye pain

**Ear, Nose & Throat:**

- Nose bleeds
- Hearing change
- Runny nose
- Sore throat

**Allergy & Immunology:**

- Hives
- Seasonal allergies
- Sinus problems
- Stuffy nose

**Hematological & Lymphatic:**

- Bleeding problems
- Blood clots
- Bruising

**Endocrine:**

- Hair pattern changes
- Hot flashes
- Stretchmarks
- Temperature intolerance
- Increased urination

**Breast:**

- New or changing breast lumps
- Nipple discharge

**Respiratory:**

- Cough
- Shortness of breath
- Wheezing

**Cardiovascular:**

- Chest pain
- Swelling of hands, feet, legs
- Irregular heartbeat
- Loss of consciousness

**Gastrointestinal:**

- Abdominal pain
- Blood in stools
- Constipation
- Diarrhea
- Heartburn
- Nausea/vomiting
- Difficulty swallowing

**Genito-Urinary:**

- Irregular/heavy menstrual cycle
- Erectile dysfunction
- Genital discharge
- Loss of bladder control
- Urinary urgency
- Urinary frequency
- Change in urinary stream

**Musculoskeletal:**

- Joint pain
- Joint stiffness
- Joint swelling
- Muscle pain
- Muscular weakness

**Neurological:**

- Dizziness
- Headaches
- Impaired balance
- Numbness/tingling
- Seizures
- Speech problems
- Shakiness

**Dermatological:**

- Acne
- Dry skin
- Eczema
- Nail changes
- Rash

## Weight History

Height: \_\_\_\_\_ ft \_\_\_\_\_ inches

Current Weight: \_\_\_\_\_ lbs

Since age 18:

The **least** you have weighed: \_\_\_\_\_ lbs.

The **most** you have weighed: \_\_\_\_\_ lbs.

Have you ever had any of the following surgical procedures for weight loss?

| Surgery              |  | Year |
|----------------------|--|------|
| Gastric Stapling     | <input type="checkbox"/> Yes <input type="checkbox"/> No |      |
| Gastric Bypass       | <input type="checkbox"/> Yes <input type="checkbox"/> No |      |
| Gastric Band         | <input type="checkbox"/> Yes <input type="checkbox"/> No |      |
| Intragastric balloon | <input type="checkbox"/> Yes <input type="checkbox"/> No |      |
| Jaw wiring           | <input type="checkbox"/> Yes <input type="checkbox"/> No |      |

If you have had weight loss surgery, was it later reversed?  Yes  No Date: \_\_\_/\_\_\_/\_\_\_\_\_

**Diet History** – list all diets and/or medications you have tried

| Diet Program | Start Date | End Date | Duration | Start Weight | End Weight | Weight Change |
|--------------|------------|----------|----------|--------------|------------|---------------|
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### Examples:

**Diet:** American Heart Association, Atkins, Blood Type, Cabbage Soup, Calorie counting, Cambridge, DASH, Dean Ornish, Diabetic Diet, Grapefruit, HMR, Increased exercise, Jenny Craig, LA Weight Loss, Mayo Clinic, MD Supervised, Metabolife, Nutrisystems, Optifast/Medifast, Overeaters Anonymous, Portion control, Prism, Pritikin, Slimfast, South Beach, Sugar Busters, Suzanne Sommers, TOPS, Weight Watchers, Zone

**Diet Pills/Medications:** Alli, Dexatrim, Meridia, Metabolife, Phen/Fen, Phentermine, Trimspa, Xenical

## Physical Activity

Are you able to exercise?  Yes  No

If yes, how often? \_\_\_\_\_

What type of exercise do you do? \_\_\_\_\_

If no, please describe the reason(s) why not: \_\_\_\_\_

## STOP-BANG (Sleep Apnea) Screening Quiz

Do you have symptoms of sleep apnea? Take the STOP-BANG screening quiz and speak to your provider about your score!

Scoring of at least three points is associated with a higher risk of Obstructive Sleep Apnea in the moderate range of severity, or worse. Please count one point for each applicable risk factor and total, the total is the STOP-BANG score.

| <b>Risk Factor</b>   | <b>Score/Points</b>        |                            |
|--|----------------------------|----------------------------|
| <b>Snoring</b>   | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 |
| <b>Tiredness during the day</b>                                    | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 |
| <b>Observed apneas</b>   | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 |
| <b>High blood pressure</b>   | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 |
| <b>BMI <math>\geq</math> 30</b>                                    | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 |
| <b>Age <math>\geq</math> 50</b>                                    | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 |
| <b>Neck circumference:</b><br>Men > 17 inches<br>Women > 16 inches | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 |
| <b>Gender (male)</b>   | <input type="checkbox"/> 0 | <input type="checkbox"/> 1 |
| <b>TOTAL</b>   |                            |                            |

## Epworth Sleepiness Scale

How likely are you to nod off or fall asleep in the following situations, in contrast to feeling just tired? This refers to our usual way of life in recent times.

Even if you have not done some of these things recently, try to work out how they would have affected you. It is important that you answer each question as best you can.

Use the following scale to choose the most appropriate number for each situation.

Add up your points to get your total score. A score of 10 or greater raises concern: you may need to get more sleep, improve your sleep practices or seek medical attention to determine why you are sleepy.

|   | <b>Would<br/>never nod<br/>off<br/>0</b> | <b>Slight<br/>chance of<br/>nodding off<br/>1</b> | <b>Moderate<br/>chance of<br/>nodding off<br/>2</b> | <b>High<br/>chance of<br/>nodding off<br/>3</b> |
|---|--|---|---|---|
| <b>Sitting and reading</b>  |  |   |   |   |
| <b>Watching TV</b>  |  |   |   |   |
| <b>Sitting, inactive</b> , in a public place (e.g. in a meeting, theater or dinner event) |  |   |   |   |
| <b>As a passenger in a car</b> for an hour or more without stopping for a break           |  |   |   |   |
| <b>Lying down to rest</b> when circumstances permit                                       |  |   |   |   |
| <b>Sitting and talking</b> to someone   |  |   |   |   |
| <b>Sitting quietly</b> after a meal without alcohol                                       |  |   |   |   |
| <b>In a car, while stopped</b> for a few minutes in traffic or at a light                 |  |   |   |   |