

Welcome to our Weight Loss Surgery Program

Please complete all pages of this form prior to your first visit with a surgeon. Bring this to your consult visit and hand to the surgeon.

Section 1. Personal Contact Information

NAME _____
Title First MI Last Suffix (Jr, Sr, etc.) (nickname)

Ethnicity African-American Caucasian Asian Hispanic Native American / Alaska Native
 Native Hawaiian/Pacific Islander Other Choose Not to Specify

Gender Female Male **Date of Birth** ____/____/____ **Age** _____

Marital Status Single Married Separated Divorced Widowed

(____) _____ - _____ (____) _____ - _____ (____) _____ - _____
Home phone number Work phone number Cell phone number

E-mail address _____ May we e-mail you? Yes No

Section 2. Primary Care Doctor Information

PRIMARY CARE PROVIDER _____
First Last Degree (MD, DO, NP, PA)

NAME OF CLINIC _____

CLINIC LOCATION _____
Street address City State Zip Code

Section 3. Employer and Insurance Information

Employment Status Full time Part time Self employed Homemaker Student
 Retired Disabled Unemployed Not specified

Occupation _____

Employer _____

Are you planning to pay for surgery yourself (no insurance)? YES NO

Do you have insurance? YES NO

Does your health insurance plan cover weight loss surgery? YES NO

NAME OF PRIMARY INSURANCE _____

NAME OF THE INSURED _____ **RELATIONSHIP TO INSURED** _____
self / spouse / child / other

NAME OF SECONDARY INSURANCE _____

Please continue on the next page ↗

Section 4. History of Weight Gain

Location of weight gain Where have you gained your weight?
 legs/thighs hips/buttocks abdomen chest neck

Duration of overweight and obesity
 How long have you been overweight? _____ years

Timing of obesity
 How much did you weigh at each of the following ages:
 13: _____ lbs 18: _____ lbs 25: _____ lbs
 30: _____ lbs 35: _____ lbs 40: _____ lbs
 45: _____ lbs 50: _____ lbs 60+: _____ lbs

Severity of weight gain
 What is your current height? Feet: _____ Inches: _____

Indicate one (1): This answer is an estimate actual

What is your current weight? Pounds: _____

Indicate one (1): This answer is based on:
 estimate home scale doctor's office scale

Section 5. Weight Loss Medications

<i>Please indicate which medications you have used to lose weight</i>	Dates (months)	pounds lost (estimate)
<input type="checkbox"/> Meridia (sibutramine)	_____	_____
<input type="checkbox"/> Alli or Xenical (orlistat)	_____	_____
<input type="checkbox"/> Adipex (phentermine)	_____	_____
<input type="checkbox"/> Redux (dexfenfluramine)	_____	_____
<input type="checkbox"/> Fen-phen	_____	_____
Did you take Fen-phen for longer than 3 months?		
<input type="checkbox"/> YES <input type="checkbox"/> NO		
<input type="checkbox"/> Other _____	_____	_____

Section 6. Weight Loss Attempt History

<i>Please indicate which diets you have tried in the past:</i>	Dates	Pounds lost
<input type="checkbox"/> Calorie counting (on my own)	_____	_____
<input type="checkbox"/> Atkins diet (or other low-carb diet)	_____	_____
<input type="checkbox"/> Weight Watchers or <input type="checkbox"/> Jenny Craig	_____	_____
<input type="checkbox"/> Optifast/Slimfast	_____	_____
<input type="checkbox"/> Cabbage Soup or <input type="checkbox"/> Grapefruit or <input type="checkbox"/> South Beach Diet	_____	_____
<input type="checkbox"/> Other _____	_____	_____
<input type="checkbox"/> Other _____	_____	_____
Context		
In pounds, what is the most weight you have lost in one attempt?		
<input type="checkbox"/> 5 <input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30 <input type="checkbox"/> 50 <input type="checkbox"/> Other _____		

Section 7. Weight Loss Surgery History (fill this out ONLY if you had weight loss surgery before)

<p><i>Have you previously had weight loss surgery?</i> <input type="checkbox"/> YES <input type="checkbox"/> NO (skip to section 8)</p> <p>What year? _____</p> <p>Which operation?</p> <input type="checkbox"/> Gastric Bypass (Roux-en-Y surgery) <input type="checkbox"/> Duodenal Switch <input type="checkbox"/> Lap Band or RealizeBand (adjustable band) <input type="checkbox"/> Vertical Banded Gastroplasty (VBG) <input type="checkbox"/> Horizontal Gastroplasty <input type="checkbox"/> Other _____ <p>Name of Surgeon: _____</p>	<p>Weight before bariatric surgery? _____ lbs This weight is <input type="checkbox"/> ESTIMATED <input type="checkbox"/> ACTUAL</p>
	<p>Lowest weight achieved after bariatric surgery? _____ lbs This weight is <input type="checkbox"/> ESTIMATED <input type="checkbox"/> ACTUAL</p>
	<p>Did you have any adverse events occur after previous bariatric surgery? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
	<p>If "yes", what happened in your words? _____</p>
	<p>_____</p>

Please continue on the next page ↗

Section 8. Dietary and Physical Activity Assessment

<p>Why are you interested in weight loss surgery? <input type="checkbox"/> Lose weight <input type="checkbox"/> Treat medical problems <input type="checkbox"/> Other _____</p> <p>Dietary Recall How many meals do you eat each day? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 or more How many times do you snack each day? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 or more</p> <p>Describe what you typically consume for each of the following (typical or most recent):</p> <p>Breakfast: _____</p> <p>Lunch: _____</p> <p>Supper: _____</p> <p>Snacks: _____</p> <p>Drinks during the day: _____</p>	<p>Dining Out History How many times do you eat out each week? <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-6 <input type="checkbox"/> 7-8 <input type="checkbox"/> 9 or more</p> <p>Where do you dine out? <input type="checkbox"/> sit-down restaurants <input type="checkbox"/> fast food</p> <p>What types of food do you order when you dine out? _____</p> <p>_____</p> <p>Physical Activity Do you exercise? <input type="checkbox"/> yes <input type="checkbox"/> no How many times do you exercise each week? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 or more</p> <p>What types of exercise do you do? <input type="checkbox"/> Climbing stairs at work <input type="checkbox"/> Swimming <input type="checkbox"/> Walking <input type="checkbox"/> Running <input type="checkbox"/> Gym membership <input type="checkbox"/> Home gym</p> <p><input type="checkbox"/> Other _____</p>
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Section 9. Psychosocial History

<p>Alcohol Use <input type="checkbox"/> yes <input type="checkbox"/> no If yes, answer one of the following: <input type="checkbox"/> Rare <input type="checkbox"/> Occasional <input type="checkbox"/> Frequent</p> <p>Prescription / Illegal Drug Abuse <input type="checkbox"/> yes <input type="checkbox"/> no If yes, answer one of the following: <input type="checkbox"/> Rare <input type="checkbox"/> Occasional <input type="checkbox"/> Frequent</p> <p>Tobacco Use <input type="checkbox"/> yes <input type="checkbox"/> no If yes, answer one of the following: <input type="checkbox"/> Rare <input type="checkbox"/> Occasional <input type="checkbox"/> Frequent</p> <p>How much do you smoke? <input type="checkbox"/> >2 packs per day <input type="checkbox"/> 1-2 packs per day <input type="checkbox"/> <1 pack per day</p> <p>Did you smoke (if you don't smoke anymore)? <input type="checkbox"/> yes <input type="checkbox"/> no Starting age? _____ What year to you quit? _____</p>	<p>Psychosocial Impairment <input type="checkbox"/> yes <input type="checkbox"/> no If yes, answer one of the following: <input type="checkbox"/> Mild impairment; able to do all tasks <input type="checkbox"/> Moderate impairment; able to do most tasks <input type="checkbox"/> Moderate impairment; unable to do some primary tasks <input type="checkbox"/> Severe impairment; unable to do most primary tasks <input type="checkbox"/> Severe impairment; unable to function</p> <p>Depression <input type="checkbox"/> yes <input type="checkbox"/> no If yes, answer one of the following: <input type="checkbox"/> Mild and episodic not requiring treatment <input type="checkbox"/> Moderate; some impairment; may require treatment <input type="checkbox"/> Moderate; significant impairment; treatment indicated <input type="checkbox"/> Severe, definitively requiring intensive treatment <input type="checkbox"/> Severe requiring hospitalization</p> <p>Mental Health Diagnosis <input type="checkbox"/> yes <input type="checkbox"/> no If yes, answer one of the following: <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Anxiety/panic disorder <input type="checkbox"/> Personality disorder <input type="checkbox"/> Psychosis</p>
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Section 10. Family History

<p><input type="checkbox"/> Obesity <input type="checkbox"/> Bleeding problems <input type="checkbox"/> Heart disease <input type="checkbox"/> Cancer (location: _____) <input type="checkbox"/> Diabetes <input type="checkbox"/> High blood pressure <input type="checkbox"/> Blood clots (in the legs or to the lungs) <input type="checkbox"/> Other: _____</p> <p>Mother is <input type="checkbox"/> Alive <input type="checkbox"/> Deceased Medical Problems? _____</p> <p>Father is <input type="checkbox"/> Alive <input type="checkbox"/> Deceased Medical Problems? _____</p> <p>Sister(s) is/are <input type="checkbox"/> Alive <input type="checkbox"/> Deceased Medical Problems? _____</p> <p>Brother(s) is/are <input type="checkbox"/> Alive <input type="checkbox"/> Deceased Medical Problems? _____</p>

Please continue on the next page ➔

Section 11. Past Medical History (please check off any medical problems you have or answer "none of the above" for each group)

<p>Blood Vessels & Heart</p> <input type="checkbox"/> Anemia <input type="checkbox"/> Irregular heart beat (afib or WPW)* <input type="checkbox"/> Bleeding problem <input type="checkbox"/> Blood clots or DVT* <input type="checkbox"/> Chest pain (angina)* <input type="checkbox"/> Heart disease* <input type="checkbox"/> Cardiomyopathy* <input type="checkbox"/> Congestive heart failure* <input type="checkbox"/> Heart attack (MI)* <input type="checkbox"/> High blood pressure* <input type="checkbox"/> High cholesterol* <input type="checkbox"/> High triglycerides* <input type="checkbox"/> Diseased leg arteries (PVD)* <input type="checkbox"/> Diseased neck arteries (carotids)* <input type="checkbox"/> No heart or blood vessel problems <p>Prior Heart Procedures</p> <input type="checkbox"/> Cardiac catheterization (angioplasty)* <input type="checkbox"/> Heart bypass* <input type="checkbox"/> No heart procedures <p>Liver, Stomach, and Intestine</p> <input type="checkbox"/> Gallstones* <input type="checkbox"/> Inflamed or diseased gallbladder* <input type="checkbox"/> Gallstone caused pancreatitis or blocked duct* <input type="checkbox"/> Fatty liver (NASH)* <input type="checkbox"/> Hepatitis (type:) <input type="checkbox"/> Reflux or heartburn (GERD)* <input type="checkbox"/> Bile reflux* <input type="checkbox"/> Hiatal hernia* <input type="checkbox"/> Barrett's esophagus* <input type="checkbox"/> Schatzki's ring* <input type="checkbox"/> Stomach or intestinal ulcer <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Ulcerative colitis <input type="checkbox"/> Colon cancer* <input type="checkbox"/> Fecal incontinence* <input type="checkbox"/> Irritable bowel disorder <input type="checkbox"/> Hernia* Incisional (ventral)*: <input type="checkbox"/> yes <input type="checkbox"/> no Umbilical*: <input type="checkbox"/> yes <input type="checkbox"/> no Non-reducible*: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> No stomach or intestinal disorders	<p>Lungs & Breathing</p> <input type="checkbox"/> Asthma?* Age of onset: _____ years old Hospitalized: <input type="checkbox"/> yes <input type="checkbox"/> no Date of last episode: _____ <input type="checkbox"/> Home oxygen use? <input type="checkbox"/> Obstructive sleep apnea* Do you use CPAP? <input type="checkbox"/> yes <input type="checkbox"/> no CPAP setting? _____ Last episode: _____ <input type="checkbox"/> Pulmonary embolus (blood clot in lung)* <input type="checkbox"/> Pulmonary hypertension* <input type="checkbox"/> COPD (emphysema or chronic bronchitis) <input type="checkbox"/> No lung or breathing problems <p>Joints</p> <input type="checkbox"/> Low back pain* <input type="checkbox"/> Neck pain* <input type="checkbox"/> Osteoarthritis* <input type="checkbox"/> Degenerative joint disease (DJD)* <input type="checkbox"/> Degenerative disk disease (DDD)* <input type="checkbox"/> Herniated disk* <input type="checkbox"/> Gout* <input type="checkbox"/> Carpal tunnel syndrome <input type="checkbox"/> Sciatica* <input type="checkbox"/> Plantar fasciitis* <input type="checkbox"/> No joint problems <p>Neurological</p> <input type="checkbox"/> stroke / CVA* <input type="checkbox"/> Pseudotumor cerebri* <input type="checkbox"/> Narcolepsy* <input type="checkbox"/> Nerve problems* <input type="checkbox"/> Migraine headaches <input type="checkbox"/> No neurological problems <p>Psychological</p> <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Anxiety <input type="checkbox"/> Prior psychiatric hospitalization <input type="checkbox"/> No psychological problems	<p>Endocrine (hormone)</p> <input type="checkbox"/> Glucose intolerance / pre-diabetes* <input type="checkbox"/> Diabetes type II* Duration: _____ years <input type="checkbox"/> Diabetes nerve problems* <input type="checkbox"/> Diabetes eye problems* <input type="checkbox"/> Diabetes ulcers* <input type="checkbox"/> Diabetes type I (juvenile onset)* <input type="checkbox"/> Infertility <input type="checkbox"/> Polycystic Ovary Syndrome (PCOS)* <input type="checkbox"/> Low thyroid level (hypothyroid) <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Metabolic syndrome* <input type="checkbox"/> Morbid obesity* <input type="checkbox"/> No hormone problems <p>Kidneys & Genito-Urinary</p> <input type="checkbox"/> Kidney infection <input type="checkbox"/> Kidney stone(s) <input type="checkbox"/> Kidney failure <input type="checkbox"/> diabetic or <input type="checkbox"/> other <input type="checkbox"/> Frequent bladder infections (UTI's) <input type="checkbox"/> Enlarged prostate <input type="checkbox"/> Prostate cancer <input type="checkbox"/> Impotence* <input type="checkbox"/> Urinary stress incontinence* <input type="checkbox"/> Prolapsed bladder* <input type="checkbox"/> None of the above <p>Skin</p> <input type="checkbox"/> Skin fold rashes* <input type="checkbox"/> Skin infection (cellulitis) <input type="checkbox"/> Lymphedema (leg swelling) <input type="checkbox"/> Hirsutism (excess hair growth) <input type="checkbox"/> None of the above <p>Other</p> <input type="checkbox"/> Please see detail below for other conditions <p>* = medical problems associated with obesity</p>
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Please provide detail of medical history marked positive above or describe any unlisted conditions:

Please continue on the next page ↗

Section 12. Review of Systems (please check off any symptoms you have or answer “none of the above” for each group)

<p>General</p> <p><input type="checkbox"/> Weakness</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Night sweats</p> <p><input type="checkbox"/> Recent weight change</p> <p><input type="checkbox"/> None of the above</p> <p>Skin</p> <p><input type="checkbox"/> Skin cancer</p> <p><input type="checkbox"/> Skin fold rashes (groin or other folds)*</p> <p><input type="checkbox"/> Excess or abnormal hair growth*</p> <p><input type="checkbox"/> Jaundice (yellow skin)</p> <p><input type="checkbox"/> Varicose veins</p> <p><input type="checkbox"/> Leg ulcer(s)</p> <p><input type="checkbox"/> None of the above</p> <p>HEENT</p> <p><input type="checkbox"/> Vision changes</p> <p><input type="checkbox"/> Hearing changes</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Lightheadness</p> <p><input type="checkbox"/> None of the above</p> <p>Neck</p> <p><input type="checkbox"/> Pain</p> <p><input type="checkbox"/> Mass (es)</p> <p><input type="checkbox"/> None of the above</p> <p>Musculoskeletal</p> <p><input type="checkbox"/> Hip pain*</p> <p><input type="checkbox"/> Knee pain*</p> <p><input type="checkbox"/> Ankle or foot pain*</p> <p><input type="checkbox"/> Back pain*</p> <p><input type="checkbox"/> Wrist pain*</p> <p><input type="checkbox"/> Shoulder pain*</p> <p><input type="checkbox"/> Muscle weakness</p> <p><input type="checkbox"/> Arthritis*</p> <p><input type="checkbox"/> Swelling of legs*</p> <p><input type="checkbox"/> None of the above</p> <p>Cardiovascular</p> <p><input type="checkbox"/> Chest pain*</p> <p><input type="checkbox"/> Palpitations*</p> <p><input type="checkbox"/> Shortness of breath*</p> <p><input type="checkbox"/> None of the above</p>	<p>Pulmonary</p> <p><input type="checkbox"/> Productive cough</p> <p><input type="checkbox"/> Coughing up blood</p> <p><input type="checkbox"/> Nighttime snoring*</p> <p><input type="checkbox"/> Loud snoring*</p> <p><input type="checkbox"/> None of the above</p> <p>Gastrointestinal</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> Difficulty swallowing (food gets stuck)</p> <p><input type="checkbox"/> Rectal bleeding</p> <p><input type="checkbox"/> Reflux / heartburn*</p> <p><input type="checkbox"/> Vomiting blood</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> None of the above</p> <p>Genitourinary</p> <p><input type="checkbox"/> Pain/burning with urination</p> <p><input type="checkbox"/> Urinary frequency</p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Urinary incontinence*</p> <p><input type="checkbox"/> Kidney stones*</p> <p><input type="checkbox"/> Urinary tract infection</p> <p><input type="checkbox"/> None of the above</p> <p>Hematological</p> <p><input type="checkbox"/> History of blood transfusions</p> <p><input type="checkbox"/> Bleeding problems</p> <p><input type="checkbox"/> Clotting problems*</p> <p><input type="checkbox"/> Superficial blood clots*</p> <p><input type="checkbox"/> None of the above</p> <p>Endocrine</p> <p><input type="checkbox"/> Intolerance to hot or cold</p> <p><input type="checkbox"/> Thyroid problems</p> <p><input type="checkbox"/> None of the above</p>	<p>Neurological</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Migraine headaches</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Loss of balance</p> <p><input type="checkbox"/> Numbness/tingling</p> <p><input type="checkbox"/> None of the above</p> <p>Psychological</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Hallucinations</p> <p><input type="checkbox"/> None of the above</p> <p>Female <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Loss of menstrual cycles*</p> <p><input type="checkbox"/> Excessive menstrual bleeding</p> <p><input type="checkbox"/> Irregular menstrual cycles</p> <p><input type="checkbox"/> Postmenopausal bleeding</p> <p><input type="checkbox"/> Vaginal discharge or itching</p> <p><input type="checkbox"/> Genital Sores/Lesions</p> <p><input type="checkbox"/> Sexually Transmitted Diseases (STDs)</p> <p><input type="checkbox"/> PID (Pelvic Inflammatory Disease)</p> <p><input type="checkbox"/> None of the above</p> <p>Male <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Penile discharge</p> <p><input type="checkbox"/> Genital sores/lesions</p> <p><input type="checkbox"/> Testicular pain or lumps</p> <p><input type="checkbox"/> Sexually Transmitted Diseases (STDs)</p> <p><input type="checkbox"/> Impotence</p> <p><input type="checkbox"/> Hernias</p> <p><input type="checkbox"/> None of the above</p> <p>* = symptom of comorbidity of morbid obesity</p>
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Please provide detail of symptoms marked positive above:

Please continue on the next page ↗

Section 13. Surgical History (please check boxes and provide year)

<input type="checkbox"/> I have never had any surgery	Details	Year
Abdominal Operations		
<input type="checkbox"/> Gallbladder removal	<input type="checkbox"/> lap <input type="checkbox"/> open	_____
<input type="checkbox"/> C-Section		_____
<input type="checkbox"/> Appendix removal	<input type="checkbox"/> lap <input type="checkbox"/> open	_____
<input type="checkbox"/> Hysterectomy (Uterus removal)		_____
<input type="checkbox"/> Transvaginal or <input type="checkbox"/> Abdominal		
Which ovary was removed	<input type="checkbox"/> Both <input type="checkbox"/> Left <input type="checkbox"/> Right	
<input type="checkbox"/> Tubal ligation ("tubes tied")	<input type="checkbox"/> lap <input type="checkbox"/> open	_____
<input type="checkbox"/> Hernia repair		_____
Was mesh placed?	<input type="checkbox"/> yes <input type="checkbox"/> no	
<input type="checkbox"/> Bowel resection surgery (colon or small intestine)	<input type="checkbox"/> lap <input type="checkbox"/> open	_____
<input type="checkbox"/> Anti-reflux procedure		_____
<input type="checkbox"/> Nissen fundoplication		_____
<input type="checkbox"/> Vagotomy		_____
<input type="checkbox"/> Plastic surgery (abdominal)		_____
Non-Abdominal Operations		
<input type="checkbox"/> Mastectomy, breast cancer		_____
<input type="checkbox"/> Irradiation for breast cancer		_____
<input type="checkbox"/> Breast biopsy or lumpectomy for breast cancer		_____
<input type="checkbox"/> Peripheral vascular procedure		_____
<input type="checkbox"/> Knee replacement		_____
<input type="checkbox"/> Hip replacement		_____
<input type="checkbox"/> Laminectomy (back surgery)		_____
<input type="checkbox"/> Vasectomy		_____
Surgical or anesthesia problems		
<input type="checkbox"/> Nausea and/or vomiting		
<input type="checkbox"/> Malignant hyperthermia		
<input type="checkbox"/> Bleeding tendency		
<input type="checkbox"/> Difficult intubation		
<input type="checkbox"/> Complications after surgery		
Please describe additional surgery:		

Section 14. OB/GYN History (women only)

Polycystic Ovary Syndrome (PCOS)
 yes no

If yes, answer one of the following:
 Diagnosis of PCOS; no treatment
 Diagnosis of PCOS; treatment with oral contraceptive pills or anti-androgens
 Diagnosis of PCOS; treatment with metformin or TZD's (Actos or Avandia)
 Diagnosis of PCOS and treatment with at least two (2) medications
 Infertility related to PCOS

Menstrual Irregularities
 yes no

If yes, answer one of the following:
 Irregular periods
 Excessive bleeding with periods
 Absent periods
 Prior total hysterectomy

Menstrual history
 At what age did menstruation start? _____
 Have you stopped menstruating? Yes No
 Hot flashes or night sweats? Yes No
 Last menstrual period normal? Yes No

Obstetric history
 Is it possible you are pregnant now? Yes No
 Do you plan more pregnancies? Yes No
 How many children do you have? _____
 How old are they? _____
 How many pregnancies? _____
 What do you use for birth control? _____

Gynecologic history
 When was your last PAP/pelvic exam? _____
 Abnormal PAPs? Yes No
 STD's? Yes No
 Cancer of ovary or uterus? Yes No

Breast history
 Have you had a mammogram? Yes No
 Have you had breast cancer? Yes No

Please continue on the next page ↗

Section 18. Medical Problems of Obesity (on the next 3 pages, answer 'yes' or 'no'; if 'yes', pick one option that best describes your diagnosis and treatment of each problem)

Heart and Blood Vessel Disease

High Blood Pressure

yes no

If yes, answer one of the following:

- borderline, no medication
- high blood pressure diagnosis, but no medication needed
- treated with single medication
- treated with more than one medication
- poorly controlled; organ damage or dysfunction

Congestive Heart Failure

yes no

If yes, answer one of the following:

- 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

yes no

If yes, answer one of the following:

- Abnormal EKG, no active ischemia
- History of heart attack or anti-ischemic medication
- Coronary ballooning or stents; heart bypass (CAB)
- Active, unresolved heart disease

Angina

yes no

If yes, answer one of the following:

- Chest pain with extreme exertion (running)
- Chest pain with moderate exertion
- Chest pain with mild exertion (walking)
- Unstable chest pain
- Previous heart attack by history or by current workup (wall motion abnormality on stress test)

Peripheral Vascular Disease

yes no

If yes, answer one of the following:

- Asymptomatic with bruit
- Claudication, anti-ischemic medication
- Transient ischemic attack (mini-stroke), rest pain
- Procedure for peripheral vascular disease
- Stroke or loss of tissue (toe/foot/leg) from poor blood flow

Leg Swelling

yes no

If yes, answer one of the following:

- Intermittent leg swelling, not requiring treatment
- Symptoms requiring treatment, diuretics (water pills), leg elevation, or hose
- Stasis ulcers
- Disability, decreased function, hospitalization

Leg or Lung Blood Clots

yes no

If yes, answer one of the following:

- History of leg blood clots with blood thinner medication at one time
- Recurrent leg blood clots with long-term blood thinner medication (warfarin or Coumadin)
- Previous lung blood clots
- Recurrent lung blood clots, decreased function, hospitalization
- Vena caval filter

Metabolic Disease

Glucose Metabolism (diabetes)

yes no

If yes, answer one of the following:

- Elevated fasting glucose (>99 mg/dl)
- Diabetes, controlled with oral medication
- Diabetes, controlled with insulin
- Diabetes, controlled with both oral medication and insulin
- Diabetes with severe complications (retinopathy, neuropathy, renal failure, blindness)

Cholesterol (Lipid) abnormality

yes no

If yes, answer one of the following:

- present, no treatment required
- Controlled with lifestyle change, step 1 or 2 diet
- Single medication control
- Multiple medication control
- Uncontrolled

Gout

yes no

If yes, answer one of the following:

- High uric acid, no symptoms
- High uric acid, treated with medications
- Joint pain caused by gout
- Destructive joints
- Disability, unable to walk

Please continue on the next page ➤

Lung Disease

Obstructive Sleep Apnea

yes no

If yes, answer one of the following:

- Symptoms but negative sleep study or not done
- Sleep apnea diagnosed but no oral appliance
- Sleep apnea requiring oral appliance (CPAP)
- Sleep apnea with hypoxia or oxygen dependent
- Sleep apnea with complications (ie pulmonary hypertension)

Obesity Hypoventilation

yes no

If yes, answer one of the following:

- Hypoxemia and/or hypercarbia on room air (PaO₂ < 60 mm Hg; PaCO₂ > 45 mm Hg)
- Severe hypoxemia and/or hypercarbia (PaO₂ < 50 mm Hg; PaCO₂ > 55 mm Hg)
- Pulmonary hypertension
- Right heart failure
- Right heart failure – left ventricular dysfunction

Pulmonary Hypertension (PH)

yes no

If yes, answer one of the following:

- Symptoms such as tiredness, shortness of breath, dizziness, fainting
- Confirmed PH diagnosis
- Well controlled on anticoagulants and/or calcium channel blockers
- Stronger medications and/or oxygen
- Patients needs or had lung transplant

Asthma

yes no

If yes, answer one of the following:

- Intermittent mild symptoms, no medication
- Symptoms controlled with oral inhaler (ie albuterol)
- Well-controlled with ongoing daily medication
- Symptoms no well controlled, steroids or anticholinergics
- Hospitalized in last 2 years, history of intubation

Stomach and Abdominal Disease

Reflux Disease

yes no

If yes, answer one of the following:

- Intermittent or variable symptoms, no medications
- Intermittent medication
- H₂ blockers or low dose PPI
- High dose PPI
- Meet criteria for antireflux surgery or history of GERD surgery

Gallbladder Stones

yes no

If yes, answer one of the following:

- I have been told I have gallstones but I don't have symptoms
- I have gallstones and some abdominal pains or nausea caused by them
- I have had severe symptoms from gallstones
- I have had bad gallstone problems and my gallbladder was removed very recently
- My gallbladder was removed and I still have bad unresolved gallstone problems

Liver Disease

yes no

If yes, answer one of the following:

- Enlarged liver; normal liver blood tests; I have been told I may have NASH (non-alcoholic fatty liver)
- Enlarged liver; elevated (abnormal) liver blood tests; I have been told I may have NASH (non-alcoholic fatty liver)
- Very enlarged liver with mild fibrosis (early cirrhosis)
- Definite NASH; cirrhosis; liver failure as shown by liver blood tests
- Liver failure; I need or already had a liver transplant

Please continue on the next page ↗

Musculoskeletal Disease

Back Pain

yes no

If yes, answer one of the following:

- Occasional symptoms but I don't need medications
- Back pain requires over the counter NSAID or Tylenol medications like ibuprofen (motrin, advil, nuprin), naproxen (naprosyn, aleve), uprin), ketorolac (Orudis), nabumetone (Relafen)
- Back pain requires narcotics (Percocet, darvocet, vicodin, percodan, oxycontin, ms contin, etc)
- X-rays have shown degenerative changes in my spine
- I have ongoing shooting nerve pains in my legs because of the back pain
- I have had surgery on my back or it has been recommended after I lose weight
- I have previously had surgery on my back and the operation failed to make my back pain go away; I still have back pain

Joint Disease

yes no

If yes, answer one of the following:

- Joint pain while walking more than 100 feet
- Joint pain requiring non-narcotic pain medication (ibuprofen, etc.)
- Joint pain while moving around for short distances or with minor activities
- Joint pain requiring surgery (ie. knee scope)
- Joint pain requiring narcotic medication **and** surgery has been done **or** is recommended
- Joint pain is disabling; all treatments have had no effect

Fibromyalgia

yes no

If yes, answer one of the following:

- Treated with exercise alone
- Treated with over the counter pain medications
- Treated with narcotic medications (i.e. Percocet, Darvocet, Vicodin)
- Treated with narcotic medications and surgery has been done or recommended
- Fibromyalgia is disabling; no treatments have had any effect

General

Stress Urinary Incontinence

yes no

If yes, answer one of the following:

- Minimal or intermittent (less than once per week)
- Frequent but not severe greater than once per week)
- Daily occurrence, requires sanitary pad
- Disabling
- Operation ineffective

Pseudotumor cerebri

yes no

If yes, answer one of the following:

- Headaches with dizziness, nausea, or pain behind the eyes; no visual symptoms
- Headaches with visual symptoms and/or controlled with diuretics
- Patient well-controlled with stronger medications
- Patient requires narcotics or has had or needs surgery

Abdominal Hernia

yes no

If yes, answer one of the following:

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

Functional Status Impairment

yes no

If yes, answer one of the following:

- Able to walk 200 ft with assistance (cane or crutch)
- Unable to walk 200 ft with assistance (cane or crutch)
- Requires wheelchair
- Bedridden

Abdominal Skin/Pannus

yes no

If yes, answer one of the following:

- Irritation when the skin rubs together
- Fat pad so large I cannot walk easily
- Recurrent infection of the fat pad or ulceration of the fat pad
- Surgical treatment of the fat pad required

Please continue on the next page ➤

Section 18. Reflux and Heartburn Questionnaire

Please fill this section out if you have ever been told that you have GERD (gastroesophageal reflux disease) or GERD symptoms (reflux, heartburn, painful swallowing) or if you have been treated or treat yourself for this problem with acid blockers such as prilosec (omeprazole), protonix (pantoprazole), nexium (esomeprazole), aciphex (rabeprazole), prevacid (lansoprazole), zantac (ranitidine), pepcid (famotidine), tagamet (cimetidine), or axid (nizatidine)

1. What is your predominant symptom (circle **ONLY** one)?

Heartburn/regurgitation Difficulty swallowing Cough Other (specify)

2. What medications do you take and how often do you take them to treat your symptoms?

ANSWER THIS QUESTIONNAIRE AS IF YOU WERE NOT TAKING REFLUX MEDICATIONS.

- Answer Scale:**
- 0 = No symptoms**
 - 1 = Symptoms noticeable but not bothersome**
 - 2 = Symptoms noticeable and bothersome but not every day**
 - 3 = Symptoms bothersome every day**
 - 4 = Symptoms affect daily activities**
 - 5 = Symptoms are incapacitating – unable to do daily activities**

QUESTION	0	1	2	3	4	5
How bad is your heartburn/regurgitation?	0	1	2	3	4	5
Heartburn/regurgitation when lying down?	0	1	2	3	4	5
Heartburn/regurgitation when standing up?	0	1	2	3	4	5
Heartburn/regurgitation after meals?	0	1	2	3	4	5
Heartburn/regurgitation made you change your diet?	0	1	2	3	4	5
Does heartburn/regurgitation wake you from sleep?	0	1	2	3	4	5
Do you have difficulty swallowing?	0	1	2	3	4	5
Do you have pain with swallowing?	0	1	2	3	4	5
If you take medication, does this affect your daily life?	0	1	2	3	4	5

Please continue on the next page ↗

Section 18. Sleep Questionnaire

General Sleep Questions

- How many hours of sleep do you usually get per night?
- Do you feel poorly rested on awakening? Yes No
- Do you nap during the day? Yes No
- Do you feel that being excessively sleepy interferes with your ability to work or concentrate? Yes No
- Have you ever been told you stop breathing at night or that your breathing pattern is irregular? Yes No
- Do you snore? Yes No
- Do you have a sensation of discomfort or restlessness in your legs that worsens prior to bedtime or with inactivity? Yes No
- Have you had problems with sleepwalking or acted out dreams at night? Yes No
- Do you ever felt sudden muscle weakness when you laughed, got angry or were surprised? Yes No
- Have you ever injured yourself or others while asleep? Yes No

The Epworth Sleepiness Scale

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

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

0 = would *never* doze 2 = *moderate* chance of dozing
 1 = *slight* chance of dozing 3 = *high* chance of dozing

Chance of Dozing
 Answer 0-3

1. Sitting, inactive in a public place (e.g., theater or a meeting) 0 1 2 3
2. Watching TV 0 1 2 3
3. Sitting and Reading 0 1 2 3
4. Sitting and talking to someone 0 1 2 3
5. Sitting quietly after lunch without alcohol 0 1 2 3
6. As a passenger in a car for an hour without a break 0 1 2 3
7. Lying down to rest in the afternoon when circumstances permit 0 1 2 3
8. In a car, while stopped for a few minutes in the traffic 0 1 2 3

Section 19. Final Thoughts

Please provide any comments or questions that you would like here:

Please continue on the next page