Bariatric Surgery Program Questionnaire

Name: _____ Date: _____

PERSONAL DEMOGRAPHICS

Last Name _____ First Name _____MI _____Maiden Name _____

Address _____City _____ State _____ Zip _____

*Home Phone ☐ _____ Cell Phone ☐ _____ Work Phone ☐ _____

***Please check next to the phone number that is the best number you can be reached on during the day**

Male ☐ Female ☐ Date of Birth: _____ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Never Married ☐

Race: White ☐ African American ☐ Hispanic ☐ Asian ☐ Native American/Alaskan Native ☐ Other ☐ _____

Email address _____ (This is only if you wish to receive communication via email.)

Employer_____ Occupation _____

SPOUSE INFORMATION: Last Name_____ First Name _____

Phone Number _____ Employer _____

PRIMARY INSURANCE COMPANY

Insurance Company Name _____Address_____

City _____ State _____ Zip_____

Policyholder's Name _____ Relation to Patient_____

Policy Number _____ Group/Plan Number_____

Customer Service Phone Number _____

Provider Inquiry/Pre-Certification Phone #_____Contact Person_____

Is Gastric Bypass and/or Laparascopic Adjustable Gastric Banding for "Clinically Severe Obesity" a covered benefit?

Yes ☐ No ☐

SECONDARY INSURANCE COMPANY

Insurance Company Name _____Address_____

City _____ State _____ Zip_____

Policyholder's Name _____ Relation to Patient_____

Policy Number _____ Group/Plan Number_____

Customer Service Phone Number _____

Provider Inquiry/Pre-Certification Phone #_____Contact Person_____

Is Gastric Bypass and/or Laparascopic Adjustable Gastric Banding for "Clinically Severe Obesity" a covered benefit?

YES ☐ **NO** ☐

Type of Bariatric Surgery Requested: (Circle Choice) Lap Band Laparoscopic Bypass Laparoscopic Sleeve

Bariatric Surgery Program Questionnaire

Name: _____ Date: _____

YOUR PRIMARY CARE PHYSICIAN

Family Physician _____ Address _____

Phone _____ Fax _____

REFERRING PHYSICIAN

Referring Physician _____ Address _____

Phone _____ Fax _____

PERSONAL STATEMENT

Please tell us, in your own words, why you are asking to have weight loss surgery – the effects on weight on your health, employment, social life, etc. Please use the back of this paper, if necessary.

Bariatric Surgery Program Questionnaire

Name: _____ Date: _____

DIET HISTORY

Current Weight: _____ Current Height: _____

Weight at 18 years of age: _____ Goal (desired) weight: _____

1. Record ALL weight loss attempts, especially professionally supervised (physician or registered dietician) programs.
2. Start with your first diet and proceed until the most recent one.
3. If you were on weight-loss medications (e.g., Apidex, Redux, Meridia, Xenical), what type of "food plan" were you following (e.g., 1200-calorie, low-fat, low-carbohydrate) in addition to taking the drug?

Year	Age at start of diet.	How long were you on this diet?	Weight at start of this diet?	Weight lost on this diet?	What kind of diet were you on?	Doctor of dietician who supervised this diet.

Bariatric Surgery Program Questionnaire

Name: _____ Date: _____

MEDICAL INFORMATION

PAST MEDICAL HISTORY

Do you have, or have you had, any of the following?

- ☐ Diabetes
- ☐ Hypertension (High blood pressure)
- ☐ High cholesterol
- ☐ Chest pain or angina
- ☐ Heart failure
- ☐ Heart attack, when? _____
- ☐ Chronic obstructive pulmonary disease/COPD (Emphysema)
- ☐ Asthma
- ☐ Sleep Apnea
  - Do you use- ☐ **CPAP** ☐ **BiPAP** ?
  - Do you use oxygen with CPAP/BiPAP ☐ **YES** ☐ **NO**
    - How many Liters? _____
- ☐ Arthritis, joint pain? Where? _____
- ☐ Gastroesophageal reflux disease/GERD (Heart burn or indigestion)
- ☐ Anxiety
- ☐ Depression
- ☐ Cancer, what kind? _____
  - When? _____
  - Treatment? ☐ **Surgical** **Radiation** ☐ **Chemotherapy**
- ☐ Crohn's disease _____ colitis _____
- ☐ Irritable bowel syndrome
- ☐ Hernia, what kind? _____
- ☐ Gallbladder trouble
- ☐ Stomach ulcers
- ☐ Thyroid disease
- ☐ Fatty liver disease
- ☐ Hepatitis B or C? _____
- ☐ HIV
- ☐ Lupus
- ☐ Polycystic ovarian syndrome (PCOS)
- ☐ Women: Last menstrual cycle date?_____
  - Menopause? ☐ **YES** ☐ **NO**
- ☐ Other: _____

PAST SURGICAL HISTORY

Date of Surgery	*Surgery*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Bariatric Surgery Program Questionnaire

Name: _____ Date: _____

MEDICAL INFORMATION *continued*

FAMILY HISTORY

FAMILY HISTORY OF:	NO	YES	WHAT RELATIVE(S)? & WHAT AGE(S)?
1. HEART DISEASE	☐	☐	_____
2. HIGH BLOOD PRESSURE	☐	☐	_____
3. LUNG DISEASE	☐	☐	_____
4. DIABETES	☐	☐	_____
5. STROKE	☐	☐	_____
6. KIDNEY DISEASE	☐	☐	_____
7. THYROID DISEASE	☐	☐	_____
8. CANCER	☐	☐	_____
9. OTHER DISEASES	☐	☐	_____

SOCIAL HISTORY

Do you or have you in the past used any tobacco products? ☐ YES ☐ NO

If so, what kind? _____

How often? (ex: ½ pack per day)_____

What year did you start? _____ Quit date: _____

Do you drink alcohol? ☐ YES ☐ NO If so, how much of the following do you drink per week?

Mixed drinks (1 oz/drink) _____ Beer (12 oz)_____ Wine (6 oz glass)_____

Do you use recreational drugs? ☐ YES ☐ NO If yes, which drugs and how often? _____

_____

Occupation _____

Do you use a wheelchair? ☐ YES ☐ NO How many hours per day? _____

How far do you walk in a normal day? _____

How many steps can you climb? _____ How many steps do you climb daily? _____

PREGNANCIES

Please list pregnancies: approximate dates, and outcome?

Date	*Outcome* (e.g., full term, premature, C-section, abortion, miscarriage)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Bariatric Surgery Program Questionnaire

Name: _____ Date: _____

MEDICAL INFORMATION *continued*

REVIEW OF SYSTEMS (please check all that apply to you)

1. Constitutional symptoms:
☐ None
☐ Fever ☐ Weight loss ☐ Weight gain ☐ Fatigue ☐ Malaise
☐ Other: _____

2. Eyes:
☐ None
☐ Dry eyes ☐ Red eyes ☐ Painful eye ☐ Change in vision
☐ Other _____

3. Ears, throat:
☐ None
☐ Sore throat ☐ Sinus congestion ☐ Sinus pain
☐ Hay fever ☐ Toothache ☐ Deafness
☐ Hoarseness ☐ Lump or mass ☐ Dry mouth
☐ Other: _____

4. Heart:
☐ None
☐ Chest pain ☐ Chest pressure ☐ Swelling feet/legs
☐ Palpitations ☐ Murmur ☐ Waking up short of breath
☐ Other: _____

5. Lungs:
☐ None
☐ Wheezing ☐ Cough ☐ Sputum
☐ Shortness of breath at rest ☐ With exertion
☐ Other _____

6. Stomach and Intestines:
☐ None
☐ Heartburn ☐ Nausea ☐ Vomiting ☐ Abdominal pain
☐ Frequent constipation ☐ Frequent diarrhea ☐ Hemorrhoids ☐ Bowel incontinence
☐ Other: _____

7. Kidneys and: Bladder
☐ None
☐ Impotence ☐ Difficulty with urination ☐ Abnormal vaginal bleeding
☐ Arising at night to urinate ☐ Pain or burning on urination ☐ Bladder incontinence
☐ Other: _____

8. Muscles and skeleton:
☐ None
☐ Joint pain: (which) _____
☐ Muscle pain ☐ Joint swelling ☐ Back pain
☐ Other: _____

Name: _____ Date: _____

MEDICAL INFORMATION *continued*

REVIEW OF SYSTEMS continued (please check all that apply to you)

9. Skin:
☐ None
☐ Rash ☐ Nodule
☐ Other: _____

10. Brain and Nerves:
☐ None
☐ Weakness ☐ Tremor ☐ Numbness ☐ Incoordination
☐ Fainting ☐ Depression ☐ Anxiety ☐ Headaches? How often? _____
☐ Other: _____

11. Glands:
☐ None
☐ Excessive thirst ☐ Low blood sugar ☐ High blood sugar
☐ Low blood pressure ☐ High blood pressure
☐ Other: _____

12. Breasts:
☐ None
☐ Pain ☐ Lump/Mass ☐ Nipple retraction ☐ Discharge
☐ Other _____

ALLERGIES

Are you allergic to any drug, food, or substance? If yes, what happens when you take or are exposed to it?
(Example: Penicillin – rash)

Drug, Food, or Substance	*Reaction*

Bariatric Surgery Program Questionnaire

Name: _____ Date: _____

MEDICAL INFORMATION *continued*

MEDICATIONS:

What medications do you take on a regular basis? Include over-the-counter (e.g., Tylenol, Ex-Lax), herbal (e.g., St. John's Wort, glucosamine-chondroitin), or vitamin-mineral supplements (e.g., Calcium, One-A-Day).

Name	Dosage (e.g., "mg")	Frequency (times per day)	Why do you take it?

STOP BANG

Screening for: OBSTRUCTIVE SLEEP APNEA

Have you been previously diagnosed with Sleep Apnea? If yes, you do not need to fill out this form.

Answer the following questions to find out if you are at risk for Obstructive Sleep apnea.

STOP

S (snore) Have you been told that you snore? YES ☐ NO ☐

T (tired) Are you often tired during the day? YES ☐ NO ☐

O (obstruction) Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep? YES ☐ NO ☐

P (pressure) Do you have high blood pressure or on medication to control high blood pressure? YES ☐ NO ☐

If you answered **YES** to two or more questions on the STOP portion you are at risk for Obstructive Sleep Apnea. It is recommended that you contact your primary care provider to discuss a possible sleep disorder. To find out if you are at moderate to severe risk of Obstructive Sleep Apnea, complete the BANG questions below.

BANG

B (BMI) Is your body mass index greater than 28? YES ☐ NO ☐

A (age) Are you 50 years old or older? YES ☐ NO ☐

N (neck) Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches. YES ☐ NO ☐

G (gender) Are you a male? YES ☐ NO ☐

The more questions you answer **YES** to on the BANG portion, the greater your risk of having moderate to severe Obstructive Sleep Apnea.

Chung F. (2008). STOP Questionnaire: A Tool to Screen Patients for Obstructive Sleep Apnea. *The American Society of Anesthesiologists, Inc.* 108:812-21.

BARIATRIC SURGERY PROGRAM SMOKING POLICY

The Ali`i Health Center Bariatric Surgery Program requires that all patients quit the use of any tobacco and nicotine containing products **3 months** prior to the date of their initial consultation.

Prior to surgery, a blood and/or urine nicotine test is required and must be negative. Your surgery will be postponed, or you could be released from consideration for surgery altogether, if you test positive for nicotine. You will not be rescheduled for surgery until you have been tobacco-free for three months.

Since you have decided to have weight loss surgery to improve your health and prolong your life, quitting tobacco use will give you even greater health benefits than weight loss alone. Nicotine and other byproducts of tobacco can cause serious problems during and after your surgery.

- Smoking increases the risk of a heart attack or stroke during surgery.
- Smoking can cause respiratory difficulties, such as pneumonia and bronchitis.
- Smoking decreases the amount of oxygen available to your body.
- Smoking slows healing and can lead to wound infections, due to reduced oxygen levels in your blood.
- Smoking causes heartburn.
- Smoking causes stomach ulcers.
- Smoking decreases your body's ability to absorb vitamins and minerals.

Please make sure that you have successfully quit using tobacco for **3 months** or more before your schedule your appointment with the surgeon to avoid any delay in scheduling your surgery date.

I have read and understand the Smoking Policy of the Bariatric Surgery Program at Ali`i Health Center. I understand the risks of smoking with Bariatric Surgery and I agree to abstain from smoking before and after surgery.

PRINT NAME:

_____ Signature: Date: _____

_____

(To be signed at your initial consultation)