YUMA REGIONAL MEDICAL CENTER
BARIATRIC SURGERY

# Bariatric Surgery Patient History Questionnaire

*Your appointment will be delayed if this form is incomplete – please print legibly*

**Personal Information**

Name _____ Date _____

SSN# (for insurance purposes) _____-_____-_____ Date of Birth _____ Age _____

Insurance: _____ ID# _____ Group#_____

Mailing Address _____
_____

City _____ State _____ Zip _____

Daytime Phone _____ Home Phone _____

Cell Phone _____ E-mail Address _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed Gender ☐ Male ☐ Female

Occupation _____ How many hours a week do you work? _____

Number of Children _____ Ages of Children _____ Do you care for elder relatives? _____

Who? _____ What is your involvement in the Care? _____

With whom do you reside? _____

How long have you been contemplating Bariatric surgery? _____

Have you done any research regarding Bariatric surgery? _____

If YES, what type? _____

How did you hear about this program? _____

Do you have a friend or family member who has had Bariatric surgery? _____ Who? _____

Language ☐ English ☐ Spanish

| Height | Weight | Ideal body weight | Excess body weight | BMI |
|---|---|---|---|---|
| | | | | |

## PERSONAL MEDICAL HISTORY (Do you have or have you ever had? Check all that apply.)

| Cardiovascular Disease | Yes | No | Don't know | Gastrointestinal | Yes | No | Don't know |
|---|---|---|---|---|---|---|---|
| Heart disease | | | | Colonoscopy date: | | | |
| MI (Heart Attack) | | | | Do you experience heartburn or regurgitation? | | | |
| Abnormal EKG | | | | How many times per week? | | | |
| Have you ever had a stress test? | | | | Medications: | | | |
| Have you ever had an echocardiogram? | | | | Urinary | | | |
| High blood pressure | | | | Difficulty with urination? | | | |
| Do your legs/ankles swell easily? | | | | Frequent bladder infections? | | | |
| Do you take medication for the swelling? | | | | Incontinence: | | | |
| If so, what medications | | | | Kidney infections? | | | |
| **Endocrine** | | | | Gynecological | | | |
| Are you a Diabetic? | | | | Last menstrual period: | | | |
| Average Daily Blood Glucose: | | | | Number of pregnancies: | | | |
| Medications: | | | | Number of births: | | | |
| Do you have thyroid problems? | | | | Last mammogram date: | | | |
| Medication: | | | | Was it normal? | | | |
| Elevated cholesterol | | | | Last pap smear date: | | | |
| Medication: | | | | Was it normal? | | | |
| **Respiratory** | | | | Are you taking hormones (Birth control/HRT)? | | | |
| Asthma: | | | | Hematological | | | |
| Do you use inhalers? | | | | Do you have a bleeding abnormality? | | | |
| Do you take oral medications? If so, what? | | | | If so, describe: | | | |
| Shortness of breath | | | | Have you ever had a blood transfusion? | | | |
| How far can you walk before you are out of breath? | | | | If so, why? | | | |
| Is it getting worse? | | | | AIDS/HIV exposure? | | | |
| Sleep Apnea: | | | | Musculoskeletal | | | |
| Do you use a C-PAP device? | | | | Back pain | | | |
| **Psychological** | | | | Hip pain | | | |
| Depression | | | | Knee pain | | | |
| Panic attacks | | | | Ankle/foot pain | | | |
| Anxiety | | | | Which of these is worse? | | | |
| Bipolar disease | | | | Have you seen an orthopedic doctor for any of the above? | | | |
| Obsessive compulsive disease | | | | Is orthopedic surgery pending for any of the above? | | | |
| | | | | Other | | | |
| | | | | Antibiotic resistant organism? | | | |
| | | | | Hepatitis | | | |

## Surgeries

| Date | Surgery |
|---|---|
| | |
| | |
| | |
| | |
| | |

## Hospitalizations

| Date | Illness | Treatment |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## Prescription Medications

| Medication | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## Non-Prescription Medications

| Medications | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |

## ALLERGIES

**Allergic to any medications?** ☐ Yes ☐ No

If yes, please list medication and reaction: _____

**Surgical tape** ☐ Yes ☐ No If yes, please list reaction: _____

**Latex** ☐ Yes ☐ No If yes, please list reaction: _____

**Iodine** ☐ Yes ☐ No If yes, please list reaction: _____

## DIETING HISTORY

Age you first started dieting: _____ Approximate weight at age 18 _____

Height: _____ Current Weight:_____ Weight range last 5 years _____ to _____

| Program | Yes | No | Date(s) | Duration | Max loss | MD supervised? |
|---|---|---|---|---|---|---|
| Jenny Craig | | | | | | |
| Nutri-systems | | | | | | |
| Weight Watchers | | | | | | |
| Opti-fast Medi Fast | | | | | | |
| Overeaters Anonymous or TOPS | | | | | | |
| Fen/Phen Redux | | | | | | |
| Meridia | | | | | | |
| Xenical | | | | | | |
| Over the counter diet aids | | | | | | |
| Atkins Diet | | | | | | |
| Other: | | | | | | |
| Other: | | | | | | |
| Other: | | | | | | |

What was the most successful weight loss you have achieved and how did you do it?

_____

What behaviors did you learn from dieting that you still use today? _ _____

_____

## FOOD PREFERENCE

Are you a sweet eater? ☐ Yes ☐ No If so, what? _____

How often? _____

Are you a pasta/bread eater? ☐ Yes ☐ No If so, what? _____

How often?_____

Are you a fast food eater? ☐ Yes ☐ No If so, what? _____

How often? _____

Is snacking from habit? ☐ Yes ☐ No Boredom? ☐ Yes ☐ No Do you binge eat? ☐ Yes ☐ No

How often?_____

What beverages do you consume throughout the day? Quantity? _____

## SOCIAL/FAMILY HISTORY

Is there obesity in the family? ☐ Yes ☐ No Who_____

Other medical illness within the family: ☐ Yes ☐ No If yes, what? ☐ Diabetes ☐ Hypertension ☐ Coronary Artery Disease ☐ Other_____

Do you exercise regularly? ☐ Yes ☐ No If yes, what do you do? _____

_____

Do you have any physical restrictions that keep you from exercising? ☐ Yes ☐ No

Explain _____

Have you ever smoked cigarettes/cigars? ☐ Yes ☐ No Do you smoke now? ☐ Yes ☐ No

When did you quit? _____ How much did you smoke per day? _____

Do you drink alcohol? ☐ Yes ☐ No What type of alcohol do you consume? _____

More than 5 drinks per week? ☐ Yes ☐ No Less than 5 drinks per week? ☐ Yes ☐ No

Have you or are you currently using any recreational/illegal drugs? ☐ Yes ☐ No

Explain: _____

Do you have a history of abuse? (Please include emotional, physical, mental, substance or other types of abuse issues you have dealt with. This information is extremely important and very confidential. Honesty is needed in order to provide you with the best possible treatment plan.)

_____

_____

_____

_____

_____

_____

_____

_____

Describe your present life stressors: _____

_____

_____

Describe the present support system you rely upon (church, spouse, family, friends, co-workers, etc)

_____

_____

_____

_____

What is your greatest fear regarding the surgery? _____

_____

_____

_____

_____

_____

_____

What is your greatest hope regarding surgery? _____

_____

_____

_____

_____

_____

_____

Why do you (what is motivating to) seek this type of intervention for weight control?_____

_____

_____

_____

_____

## The Epworth Sleepiness Scale (ESS)

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 done 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
1 = *slight* chance of dozing
2 = *moderate* chance of dozing
3 = *high* chance of dozing

| Situation | Chance of Dozing |
|---|---|
| Sitting and reading | |
| Watching television | |
| Sitting inactive in a public place | |
| 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 traffic | |
| Total Score | |

**SCORE RESULTS:**

| | |
|---|---|
| 1-6 | Congratulations, you are getting enough sleep! |
| 7-8 | Your score is average |
| 9 **and** up | Very sleepy and should seek medical advice |

*Johns, M.W. (1991). A new method for measuring daytime sleepiness: The Epworth sleepiness scale. Sleep, 14, 540-545. Permission for single-use of the information contained in this material was obtained from the Associated Professional Sleep Societies, LLC, September 2006.*

## Physicians

Complete information is mandatory, including address, email, phone and fax.

| Specialty Name | Address | Phone and Fax Numbers |
|---|---|---|
| Primary Care | | |
| GYN | | |
| Orthopedic | | |
| Cardiologist | | |
| Pulmonologist | | |
| Endocrinologist | | |
| Psychologist/ Psychiatrist | | |
| Chiropractor | | |
| Other | | |

**Signature**_____ **Date** _____

Please return completed form along with a copy of your insurance card and current authorization (if applicable) to:

**Yuma Regional Medical Center**
**Bariatric Surgery Program, Parkview Medical Plaza**
yumalite@yumaregional.org
2460 S. Parkview Loop, Suite 3
Yuma, Arizona 85364
928-336-LITE (5483)