Weight Loss Surgery: New Patient Questionnaire

Name: Date of birth: MRN (if known):
Date:
Best phone # and best time of day to reach you:
Email:
Address:

Insurance Carrier and ID:

Primary Care Provider (PCP):
PCP Telephone: Fax:
PCP Address:

How did you hear about our program?:
Referring MD if different than PCP:

Height: Weight: BMI:

BMI Calculator: https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm

Have you been previously screened at another WLS program?
If yes, where?:
Have you ever had weight loss surgery? □ No □ Yes

I am interested in the: □ Lap Band □ Gastric Sleeve □ Gastric Bypass

Do you have a history of any of the following conditions? (Check all that apply):

□ Migraines
□ Stroke
□ High blood pressure
□ Atrial fibrillation/flutter
□ Sleep apnea
□ Pulmonary embolism
□ Barrett's esophagus
□ Ulcerative colitis
□ Fatty liver disease
□ Kidney stones
□ Polycystic ovarian syndrome
□ Hypothyroidism
□ Anemia or iron deficiency
□ Anxiety
□ Schizophrenia
□ Borderline personality disorder
□ Bulimia
□ Other:_____

□ Seizures
□ Coronary artery disease
□ High cholesterol
□ Blood clots
□ Asthma
□ Gastroesophageal reflux (GERD)
□ Gastric ulcers
□ Celiac disease
□ Hepatitis/Cirrhosis
□ Prostate issues
□ Diabetes, most recent A1C%:____
□ Grave's disease
□ Gout
□ Bipolar disorder
□ Past suicide attempts
□ Binge eating
□ Cancer, if so specify: _____

□ Pseudotumor cerebri
□ Congestive heart failure
□ Peripheral vascular disease
□ Heart murmur
□ COPD
□ Heartburn
□ Crohn's disease
□ Irritable bowel syndrome
□ Kidney disease
□ Infertility
□ Hypoglycemia
□ Arthritis
□ Depression
□ Panic attacks
□ Anorexia
□ Purging

Medications: *List all prescription and over-the-counter medicines (OTC) that you take at home (such as blood pressure medication, allergy medication, herbals, vitamins and nutritional supplements).*

□ **I take no medications or supplements**

Medication/Supplement Name	Dose	How do you take it? (Mouth, injection, etc.)	Time of day/ How often

Are you currently breastfeeding? □ **No** □**Yes**

Past Surgical History:

Have you ever had any operations or surgical procedures? □ **No** □ **Yes** If yes, please list:

Date:	**Operation/Procedure:**
___/___/___	
___/___/___	
___/___/___	
___/___/___	
___/___/___	

Allergies (circle): Y N □ I have no known allergies

Allergy/ Sensitivity	**Type of Reaction**
Medications:	
Vaccinations:	
Contrast Dye:	
Latex:	
Food:	
Seasonal Allergies:	
Environmental Allergies:	
Insects/ Venom (Bee Stings, etc.)	
Other:	

Family History: *Please indicate if your grandparents, parents, siblings, and/or your children have had any of the following conditions.*

	Which family member?	**At what age?**	**Living or deceased?**
Heart disease			
Hypertension			
High cholesterol/lipids			
Diabetes			
Stroke			
Obesity			
Arthritis			
Blood clots			
Asthma			
Cancer			

Sleep History:

Do you have a history of snoring that is disruptive to others? ↑ □ **No** □**Yes** ↑
Has anyone ever told you that you stop breathing during sleep? ↑ □ **No** □**Yes** ↑
Do you ever awaken choking or gasping for air at night? ↑ □ **No** □**Yes** ↑

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.

0 = no chance of dozing
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 ____

Being a passenger in a motor vehicle for an hour or more ____

Lying down in the afternoon ____

Sitting and talking to someone ____

Sitting quietly after lunch (no alcohol) ____

Stopped for a few minutes in traffic while driving ____

Total score: ____

Total Score	
0-6	**Minimal Sleepiness**
7-8	**Average**
>/=9	**Excessive Sleepiness**

Diet Attempts:
*** Please be aware that although eating better and exercising on your own are good and appreciated efforts, those do not count as an attempt here.*

Have you tried any of the following? (Check all that apply):

	Weight Watchers ®		Jenny Craig		LA Weight Loss ®
	Slimfast		Atkins ®		South Beach
	Nutrisystem®		The Zone		Medifast ®
	Dietitian/Nutrition visits # of visits:_____		Diet Workshop		Metabolife
	OA		Pondimin		Hypnosis
	TOPS		Fen-Phen		Optifast ®
	Trimspa ®		HMR		Laxatives
	Orlistat (Xenical ™)		Dexatrim		Phentermine (Fastin ®, Adipex ®)
	Sibutramine (Meridia ®)		Ephedra		Topiramate (Topamax ®)
	Amphetamines		Acupuncture		Behavior Therapy
	Psychotherapy		Previous Gastric Surgery/Stomach Stapling		Other OTC Diet Aids/Herbs, Specify:_____
	Garcinia Cambogia		Herbalife		Other:_____

In your opinion, what are some factors that contribute to your excess weight? (Check all that apply):

	Portion size		Emotional eating
	Compulsive eating		Genetics
	Eating too many fats and/or carbs		Lack of exercise
	Stress		Lack of knowledge about healthy living

Other:_____
_____
_____
_____
_____
_____

Substance Use:

Current	Amount	Frequency	Years of use	Type
Tobacco				
Alcohol				
*Drug Use				

*****If you are using marijuana for medicinal purposes, please provide the indication for use, name of prescriber, and form in which taken (ex: inhaled, edibles, etc.): _____

Former	Amount	Frequency	Years of use	Type
Tobacco				
Alcohol				
Drug Use				

Have you been hospitalized in the past year for either a medical or psychiatric Issue?
If yes, diagnosis?:

Designated support person for after surgery:

Name **Relationship**

_____ _____

_____ _____

Therapist or Mental Health Counselor: _____ Phone: (___)_____

Psychopharmacologist: _____ Phone: (___)_____

Functional Health Status:

□ Independent – no assistance needed to complete activities of daily living
□ Partially dependent – some assistance needed
□ Totally dependent on others for self-care

My Availabilities:

Day	AM	PM
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

I have carefully read all the materials in this assessment and have answered the questions to the best of my ability.

_____ _____

Signature Date

Once you have completed this form, please send it back to us using one of the options below:

FAX: 617-667-4704

Email (preferred): wls@bidmc.harvard.edu

Post or drop-off:
Beth Israel Deaconess Medical Center
Shapiro 3- Bariatric Surgery
330 Brookline Ave
Boston MA, 02215

** Once we receive your completed form, it will be reviewed by our clinical team. After it has been reviewed, you will receive a call to discuss the next steps.