surgeryspecialists
OF HOT SPRINGS

1900 Malvern Ave., Ste 302
Hot Springs, AR 71901
(501) 623-9300
Fax (501) 623-9305
www.surgeryspecialistshs.com

Bariatric Surgery Patient History Questionnaire

Last Name:	First Name:	Date:
Birthdate: Age:	Sex:	Race:
Home address:		
Home Phone:	Cell Phone:	Work Phone:
Email Address:		
Height:	Weight:	BMI (We will calculate this for you):

When listing your physicians be sure to include how many years they have been treating you. This information is needed as part of the insurance approval process.

Primary Care physician:

Address:

Telephone #:

Years treated:

Please provide us with the following:

Cardiologist's Name:

Telephone #:

Date of most recent visit:

Date of last stress test (Nuclear or treadmill):

Reason for seeing doctor?

Do you know which surgery you are interested in?

Have you attended a seminar? [ ] Yes [ ] No If yes, which seminar?

Are you currently taking any of the following medications? Please check all that apply to you.

[ ] Birth control pills [ ] Hormone replacement [ ] Aspirin [ ] Plavix

_____ _____

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Family History (Grandparents, Parents, Siblings):

What other family members are obese? (indicate mother's/father's side of your family)

Family members who have or have had breast, colon, or prostate cancer:

Cancer (specify type):

Diabetes:

Heart attack:

Stroke:

High blood pressure:

Other problems not listed above:

☐ **I agree to a blood transfusion in an emergency situation.**

Do you currently have an abdominal/incisional hernia? ☐ Yes ☐ No

Do you take any blood thinning medications such as Coumadin, warfarin, aspirin or Plavix?
☐ Yes ☐ No

Tape Allergies? ☐ Yes ☐ No

Latex Allergies? ☐ Yes ☐ No

Do you take any NSAIDS such as Ibuprofen, Motrin, Aleve, Celebrex or Naprosyn?
☐ Yes ☐ No

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Social Information:

Please briefly state the feelings of your spouse or partner in regards to bariatric surgery:

Please briefly state the feelings of your family in regards to bariatric surgery:

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ]Widowed

Number of children:_____ **Number of people living in your home:** _____

Education (Please check all that apply):

[ ] Some school [ ] High school graduate [ ] Some college
[ ] College graduate [ ] Post graduate

Tobacco history (including smoke, dip, chew, nicotine gum/patches): [ ] None

Tobacco product used: _____ Frequency: _____

How Many Years:_____ When Did You Quit? _____

Alcohol Consumption: [ ] None [ ] Occasional/Socially

Frequency:_____ How Many Years:_____ When Did You Quit?_____

Recreational Drug use: [ ] None [ ] Occasional/Socially

Frequency:_____ How Many Years:_____ When Did You Quit?

Birth Control: [ ] None

[ ] Pills [ ] Condoms [ ] Tubal Ligation [ ] Other:_____

_____ _____

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Coffee/Caffeine use: [ ] None

Type:_____ Amount per day: _____

Carbonated Beverages: [ ] None

Type: _____ Amount per day: _____

Diet: [ ] None

Type: _____ Amount per day: _____

Frequent snacking: [ ] None

Type: _____ Amount per day: _____

Physical Limitations (Please check all that apply):

[ ] Climbing stairs [ ] Use of public seating [ ] Caring for personal needs

[ ] Work duties [ ] Playing with children [ ] Airline travel [ ] Other:

How did you hear about Surgery Specialists of Hot Springs?

[ ] Seminar [ ] Website [ ] Referring physician [ ] Word of Mouth [ ] Newspaper

In the spaces provided below, please completely answer all questions to the best of your ability.

Have you ever had any upper abdominal surgeries? [ ] Yes [ ] No

If yes, explain type of surgery, doctor, and dates: _____

_____

_____

Please list all previous surgeries with date performed: _____

_____

_____

_____ _____

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Major Illnesses: _____

_____

How many pregnancies and list dates of each: _____

Miscarriages: _____

Do you have or use any of the following:

[ ] Acid Metallic Taste in Mouth/Sour Stomach
[ ] Amenorrhea
[ ] Arthritis- { } Knees { } Ankles { } Hips
[ ] Asthma
[ ] Blood Clots
[ ] Blood Transfusion
[ ] Cancer- { } Breast { } Colon { } Uterine
[ ] Chest Pain
[ ] Chronic Back and Joint Pain
[ ] Chronic leg ulcers
[ ] Chronic skin disorders or infections
[ ] Cirrhosis
[ ] Colitis
[ ] Coronary artery Disease
[ ] Couching/Hoarseness
[ ] Crohn's Disease/Ulcerative Colitis
[ ] Degenerative Joint Disease
[ ] Depression/Bipolar Disorder/Anxiety
[ ] Diabetes Mellitus
[ ] Edema (Leg Swelling)
[ ] Family History: Obesity, Diabetes, Hypertension, Heart Disease, Cancer
[ ] Food gets stuck in your throat
[ ] Frequent Prednisone Use
[ ] Gassiness/Bloating
[ ] GERD (Gastroesophageal reflux disease)
[ ] Gestational Diabetes
[ ] Heart Attack
[ ] Heart Disease
[ ] Heart Failure
[ ] Heart Stents
[ ] Heart burn/Reflux
[ ] HIV/AIDS
[ ] Hypercholesterolemia (Elevated Cholesterol)
[ ] Hypertriglyceridemia (Elevated Triglycerides)
[ ] Hypertension (high blood pressure)
[ ] Indigestion/Dyspepsia
[ ] Kidney Disease- { } Dialysis
[ ] Liver Disease (Hepatitis B, Hepatitis C)
[ ] Lupus
[ ] Lumbar disc disease
[ ] Lung Disease (COPD/Emphysema)- { } Home Oxygen
[ ] Migraine Headaches
[ ] Plantar Fasciitis
[ ] Polycystic Ovarian Syndrome
[ ] Problems Swallowing/Excessive Clearing of Throat
[ ] Pulmonary Embolism
[ ] Pseudotumor Cerebri
[ ] Rheumatoid Arthritis
[ ] Scleroderma
[ ] Shortness of Breath & Exercise Intolerance due to Obesity
[ ] Sleep Apnea- { } CPAP or BI PAP
[ ] Stomach Ulcer
[ ] Stroke
[ ] Syndrome X
[ ] Thyroid Problems
[ ] Urinary Stress Incontinence (Weak Bladder)
[ ] Varicose Veins
[ ] Vomiting or Regurgitation when lying down

_____ _____

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Review of Systems:

Please read the following carefully and check all that apply:

Symptoms	Yes	No	Comment
Anemia			
Anxiety			
Any history of blood transfusion			
Any history of head injury w/loss of consciousness			
Any history of bladder surgery			
Asthma			
Birth control			
Bleeding tendency			
Breast lump, pain, or discharge			
Chest pain at rest			
Chest pain on exertion			
Chronic skin rash or hives			
Chronic sinus congestion			
Convulsions or seizures			
Coughing			
Delayed healing of sores or wounds			
Dental problems			
Dentures			
Depression			
Difficulty breathing while laying flat			
Discoloration of lower leg			
Do you involuntarily lose your urine			
Do you have thyroid problems			
Do you take blood pressure medications			
Do you take medication for cholesterol			
Drug or alcohol use			
Eating disorders			
Excessive snoring			
Eyeglasses or contact lenses			
Falling asleep during daytime activities/driving			
Feeling like you aren't getting enough sleep			
Fever/chills/sweats			
Fluid coming up in throat while lying flat			
Food getting stuck when swallowing			
Frequent/severe fatigue or weakness			
Frequent/severe headaches			
Frequent urination at night			
Hay fever			
Hearing problems			
Heart murmur			

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Symptoms	Yes	No	Comment
Heartburn after eating			
Heavy or abnormal menstrual cycles			
High blood pressure			
Hospitalization for psychiatric treatment			
Infertility			
Irregular periods			
Loose urine when bending/laughing			
Loose urine when sneezing/coughing			
Memory loss			
Mood swings			
Morning headaches			
Must prop up on multiple pillows to sleep			
Numbness/pain going down on one or both legs			
Numbness or tingling			
Pain in joints			
Paralysis			
Psychiatric treatment			
Shortness of breath			
Skipping menstrual cycles			
Sleep problems			
Stop breathing during sleep			
Swelling in feet			
Visual problems that are not correctable			
Waking up at night short of breath			
Wheezing			

_____ _____

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Medications & Physicians

Last Name: _____ First Name: _____ Birthdate: _____

Medication Allergies? [ ] Yes [ ] No If yes, please list: _____
_____

Please list ALL medications you are currently taking in the table below. This includes over-the-counter products, prescription medications, and any herbal supplements and/or vitamins you use.

Medication Name	Dose/Frequency	#Pills/Refill	Reason	Date	Date	Date

Please list doctors and healthcare providers you are currently seeing (including primary care, cardiology, psychiatry, dietitian, therapist, etc.); if you do not know the address (including zip code), please call the provider's office to obtain a complete address.

Name	Specialty	Phone	Fax	Mailing Address	City/State/Zip

_____ _____

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Weight-Related History

Weight History – Please list your average weight over the last 5 years:

YEAR	AGE	WEIGHT	YEAR	AGE	WEIGHT
2011			2014		
2012			2015		
2013			2016		

How long have you been overweight? _____

Were you overweight as a child? [ ] Yes [ ] No Comment: _____

Were you overweight after childbirth? [ ] Yes [ ] No Comment: _____

What is the most weight you have lost at one time? _____

Diet History

Supervised Weight Loss Attempts – Please check all of the weight loss efforts you have tried:

- ☐ Acupuncture
- ☐ Atkins Diet
- ☐ Cabrini Eating Disorder
- ☐ Calorie Counting
- ☐ Diet medications
- ☐ Diet Pills from MD
- ☐ Diet Shots from MD
- ☐ Diet Center
- ☐ Gym Membership
- ☐ Harris Fast
- ☐ Health Spa
- ☐ Herbal Life
- ☐ High Protein
- ☐ HMR
- ☐ Home Gym Equipment
- ☐ Hypnosis
- ☐ Jenny Craig
- ☐ LA Weight Loss
- ☐ Liquid Protein
- ☐ Living Well Lady
- ☐ Low Carb
- ☐ Low Fat
- ☐ Magazine Diets
- ☐ Mayo Clinic Diet
- ☐ Numerous Book Diets
- ☐ Nutri System
- ☐ Overeaters Anonymous
- ☐ Over-the-counter Preparations
- ☐ Optifast/Medifast
- ☐ Physician supervised diet
- ☐ Pritikin Diet
- ☐ Psychological Counseling
- ☐ Radar Institute
- ☐ Richard Simons
- ☐ Scarsdale Diet
- ☐ Self Imposed Fasts
- ☐ Slim Fast
- ☐ South Beach Diet
- ☐ Subliminal Tapes
- ☐ Sugar Busters
- ☐ Supervised Calorie Counting
- ☐ Toopfast
- ☐ T.O.P.S.
- ☐ Virginia Mason Clinic
- ☐ Weight Watchers

Any other program not listed: _____

_____ _____

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Check each medication you have tried:

- ☐ Acutrim OTC
- ☐ Adipex
- ☐ Amphetamines
- ☐ Dexatrim OTC
- ☐ Fastin
- ☐ Fen-Phen ~Duration: _____
- ☐ Herbal Remedies OTC
- ☐ Ionamin
- ☐ Meridia
- ☐ Metabolife OTC
- ☐ Phentermine
- ☐ Pondimin
- ☐ Redux
- ☐ Sanorex
- ☐ Tenuate
- ☐ Trimspa OTC
- ☐ Xenical
- ☐ Zenadrine OTC

Please list any over-the-counter diet medications you have tried:_____

How did any of the above fail to meet your needs? _____

At what age did you begin dieting: _____

Level of Activity:

Activity:	**Duration:**	**Frequency:**	**Limitations (Shortness of breath/Pain):**
Aerobics – Land			
Aerobics – Water			
Biking			
Organized Exercise			
Stairs			
Swimming			
Walking			
Other (List):			

Do you use any of these walking aids daily? ☐Cane ☐Walker ☐ Wheelchair ☐ Motorized Cart

_____ _____

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What You Hope to Achieve

Last Name:	First Name:	Birthdate:
In the space below, please describe in your own words what you hope to accomplish and how you believe your life will change by losing weight:		

_____ _____

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STOP-Bang Questionnaire

☐ Yes	☐ No	**Snoring?** Do you **Snore Loudly** (loud enough to be heard through closed doors or your bed-partnr elbows you for snoring at night)?
☐ Yes	☐ No	**Tired?** Do you often feel **Tired, Fatigued or Sleepy** during the daytime (such as falling asleep during driving)?
☐ Yes	☐ No	**Observed?** Has anyone **Observed** you **Stop Breathing** or **Choking/Gasping** during your sleep?
☐ Yes	☐ No	**Pressure?** Do you have or are you being treated for **High Blood Pressure**?
☐ Yes	☐ No	**Body Mass Index more than 35?**
☐ Yes	☐ No	**Age older than 50 years old?**
☐ Yes	☐ No	**Neck size large?** (Measured around Adams Apple) For male, is your shirt collar 17" or larger? For female, is your shirt collar 16" or larger?
☐ Yes	☐ No	**Gender** = Male?

Scoring Criteria*:

For general population

Low Risk of OSA: Yes to 0-2 Questions

Intermediate Risk of OSA: Yes to 3-4 Questions

High Risk of OSA: Yes to 5-8 Questions

*For validated scoring criteria in obese patients, please refer to UpToDate topic on surgical risk and the preoperative evaluation and management of adults with obstructive sleep apnea.

Adapted from: STOP Questionnaire A Tool to Screen Patients for Obstructive Sleep Apnea Frances Chung, F.R.C.P.C.,* Balaji Yegneswaran, M.B.B.S.,† Pu Liao, M.D.,‡ Sharon A. Chung, Ph.D.,§ Santhira Vairavanathan, M.B.B.S.,_ Sazzadul Islam, M.Sc.,_ Ali Khajehdehi, M.D.,† Colin M. Shapiro, F.R.C.P.C.# Anesthesiology 2008; 108:812–21

_____ _____

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