Bariatric Questionnaire

The information you provide will help us to plan your treatment, please carefully fill out and sign the last page.

PERSONAL DETAILS

Hospital Desired: _____

Desired Medical Procedure: _____

First Name: _____ **Last Name:** _____

Address: _____

_____

Postal Code: _____ **Telephone No.(Home):** _____

Your Email Address: _____

Telephone No.(Business): _____ **Mobile No:** _____

Date of Birth: ___ / ___ / _____ **Age:** _____
(mm / dd / yyyy)

Occupation: _____

Language Spoken: (Example: English) _____

Proposed Surgical Date: _____

Do you have a passport? Yes ____ No _____

PRIMARY HEALTHCARE PROVIDER

Name: _____ **How long he/she has been treating you?**_____

Conditions treated:_____

Telephone:_____ **Any other physician/s?**_____

Address:_____

Telephone: _____

CONTACT PERSONS:

This information is often vital to us if we need to contact you urgently. Occasionally people move or have new phone numbers and do not let us now.

1. NEXT OF KIN:

Name: _____ **Relationship:** _____

Address: _____

_____

Telephone No.(Home): _____ **Telephone No. (Business):** _____

Emergency Contact No: _____

SOCIAL PROFILE

FAMILY STRUCTURE:

Married: _____ Unmarried: _____

If married or previously married, what is your current status? Divorced : ___Partnership/Relationship:___

Children / Ages: _____

WEIGHT HISTORY

Please indicate your weight at the following times. Please indicate whether you consider your weight was below average, average, above average or very heavy in the relevant boxes.

	Below Average	Average Weight	Above Average	Very Heavy
*Birth Weight				
*Weight at beginning of high school (10-12 yrs)				
*Weight at end of high school (15-18 years)				
*Weight at time of commencing work (21 years)				
Weight at time of marriage (if applicable)				

*** Current Weight: _____lbs* Current Height: ____ft_____ inches * Current BMI: _____**

*** Current Body Shape: ____ Apple ____ Pear ____ Other _____ Don't Know _____**

Other * Waist Circumference:

WEIGHT LOSS HISTORY

PLEASE CHECK THE DIET PROGRAMS THAT APPLY TO YOU and indicate the DURATION:

	DIET PROGRAM	DURATION
	WEIGHT WATCHERS	
	JENNY CRAIG	
	GLORIA MARSHALL	
	APPETITE SUPPRESSANTS	
	ANY OTHER DRUG TREATMENT	
	OTHERS (Pls indicate): _____	

***Were there any particular events that lead to significant weight gain? _____ Yes _____ No If yes, please explain:**

_____

_____

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following and if so, please indicate:

	PARENT	SIBLING/CHILD	OTHER RELATIVES (cousins,aunts, grandparents,etc)	NO FAMILY HISTORY	DON'T KNOW
*Diabetes					
* Heart Disease					
* Hypertension					
* Gout					
* Gallstones					
* Obesity					
*Snoring/Sleep Apnea					
*Asthma					
*Allergies					
*Hay Fever					
*Dermatitis/ Eczema					
* High Cholesterol					
* Osteoporosis					
*Hip fractures					

ANY DRUG/FOOD ALLERGIES ? _____ Yes _____ No

If yes, pls list (include food, medications, dressings)

_____

ALCOHOL:

***Do you drink alcohol? ____Never _____Rarely _____Regularly**

How many standard glasses do you drink per day? _____How many days do you drink per week? _____

What do you drink?_____ Beer _____ Wine _____ Spirits

SMOKING:

Do you smoke? _____Yes _____ No _____ Never If yes, how many per day? _____

If no, have you smoked in the past? _____ Yes _____ No

If yes, how many per day? _____ If yes, for how many yeas?_____

When did you stop smoking?

SURGICAL HISTORY - Please give details of any past operations(especially bariatric):

SURGERY	DATE	REASON

PERSONAL MEDICAL HISTORY

Have you ever suffered from any of the following health problems? Pls check all that apply and provide details)

	ILLNESS/HEALTH PROBLEM	DETAILS
	Diabetes	
	Diabetes while Pregnant	
	Asthma	
	Respiratory / Breathing problems	
	Arthritis or joint pain	
	Back Pain	
	Kidney or urinary discorder	
	Neurological	

	Psychological/Nervous disorder	
	Gallstones	
	*** Reflux or heartburn**	
	Gastric or duodenal ulcer	
	Hepatitis or liver disease	
	High Blood Pressure	
	Heart Disease	
	High Cholesterol	
	Anemia or bleeding disorder	
	Thrombosis or clotting disorder	
	Varicose Veins or leg swelling	
	Eczema or skin condition	
	Hay Fever or Rhinitis	
	OTHER (pls pecify) _____	

SLEEP HISTORY

*** How many hours sleep do you get at night? _____**

*** Is there anything else that keeps you awake at night? ____Yes _____ No**

If yes, Details? _____

SYMPTOMS OF SLEEP APNEA

	Never	Rarely	Occasionally	Frequently	Always
How often do you snore?					
Do you wake during the night with a choking feeling?					
How often would you sleep more than 8 hours in total in a 24 hour period ?					
Do you feel sleepy during the day?					

Has anyone noticed that you momentarily stop breathing during your sleep?					
How often do you doze off or fall asleep while driving?					

EMPLOYMENT

Are you currently employed? ____ Yes _____No

Current Employment _____

Are you full-time, part-time or casual? _____ Full time _____ Part Time _____ Casual

If you are unemployed, what is the reason? _____

*** Are you actively looking for work? ____ Yes _____ No**

*** Has your weight made it difficult to find employment? _____ Yes _____ No**

If employed, please state what level of activity your job involves:
_____ Little (sedentary) _____ Moderately active _____Very Active (labouring)

MEDICATIONS

Please list in detail all medications that you have used in the last 12 months. Please include any dietary supplements, cremes, eye drops,medications to assist in weight loss, for psychiatric disorder, asthma, hormones, etc

Name of medication	Dose	Frequency	Purpose	When use started

BREATHING HISTORY

*** Does being at work ever make your chest tight or wheezy? _____Yes ____ No**

If yes, Details : _____

ASTHMA

Have you ever had asthma? (tick one of the following)___Never ___Current ___In the past ___Don't know If

yes, Details : _____

GASTROESOPHAGEAL REFLUX / INDIGESTION

*** Do you have a history of heartburn or indigestion? _____Yes ____ No**

If yes, how often do you have reflux during the day? _____

___ Many times a day ___Everyday ___ Most days ___ Most weeks___ Occasionally

Do you suffer heartburn/indigestion during the night? ___ Yes ___ No

If yes, how often ___ Many times a day ___ Everyday ___ Most days ___ Most weeks ___ Occasionally

What aggravates or causes your reflux ? _____

*** Do you have difficulty in swallowing? ___ Yes ___ No**

If yes, Details? _____

*** Does food or fluid reflux into the mouth? ___Yes ___ No**

If yes, Details? _____

*** Do you vomit with reflux? ___ Yes ___No**

If yes, Details? _____

*** Do you suffer from recurrent sore throats? ___Yes ___ No**

If yes, Details? _____

*** Do you suffer from a hoarse voice ? ___ Yes ___ No**

If yes, Details? _____

*** Do you suffer from a regular cough at night ? ___ Yes ___ No**

If yes, Details? _____

Please list any treatments you may use for reflux / heartburn or indigestion:

_____

OB/GYN:

Please specify pregnancies, births , abortions:

_____

I understand that full disclosure is necessary for my medical safety. I have filled out this medical history to the best of my knowledge, and I have answered these questions with complete honesty to ensure my health and safety.

_____

Patient's Full Name **Signature Date**