BROWN SURGICAL ASSOCIATES
BROWN PHYSICIANS, INC.

BARIATRIC SURGERY PATIENT QUESTIONNAIRE

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Last Name:	First Name:	Sex:	PROVIDER NOTES
Height: Weight:	Birthdate:	Age:	

Phone number:

From what age have you been at your current weight: _____________

How long have you been obese? ______________

Please list your weight for the past five years ______, ______, ______, ______, ______

Weight at age: 12 _18 _____ 25 ______ 35______ 45 ______

Why do you think you have a weight problem?

Have you ever had bariatric surgery? If so, what type and when? Who was the surgeon/hospital? What was your preop weight and what was the lowest weight achieved after surgery? How many pounds have you regained?

Describe your reason for seeking a revision surgery or other bariatric procedure.

Have you ever started the process towards bariatric surgery here in the past? Or at another program? Why did you not have the bariatric surgery? Please describe. Also, list what tests you have done and where/when they took place.

Reason for considering weight loss surgery/How does the extra weight impact your daily life?

What concerns do you have regarding bariatric surgery? If any, please describe:

List three (3) goals you would like to achieve after surgery:

1.

2.

3.

BROWN SURGICAL ASSOCIATES BARIATRIC HEALTH HISTORY QUESTIONNAIRE

Last Name:	**First Name:**	**DOB:**

Please list all attempts at weight loss below:			
Diet	Length of attempt	Weight lost	Weight regained

						PROVIDER NOTES
Have you seen a nutritionist? If Yes, who and when?				Y	N	
Have you participated in a medically supervised weight loss program? If Yes: please list the name, dates, and amount of weight lost:				Y	N	
Have you ever taken Fen-Phen? If Yes: If so, have you ever had a cardiac echocardiogram to evaluate for any cardiac side effects?				Y	N	
Have you told your family and/or close friends about surgery for weight loss? If Yes: how do they feel about you having surgery for weight loss?				Y	N	
Are you an emotional eater?	Y	N	**Would you be interested in behavioral therapy to help avoid postoperative weight regain?** If Yes: please indicate either: Before / after surgery / both	Y	N	
Do you worry about regaining weight after surgery or that you would go back to old eating habits?	Y	N				
Have you read literature about weight loss surgery?	Y	N	**Do you have someone to care for you after surgery?**	Y	N	
Do you eat alone?	Y	N	**Are you a binge eater?**	Y	N	
Do you eat until you are uncomfortable?	Y	N	**Do you force yourself to vomit after eating too much?**	Y	N	
Do you eat until you are full?	Y	N	**Do you wake to eat at night?**	Y	N	
Do you eat a lot of sweets?	Y	N				
Please list any quality of life issues that are affected by your weight:						
At what age did you actively start trying to lose weight?						
What types of foods do you eat mostly (i.e. carbohydrates, salt, sugar, etc.)?						
Describe a typical day's diet with food items and amounts: Breakfast						
Lunch						
Dinner						
Snacks						

BROWN SURGICAL ASSOCIATES BARIATRIC HEALTH HISTORY QUESTIONNAIRE

Last Name:	**First Name:**	**DOB:**

For the below medical history questions, if yes, please describe who the treating doctor is and what medication/s and/or specific treatments you have for the condition. **If yes, also list what testing you have had for the condition.**						**PROVIDER NOTES**
High blood pressure?	Y	N	**Migraine headaches?**	Y	N	
High cholesterol?	Y	N	**Glaucoma?**	Y	N	
Angina/chest pain? If Yes, Describe:	Y	N	**Epilepsy?** If Yes, when was your last seizure?	Y	N	
Heart attack? If so, when? When was your most recent stress test? Have you had a cardiac catheterization? Or cardiac stent? If so, when?	Y	N	**Dementia**	Y	N	
			Mental illness? (Depression, Anxiety or other) Please describe. Have you ever been diagnosed with Bipolar disorder? No Yes If Yes, describe any manic or depressive episodes.	Y	N	
Heart murmur? If yes, Describe:	Y	N	**Anemia?** If so, describe why. Have you ever had an iron infusion?	Y	N	
Tachycardia? Palpitations/Irregular heart rate?	Y	N	**Stroke? (CVA/TIA)** If yes, when:	Y	N	
Asthma?	Y	N	**Gallstones?**	Y	N	
Emphysema?	Y	N	**Diverticulitis?**	Y	N	
COPD?	V		**Atrial Fibrillation?**	Y	N	
Sleep apnea? If so, do you use a CPAP or BIPAP? What is your CPAP or BIPAP setting and where/when did you have the sleep study? Have you ever been hospitalized for your sleep apnea?	Y	N	**Uterine fibroids?**	Y	N	
			Endometriosis?	Y	N	
			Polycystic ovarian disease?	Y	N	
			Ulcers?	Y	N	
			ADD? Autism? Other Spectrum disorder?	Y	N	
Osteoporosis? Arthritis? If so, what type? (osteo or rheumatoid?)	Y	N	**GERD** (reflux or heart burn, Barrett's Esophagus?)	Y	N	
			Do you have trouble swallowing Food or Liquid?	Y	N	
Thyroid disease?	Y	N	**Tuberculosis?**	Y	N	
HIV?	Y	N	**Lymphoma?**	Y	N	
Von Willebrand's disease?	Y	N	**Hemophilia?**	Y	N	
Factor V Leiden disorder?	Y	N	**Multiple Sclerosis?**	Y	N	
Crohn's?	Y	N	**Colitis?**	Y	N	
Cirrhosis	Y	N	**Pancreatitis?**	Y	N	
Kidney disease/failure? If yes, are you on dialysis? If so, what days of the week do your go for dialysis?	Y	N	**Hepatitis?** If so, what type?	Y	N	
Blood clots? If yes, describe. Have you seen a hematologist to evaluate for an underlying blood clotting disorder? If yes, who?	Y	N	Pre-Diabetes?	Y	N	
			Diabetes: If yes, type I or II? Date of Diagnosis? What is your most recent A1C?	Y	N	
Cancer? Describe below:	Y	N	**Hernia?** If yes, describe.	Y	N	
Fibromyalgia?	Y	N	**Chronic pain issues?** If yes, describe.	Y		
Celiac disease?	Y	N	**IBS?**	Y	N	

Last Name:	**First Name:**	**DOB:**

Please indicate other known medical problems:			**PROVIDER NOTES**
How often do you have a bowel movement?			
Have you ever had any bleeding problems? If yes, describe.	Y	N	
Have you ever had a blood transfusion? If yes, describe why.	Y	N	
Have you have any problems with anesthesia? If yes, describe.	Y	N	
Do you have any metal implants? If yes, describe.	Y	N	

SURGICAL HISTORY: Please list operations that you have had:		
If you have ever had a hysterectomy? No Yes Please describe why. **Have you ever had an EGD or colonoscopy?** No Yes If yes, when and why? Who performed the procedure?	**Have you ever had emergency abdominal surgery, or abdominal surgery as an infant or child?** If so, describe. Name of operation Year	
Other Operation/Procedure:	**Year**	**Hospital/Physician:**

FAMILY HISTORY: Please indicate conditions such as heart disease, stroke, cancer, blood disorders:						
Is there a family history of:	Anesthesia Problems	Y	N	Blood clots/clotting disorders	Y	N
	Bleeding problems/disorders	Y	N	Gastric (stomach) or esophageal cancer	Y	N
	Pancreatic cancer	Y	N			

Other Family Conditions	**Relationship to you**	**Age when diagnosed**

SOCIAL HISTORY/PERSONAL HABITS/RISK FACTORS:
Have you had any major life changes in the past year?
Are you: ☐ married ☐ divorced ☐ single ☐ widowed
Who do you live with?
Who would you describe as your support system?

Last Name:	**First Name:**	**DOB:**

What language(s) do you speak?			What is your primary language?		
Do you think that you may need an interpreter for your office visits?					
Are you working? No Yes: if so describe what you study, what school you attend and what our future plans are:					
Are you a student? No Yes: If so, describe what you study, what school you attend and what your future plans are.					
Do you have children? No Yes: if so, list their ages:					
Are you considered "disabled"? No Yes: if so, describe:					
Do you exercise? No Yes					
Do you smoke?	No	Yes	How many packs/day?	What age began?	
Have you ever smoked?	No	Yes	Date stopped:		
Do you use: E-cigarettes?	No	Yes	Vaping? No	Yes: if so, does it contain nicotine?	No Yes
Do you drink alcohol?	No	Yes	Frequency?	Amount?	
What do you usually drink?					
Do you or have you had a problem with alcohol? No Yes					
Are you receiving or have your received treatment for an alcohol problem? No Yes					
Do you use drugs recreationally? No Yes					
Do you smoke marijuana?	No	Yes: If so, why?	Do you have a medical marijuana card?		
Are you or have you received treatment for recreational drugs? No Yes: Please explain					
Have you ever had a problem with opioid dependence (for example, Oxycontin, Oxycodone or Vicodin?) No Yes: If so, describe the instances/substances used and any treatment?					

PSYCHIATRIC HISTORY:		
Have you ever been physically abused?	N	Yes – When?
Have you ever been sexually abused?	N	Yes – When?
Have you seen a psychiatrist or counselor regarding this abuse?	N	Yes – When?
Are you currently under the care of a psychiatrist our counselor?	N	Yes
Have you been hospitalized for psychiatric disorders?	N	Yes
Have you taken medications for psychiatric disorders or depression?	N	Yes
Have you been in a chemical dependency treatment program?	N	Yes

OB/GYN HISTORY (WOMEN)		
Are you sexually active? No Yes	Do you use birth control? No	Yes: What type(s)?
When was your last menstrual period?	Was it regular? No Yes	How long did it last?
Have you ever been pregnant? No Yes: How many times?		
How many of these pregnancies were live births:	Miscarriages:	Abortions:
How many of these pregnancies were natural births:	C-section:	
Did you have difficulty getting pregnant? No Yes – Explain:		

Last Name:	**First Name:**	**DOB:**

ALLERGIES AND REACTION: Please list medication and reaction	
Do you have an allergy to LATEX? ☐ yes ☐ no	No known drug allergy ☐
Medication/Allergen	Reaction

MEDICATION: List all medication including: prescribed, over the counter, vitamins and supplements			
Drug Name	Dosage	Instructions (how often taken)	Date prescribed

OTHER MEDICATION HISTORY					
Do you take aspirin or Plavix?	Y	N	Do you take any blood thinning medications?	Y	N
Do you take ibuprofen or other anti-inflammatory medication frequently?	Y	N	Have you taken steroids in the past year?	Y	N

BROWN SURGICAL ASSOCIATES BARIATRIC HEALTH HISTORY QUESTIONNAIRE

Last Name:	First Name:	DOB:

REVIEW OF SYSTEMS: *Please indicate all that apply to you*

General symptoms	Y	N	Cardiovascular	Y	N	Hematologic/ Lymphatic	Y	N
Fevers			Chest pain/heaviness			Abnormal bleeding		
Sweats			Palpitations			Swollen glands		
Chills			Shortness of Breath			Spontaneous bleeding		
Weight loss			Edema			Easy Bruising		
Weight gain			Syncope (fainting)			Clotting problems		
Fatigue			Poor Circulation			Transfusion problems		
Lightheadedness			Dizziness			Anemia		
Loss of appetite			Angina (chest pain)			Blood clots		
			Shortness of breath with			Had any blood transfusions?		
Eyes	**Y**	**N**	Irregular heart rate			Neck pain		
Double vision (diplopia)						Groin pain		
Blurry Vision			**Gastrointestinal**	**Y**	**N**	Pain under arm		
Sensitivity to light (photophobia)			Abdominal pain					
Any vision changes			Nausea			**Endocrine**	**Y**	**N**
			Vomiting			Heat intolerance		
Ears, Nose, Mouth, Throat	**Y**	**N**	Vomiting blood (hematemesis)			Cold intolerance		
Hearing Loss			Constipation			Frequent urinating (polyuria)		
Ringing in the ear (tinnitus)			Diarrhea			Frequent water intake (polydipsia)		
Voice Changes			Hemorrhoids			Excessive thirst		
Sore throat			Rectal Bleeding			Change in menstrual cycle		
Painful/difficult swallowing			Heartburn			Excessive appetite		
Nose bleeds			Blood in Stool			Excessive hair growth		
Skin and Breast	**Y**	**N**	**Genitourinary**	**Y**	**N**	**Psychiatric**	**Y**	**N**
Rashes			Frequent/Urgency voiding			Depression		
Breast Cysts/Lumps			Pain with voiding (dysuria)			Anxiety		
New lesions/sores			Blood in urine (hematuria)			Hallucinations		
Breast pain			Incontinence			Suicidal ideation		
Nipple discharge			Flank pain					
Hives			Frequent nighttime voiding			**Neurologic**	**Y**	**N**
			Scrotal swelling			Headache/Migraine		
Respiratory	**Y**	**N**	Impotence			Numbness/Tingling		
Cough *(if yes check below)*			Groin pain			Paralysis/Paresis/Ataxia		
Check all that applies:			Discharge			Weakness		
___ Dry ___ Bloody						Syncope		
___ Green ___ White			**Musculoskeletal**	**Y**	**N**			
___ Other (describe)			Joint pain/swelling			Dizziness/vertigo		
Wheezing			Back pain/sciatica			Have you had any anesthesia		
Pleuritic chest pain w/breathing			Muscle aches					
Snoring			Stiffness					
Sleep apnea			Swelling			**Allergic/Immunologic**	**Y**	**N**
Pneumonia			Palpable mass left groin			Eczema		
Shortness of breath			Weakness of limbs			Hives		
			Have any metal implants?			Hay Fever		
						Asthma		

Signature: ______________________________ Date: ______________________