# Bariatric & Metabolic Interdisciplinary Clinic

Stanford Hospital and Clinics
Bariatric & Metabolic Interdisciplinary (BMI) Clinic
900 Blake Wilbur Drive, W0048, MC 5355, Palo Alto, CA 94304
New Patient Coordinator: (650) 736-5800, option 1 Fax: (650) 723-8378

## Patient Questionnaire

This questionnaire is required.

Please complete and return as soon as possible to allow us to schedule your appointment.

**Name:** _____ **DOB:** _____ **Age:** _____

**Address:** _____

**Phone: Home:** _____ **Cell:** _____ **Work:** _____

**E-Mail:** _____

**Referring physician and clinic:** _____

**Physician's address:** _____

**Physician's phone #:** _____ **Physician's Fax #:** _____

**Other physicians that care for you:** _____

_____

**How did you hear about us? (Internet, primary care physician, friend, etc.)** _____

_____

_____

## CONSIDERING WEIGHT LOSS SURGERY

How long have you been considering weight loss surgery? _____

What have been your main sources of information about weight loss surgery?

_____

Do you know other people that have had an operation for obesity? ❑ Yes ❑ No

Have those operations been successful? ❑ Yes ❑ No

Do you have family and friends supportive of your decision to undergo an operation to help you lose weight?

_____

What are your main reasons for considering an operation to help you lose weight?

_____

_____

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STANFORD, CALIFORNIA 94305



# DIET HISTORY

**List major diet programs that you have tried, including dates and amount of weight lost:**

| Diet program | Approx. date | Number of pounds lost |
|---|---|---|
| **1.** | | |
| **2.** | | |
| **3.** | | |
| **4.** | | |
| **5.** | | |
| **6.** | | |
| **7.** | | |

**Have you used any of the following to control your weight?**

Binging and purging ❑ Yes ❑ No

Binging followed by food restriction ❑ Yes ❑ No

Vomiting ❑ Yes ❑ No

Laxatives ❑ Yes ❑ No

Diuretics ❑ Yes ❑ No

# WEIGHT HISTORY

What was your lifetime maximum weight?_____ When? _____

Were you obese before puberty? ❑ Yes ❑ No

Current weight _____

Current height _____

**Please fill out a timeline of weight during your life as best as you can, include any important personal events (i.e. pregnancy, marriage, etc.):**

| Age | Maximum Weight | Important Events |
|---|---|---|
| **0-13** | | |
| **13-18** | | |
| **18-30** | | |
| **30-50** | | |
| **50+** | | |

# CURRENT HABITS

How many carbonated beverages do you drink a day? _____ ❑ Diet ❑ Regular

How many meals a day do you eat? _____

Do you snack? If yes, describe:_____ How often: _____

Do you eat in the middle of the night?_____

How many calories do you think you eat in a typical day? _____

How many times a week do you eat out in a restaurant? _____

How many times a week do you bring home take-out food? _____

How many glasses of water do you drink a day? _____

How many cups of coffee do you drink a day? _____ ❑ Decaffeinated ❑ Regular

Do you drink alcoholic beverages? If yes, describe weekly intake: _____

Who does the cooking in your household? _____

Who does the food shopping in your household? _____

## MEDICAL HISTORY

**Have you ever had any of the following medical problems? Please explain in the space below:**

### Neurological:

❑ Stroke_____Year:_____ Any residual now? _____

❑ Seizures or Epilepsy _____

❑ Migraine headaches _____

### Cardiac:

❑ Angina (Chest pain, pressure or tightness)_____

❑ Heart Attack (Myocardial Infarction) ❑ Previous cardiac surgery ❑ Stent

❑ Previous Angioplasty or Percutaneous Coronary Intervention (PCI) for coronary blockage

❑ Hypertension (High blood pressure) _____

❑ Number of high blood pressure medications taken daily _____

❑ High cholesterol ❑ Number of cholesterol meds taken daily_____

❑ High triglycerides ❑ Number of triglyceride meds taken daily_____

❑ Irregular heart rhythm ❑ Palpitations ❑ Rapid heart beat

❑ Congestive Heart Failure (Fluid in the lungs) _____

❑ Peripheral Edema (Swelling of the ankles or legs) _____

### Pulmonary:

❑ Asthma _____

❑ Sleep Apnea ❑ Use CPAP or BiPap mask ❑ Mask was prescribed, but cannot tolerate

❑ Other lung or breathing problems ❑ Severe COPD ❑ Tuberculosis

❑ Pulmonary Embolus (Blood clot to lung) ❑ Use oxygen at home

### Endocrine:

❑ Diabetes ❑ Oral medicine ❑ Insulin ❑ Diet controlled _____

❑ Thyroid problems _____

### Gastrointestinal / Liver:

❑ Gastroesophageal Reflux (GERD) or frequent heartburn ❑ on GERD meds daily

❑ Gallstones ❑ had gallbladder removed_____

❑ Hernia: ❑ Umbilical ❑ Groin ❑ Incisional ❑ Ventral/other type of hernia

❑ Hepatitis or liver problems Please list: _____



## Renal:

❑ Kidney or bladder problems ❑ Renal insufficiency ❑ on Dialysis treatments
❑ Stress Incontinence (Leak urine with coughing or laughing)

## Vascular:

❑ Blood Clot or Embolus Please state body location and date:_____
❑ Venous stasis in legs or poor circulation
❑ Abnormal bleeding or bruising
❑ Blood transfusion - list reason:_____ Year _____

## Musculoskeletal:

❑ Low back pain ❑ Neck pain ❑ Diagnosis?_____
❑ Arthritis or Degenerative Joint Disease ❑ Hips ❑ Knees ❑ Ankles ❑ Feet
❑ Activity is limited by pain ❑ Pain requires daily pain medication
❑ Use mobility device ❑ Cane ❑ Walker ❑ Wheel Chair
❑ Surgery for back pain or joint pain has been done or is planned
Area of body: _____ Year _____

## Functional Health Status in Performing Activities of Daily Living:

❑ Independent in caring for self - bathing, dressing, going to bathroom
❑ Partially dependent on others for:_____
❑ Totally dependent on others for help

## Psychiatric:

❑ Depression ❑ Treated with medications ❑ Treated with counseling
❑ Anxiety ❑ General ❑ Social ❑ Treated with medications ❑ Counseling
❑ Psychiatric illness ❑ Bipolar ❑ Major Depressive Disorder ❑ Other: _____
❑ History of: ❑ Physical Abuse or ❑ Sexual Abuse - When? _____
❑ Alcoholism: How much alcohol consumed daily?_____ If quit, date:_____
❑ Substance abuse / street drugs What type:_____ If quit, date:_____
❑ Suicide attempt

## Other Pertinent Health Issues:

❑ Cancer - year and treatment: _____
❑ Gout
❑ Rheumatic Fever
❑ Other - Specify: _____

## For Women:

| | | |
|---|---|---|
| Have you had problems with Anemia (low blood count)? | ❑ Yes | ❑ No |
| Do you have a family history of Osteoporosis? | ❑ Yes | ❑ No |
| Are you post-menopausal? | ❑ Yes | ❑ No |
| Are you pregnant? | ❑ Yes | ❑ No |
| Have you ever been pregnant? | ❑ Yes | ❑ No |

How many times have you been pregnant?_____
How many children do you have?_____

# SURGICAL HISTORY

**List all the previous operations you have had:**

| Operation | Year | Type of Anesthesia | Problems? |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

# HOSPITALIZATIONS

| List any hospitalizations you had for an illness or accident, not requiring surgery: | Year |
|---|---|
| 1. | |
| 2. | |
| 3. | |

# MEDICATIONS

**List all the medications you take, including those which do not require a prescription:**

| Medication name | Dosage/ Amount | Number of times taken daily |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |

**Have you taken Steroids (Prednisone or Cortisone) in past 6 months? ❑ Yes: _____ ❑ No**

# ALLERGIES

**List all medications/ medical products that cause an allergic or adverse reaction:**

| Medication/ Latex / Food / Betadine, etc. | Type of reaction |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |

# HABITS

**Have you ever smoked?**

- ❑ Never
- ❑ Yes, but I quit in _____(year), and smoked about _____ packs per day for ____ years
- ❑ Yes, I currently smoke _____ packs per day and have smoked for _____ years

**Do you drink alcoholic beverages now?**

- ❑ Yes, I drink more than 7 drinks per week
- ❑ Yes, I drink less than 7 drinks per week
- ❑ I used to drink, but I quit in _____ (year)
- ❑ No

Do you currently use recreational or illegal drugs now? ❑ Yes ❑ No

Type/Frequency: _____

I previously used drugs, but I quit in _____ (year)

# SOCIAL HISTORY

| |
|---|
| With whom do you live? |
| What is your occupation? |
| Do you work night shifts? |
| How many hours a day are you employed outside the home? |
| How many hours a day do you watch TV? |
| If you are disabled, it is because: |
| Could someone help care for you if you became seriously ill? |
| Are you the primary care giver for someone else (dependent children, parents, etc.)? |
| What hobbies are important to you? |
| |
| |

# EXERCISE

Do you exercise? If yes, describe_____

If not, what is the most strenuous physical activity that you do in a typical week?

_____

Which of the following activities can you do without stopping to rest?

- ❑ Walk to a building from a distant parking space
- ❑ Climb **one** flight of stairs
- ❑ Climb **two** flights of stairs
- ❑ None of the above

# FAMILY HISTORY

**Do any of your blood relatives have the following problems? Explain which relative and type of problem in the space provided.**

- ❑ Heart Disease_____
- ❑ Diabetes_____
- ❑ Lung Disease_____
- ❑ Stroke_____
- ❑ Kidney Disease_____
- ❑ Liver Disease_____
- ❑ Cancer_____
- ❑ Rheumatoid Arthritis_____
- ❑ Alcoholism_____
- ❑ Serious Mental illness_____
- ❑ Other illnesses that run in the family_____

**Have you or any of your blood relatives had a serious problem with anesthesia?**

- ❑ **Yes** **Please explain:**_____
- ❑ **No**

**List the approximate weights of all family members (normal and overweight):**

Maternal Grandmother_____ Paternal Grandmother_____

Maternal Grandfather _____ Paternal Grandfather_____

Mother_____ Sister(s)_____

Father_____ Brother(s)_____

Children_____

# REVIEW OF SYMPTOMS

**Do you <u>currently</u> have any of the following symptoms? If yes, please explain:**

**Yes No**

- ❑ ❑ Chest pain_____
- ❑ ❑ Blackouts or periods of dizziness_____
- ❑ ❑ Palpitations or irregular heart beats_____
- ❑ ❑ Swelling in the ankles_____
- ❑ ❑ Shortness of breath with activity_____
- ❑ ❑ Shortness of breath when walking up one flight of stairs_____
- ❑ ❑ Chronic cough or sputum (phlegm) production_____

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**CLINICS • BARIATRIC SURGERY**
**PATIENT QUESTIONNAIRE**



| Yes | No | |
|---|---|---|
| ❑ | ❑ | Excessive thirst |
| ❑ | ❑ | Blood in your phlegm |
| ❑ | ❑ | Black or tarry stools |
| ❑ | ❑ | Diarrhea |
| ❑ | ❑ | Frequent or new constipation |
| ❑ | ❑ | Temporary loss or blurring of vision |
| ❑ | ❑ | Teeth or gum problems |
| ❑ | ❑ | Temporary weakness of one or more limbs |
| ❑ | ❑ | Facial weakness or numbness |
| ❑ | ❑ | Burning with urination or frequent urination |
| ❑ | ❑ | Arthritis or severe joint pain |
| ❑ | ❑ | Back pain |
| ❑ | ❑ | Rash or other skin conditions |
| ❑ | ❑ | Excessive bleeding following minor cuts or dental surgery |
| ❑ | ❑ | Fever |
| ❑ | ❑ | Depression/Anxiety |
| ❑ | ❑ | Weight **gain** or **loss** greater than 10 pounds in the past 3 months (circle which one) |

Signature (Patient or Properly Designated Representative) _____ Print Name _____

Relationship to Patient _____ Date _____ Time _____

Thank you for completing this questionnaire.
This will help your doctor understand your health better.
**Please mail or fax the questionnaire back to this address:**

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*Instructions to Attending Physician:*
*Your signature below indicates that you have reviewed the information contained in the entire questionnaire and you have reviewed the pertinent or key finding(s) with the patient and/or family.*

*Key finding(s) must be summarized in your progress note; however, the questionnaire may be referenced for additional details.*

Attending Physician Signature: _____ Print Name: _____ Date: _____ Time: _____

Pager # _____