UR MEDICINE | HIGHLAND HOSPITAL

Bariatric Surgery Questionnaire

Name: _____ Date of Birth: _____ Phone: _____

Seminar ☐ Dr. O'Malley ☐ Dr. Johnson ☐ Dr. Sabbota ☐ Online

Attended Seminar Date: _____

This questionnaire must be completed and returned prior to scheduling your first appointment.

Email: *Send to WeightLossSurgery@urmc.rochester.edu. Please include the completed email consent form (last page of this document). The email consent form verifies that you acknowledge any risks associated with using an unsecure email.*

Mail: *Highland Hospital, Department of Surgery*
c/o Bariatric Questionnaire
1000 South Avenue, Box 95, Rochester, NY 14620

Fax: *585-341-0215*

Step 1: Medical History

Check any condition that applies to you

- ☐ Problems with Anesthesia
- ☐ Acid Reflux
- ☐ Angina
- ☐ Anxiety
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Bleeding
- ☐ Blood Clot
- ☐ Blood Transfusion
- ☐ Cardiomyopathy
- ☐ Carpal Tunnel
- ☐ Cirrhosis
- ☐ Clotting Disorder
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Depression
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Difficulty Swallowing
- ☐ Dizzy/Loss of Balance
- ☐ Fatigue
- ☐ Fibromyalgia
- ☐ Gallbladder Disorder
- ☐ GI Ulcer
- ☐ Gout
- ☐ Headaches
- ☐ Heart Attack
- ☐ Hearing Loss
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Insomnia
- ☐ Irritable Bowel Syndrome
- ☐ Liver Disease
- ☐ Low Blood Sugar
- ☐ Lupus
- ☐ Malignant Hyperthermia
- ☐ Metabolic Disorder
- ☐ Morbid Obesity
- ☐ Numbness/Tingling
- ☐ Osteoarthritis
- ☐ Peripheral Vascular Disease
- ☐ Polycystic Ovarian Syndrome
- ☐ Pseudotumor Cerebri
- ☐ Rash/Skin Problem
- ☐ Rheumatoid Arthritis
- ☐ Scleroderma
- ☐ Seizures
- ☐ Shortness of Breath/ on Exertion
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Leak Urine when Cough/Sneeze
- ☐ Stroke
- ☐ Supraventricular Tachycardia
- ☐ Swelling in Legs
- ☐ Varicose Veins
- ☐ Vision Problems
- ☐ Other _____

Step 2: Family History

Indicate any known family history

Anesthesia Problem
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Son
- ☐ Daughter
- ☐ Maternal Aunt
- ☐ Maternal Uncle
- ☐ Paternal Aunt
- ☐ Paternal Uncle
- ☐ Maternal Grandmother
- ☐ Maternal Grandfather
- ☐ Paternal Grandmother
- ☐ Paternal Grandfather
- ☐ No Family History

Arthritis
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Son
- ☐ Daughter
- ☐ Maternal Aunt
- ☐ Maternal Uncle
- ☐ Paternal Aunt
- ☐ Paternal Uncle
- ☐ Maternal Grandmother
- ☐ Maternal Grandfather
- ☐ Paternal Grandmother
- ☐ Paternal Grandfather
- ☐ No Family History

Asthma
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Son
- ☐ Daughter
- ☐ Maternal Aunt
- ☐ Maternal Uncle
- ☐ Paternal Aunt
- ☐ Paternal Uncle
- ☐ Maternal Grandmother
- ☐ Maternal Grandfather
- ☐ Paternal Grandmother
- ☐ Paternal Grandfather
- ☐ No Family History

Cancer
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Son
- ☐ Daughter
- ☐ Maternal Aunt
- ☐ Maternal Uncle
- ☐ Paternal Aunt
- ☐ Paternal Uncle
- ☐ Maternal Grandmother
- ☐ Maternal Grandfather
- ☐ Paternal Grandmother
- ☐ Paternal Grandfather
- ☐ No Family History

COPD
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Son
- ☐ Daughter
- ☐ Maternal Aunt
- ☐ Maternal Uncle
- ☐ Paternal Aunt
- ☐ Paternal Uncle
- ☐ Maternal Grandmother
- ☐ Maternal Grandfather
- ☐ Paternal Grandmother
- ☐ Paternal Grandfather
- ☐ No Family History

Depression
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Son
- ☐ Daughter
- ☐ Maternal Aunt
- ☐ Maternal Uncle
- ☐ Paternal Aunt
- ☐ Paternal Uncle
- ☐ Maternal Grandmother
- ☐ Maternal Grandfather
- ☐ Paternal Grandmother
- ☐ Paternal Grandfather
- ☐ No Family History

Diabetes Type 1
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Son
- ☐ Daughter
- ☐ Maternal Aunt
- ☐ Maternal Uncle
- ☐ Paternal Aunt
- ☐ Paternal Uncle
- ☐ Maternal Grandmother
- ☐ Maternal Grandfather
- ☐ Paternal Grandmother
- ☐ Paternal Grandfather
- ☐ No Family History

Diabetes Type 2
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Son
- ☐ Daughter
- ☐ Maternal Aunt
- ☐ Maternal Uncle
- ☐ Paternal Aunt
- ☐ Paternal Uncle
- ☐ Maternal Grandmother
- ☐ Maternal Grandfather
- ☐ Paternal Grandmother
- ☐ Paternal Grandfather
- ☐ No Family History

Early Death
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Son
- ☐ Daughter
- ☐ Maternal Aunt
- ☐ Maternal Uncle
- ☐ Paternal Aunt
- ☐ Paternal Uncle
- ☐ Maternal Grandmother
- ☐ Maternal Grandfather
- ☐ Paternal Grandmother
- ☐ Paternal Grandfather
- ☐ No Family History

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Heart Disease
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Son
- ☐ Daughter
- ☐ Maternal Aunt
- ☐ Maternal Uncle
- ☐ Paternal Aunt
- ☐ Paternal Uncle
- ☐ Maternal Grandmother
- ☐ Maternal Grandfather
- ☐ Paternal Grandmother
- ☐ Paternal Grandfather
- ☐ No Family History

High Blood Pressure
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Son
- ☐ Daughter
- ☐ Maternal Aunt
- ☐ Maternal Uncle
- ☐ Paternal Aunt
- ☐ Paternal Uncle
- ☐ Maternal Grandmother
- ☐ Maternal Grandfather
- ☐ Paternal Grandmother
- ☐ Paternal Grandfather
- ☐ No Family History

High Cholesterol
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Son
- ☐ Daughter
- ☐ Maternal Aunt
- ☐ Maternal Uncle
- ☐ Paternal Aunt
- ☐ Paternal Uncle
- ☐ Maternal Grandmother
- ☐ Maternal Grandfather
- ☐ Paternal Grandmother
- ☐ Paternal Grandfather
- ☐ No Family History

Kidney Disease
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Son
- ☐ Daughter
- ☐ Maternal Aunt
- ☐ Maternal Uncle
- ☐ Paternal Aunt
- ☐ Paternal Uncle
- ☐ Maternal Grandmother
- ☐ Maternal Grandfather
- ☐ Paternal Grandmother
- ☐ Paternal Grandfather
- ☐ No Family History

Mental Illness
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Son
- ☐ Daughter
- ☐ Maternal Aunt
- ☐ Maternal Uncle
- ☐ Paternal Aunt
- ☐ Paternal Uncle
- ☐ Maternal Grandmother
- ☐ Maternal Grandfather
- ☐ Paternal Grandmother
- ☐ Paternal Grandfather
- ☐ No Family History

Morbid Obesity
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Son
- ☐ Daughter
- ☐ Maternal Aunt
- ☐ Maternal Uncle
- ☐ Paternal Aunt
- ☐ Paternal Uncle
- ☐ Maternal Grandmother
- ☐ Maternal Grandfather
- ☐ Paternal Grandmother
- ☐ Paternal Grandfather
- ☐ No Family History

Obesity
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Son
- ☐ Daughter
- ☐ Maternal Aunt
- ☐ Maternal Uncle
- ☐ Paternal Aunt
- ☐ Paternal Uncle
- ☐ Maternal Grandmother
- ☐ Maternal Grandfather
- ☐ Paternal Grandmother
- ☐ Paternal Grandfather
- ☐ No Family History

Stroke
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Son
- ☐ Daughter
- ☐ Maternal Aunt
- ☐ Maternal Uncle
- ☐ Paternal Aunt
- ☐ Paternal Uncle
- ☐ Maternal Grandmother
- ☐ Maternal Grandfather
- ☐ Paternal Grandmother
- ☐ Paternal Grandfather
- ☐ No Family History

Other Conditions _____
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Son
- ☐ Daughter
- ☐ Maternal Aunt
- ☐ Maternal Uncle
- ☐ Paternal Aunt
- ☐ Paternal Uncle
- ☐ Maternal Grandmother
- ☐ Maternal Grandfather
- ☐ Paternal Grandmother
- ☐ Paternal Grandfather
- ☐ No Family History

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Step 3: Surgical History

Check any surgery that applies to you.

- ☐ Adenoidectomy
- ☐ Appendectomy
- ☐ Bariatric Surgery
  - ☐ Duodenal Switch
  - ☐ Gastric Bypass
  - ☐ Lap Band
  - ☐ Sleeve Gastrectomy
- ☐ Biliopancreatic Diversion
- ☐ Brain Surgery
- ☐ Breast Surgery
- ☐ Cardio Defibrillator
- ☐ Colon/Large Intestine Surgery
- ☐ Coronary Angioplasty
- ☐ C-Section
- ☐ Eye Surgery
- ☐ Fracture Surgery
- ☐ Gallbladder Removal
- ☐ Gastric Stimulator Implant
- ☐ Heart Bypass
- ☐ Heart Stents
- ☐ Heart Valve Replacement
- ☐ Hernia Repair
- ☐ Hysterectomy
- ☐ Intestinal Bypass
- ☐ Joint Replacement
- ☐ Pacemaker Insertion
- ☐ Plastic Surgery
- ☐ Small Intestine Surgery
- ☐ Spine Surgery
- ☐ Tonsillectomy
- ☐ Tubes Tied
- ☐ Vertical Banded Gastroplasty
- ☐ Other _____

Step 4: Social History

Do you drink alcohol? ☐ Yes ☐ No

If yes, how many per week?

Glasses of Wine _____

Cans of Beer _____

Shots of Liquor _____

Comments on alcohol use:

_____

Do you currently use illicit/street drugs? ☐ Yes ☐ No

If yes, how many times per week? Date Last Used: _____

Marijuana _____ Cocaine _____ Methamphetamines _____

Inhalants _____ IV _____ Other _____

Comments on drug use:

_____

Tobacco use:

- ☐ Current every day smoker
- ☐ Never a smoker
- ☐ Former smoker, quit date: _____
- ☐ Smokeless tobacco user:
  - ☐ Vape
  - ☐ Chew
  - ☐ Snuff

Comments on history with tobacco:

_____

Sexually Active? ☐ Yes ☐ No ☐ Not currently

Birth Control/Protection (check all that apply)

☐ Abstinence ☐ Implant ☐ IUD ☐ Patch ☐ Surgical

☐ Condom ☐ Injection ☐ Pill ☐ Post-menopausal ☐ None

☐ Other _____

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Step 5: Medications/Allergies

Please list below all medications you are currently taking. Ex. Lipitor, 10mg, one tablet daily at bedtime.

Name	Dose	Frequency

Vitamins (*Check those that you are currently taking; indicate dose and frequency*)

- ☐ Multi Vitamin _____
- ☐ Vitamin B complex _____
- ☐ Vitamin E_____
- ☐ Vitamin A _____
- ☐ Vitamin K _____
- ☐ Calcium w/ Vitamin D_____
- ☐ Vitamin A, D, E combo _____
- ☐ Vitamin D _____
- ☐ Calcium_____
- ☐ Vitamin C _____
- ☐ Iron_____
- ☐ Omega Fatty Acids_____
- ☐ Vitamin B-12_____
- ☐ Other_____

Allergies *Do you have allergies to any of the following?*

Allergy	Reaction(s)
☐ Medications:	
☐ Foods, type:	
☐ Latex	
☐ Iodine	
☐ IV Contrast	
☐ Adhesives, type: _____	
☐ No Known Allergies	

Step 6: Bariatric Sleep Assessment

On a scale of 0-3, how likely are you to doze off in these situations?

0= would never doze
1= slight chance of dozing
2= moderate chance of dozing
3= high chance of dozing

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (ex. in a movie theater or a meeting)	
As a passenger in a car for an hour or more	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (without alcohol consumption)	
In a car, while stopped for a few minutes in traffic (you're the driver)	

How frequently do you snore or have you been told you snore loud enough to disturb other's sleep?

- ☐ Never
- ☐ Rarely- less than once a week
- ☐ Occasionally- 1-3 times a week
- ☐ Frequently- More than 3 times a week
- ☐ Unsure

How often have you been told you pause or stop breathing while sleeping?

- ☐ Never
- ☐ Rarely- less than once a week
- ☐ Occasionally- 1-3 times a week
- ☐ Frequently- More than 3 times a week
- ☐ Unsure

Do you sleep during the day?

- ☐ Yes
- ☐ No

Do you sleep excessively?

- ☐ Yes
- ☐ No

Step 7: Weight Loss Medications *(Check all that you have taken)*

- ☐ Accutrim
- ☐ Amphetamines
- ☐ Anorex
- ☐ Belviq
- ☐ Byetta
- ☐ Contrave
- ☐ Dexatrim
- ☐ Didrex
- ☐ Fastin
- ☐ Fen-Phen
- ☐ Ionamin/Adipex
- ☐ Mezanor
- ☐ Meridia
- ☐ Obalan
- ☐ Phendiet
- ☐ Phentermine
- ☐ Phentrol
- ☐ Plegine
- ☐ Pondimin
- ☐ Prozac
- ☐ Qsymia
- ☐ Redux
- ☐ Sanorex
- ☐ Saxenda
- ☐ Tenuate
- ☐ Tepanol
- ☐ Wellbutrin
- ☐ Xenical
- ☐ Other_____

If you have taken Fen-Phen, what year and for how long did you use it? _____

Step 8: Weight Loss Diets *Only document your weight loss attempts in the past 5 years.*

Diet Program	Number of Months	How much weight did you lose?	Physician Supervised? Y/N	Year
Atkins				
Jenny Craig				
LA Weight Loss				
Nutri-System				
Weight Watchers				
South Beach				
Registered Dietitian				
Optifast/Medifast				
Calorie Controlled				
Other:				

Step 9: Morbid Obesity History

Have you been morbidly obese for greater than 5 years? ☐ Yes ☐ No

Have you been obese since childhood? ☐ Yes ☐ No

Have you been obese since pregnancy? ☐ Yes ☐ No

Step 10: Disability

Are you disabled? ☐ Yes ☐ No Years disabled: _____

Reason Disabled *(check all that apply)*

☐ Motor Vehicle Accident ☐ Work Related Injury

☐ Illness ☐ Other _____

Assistive Device *(check all that apply)*

☐ Cane ☐ Walker ☐ Wheelchair Years in wheelchair/ scooter: _____

☐ Crutches ☐ Sling ☐ Power Scooter

Step 11: Exercise Tolerance

Can you independently perform acts of daily living (ADLs)? ☐ Yes ☐ No

Do you perform any additional exercise? *(Check all that apply)*

☐ Walking/Treadmill ☐ Swimming

☐ Chair Exercise ☐ Stationary Cycling/Biking

☐ Other _____

How many times per week do you exercise? _____

How long, in minutes, do you exercise each week? _____

Functional Limits (Check all that apply)

☐ None (Can walk 200 ft. without assistance) ☐ Require assistance with ADLs

☐ Require wheelchair ☐ Can only perform ADLs

☐ Cane/Crutch ☐ Dependent for ADLs

☐ Bedridden ☐ Other _____

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PATIENT E-MAIL CONSENT FORM

(E-mail should be used only when a secure EMR messaging portal is not available)

Patient name: _____
Patient MR#: _____
Patient E-mail: _____
Provider: _____
Provider E-mail: _____
Personal Representative*:
Name: _____
Relationship: _____
E-Mail: _____
** see HIPAA Policy 0P16 Personal Representative*

1. RISK OF USING E-MAIL

Transmitting patient information by E-mail has a number of risks that patients should consider. These include, but are not limited to, the following:

a) E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b) E-mail senders can easily misaddress an E-mail.
c) Backup copies of E-mail may exist even after the sender or the recipient has deleted his or her copy.
d) Employers and on-line services have a right to inspect E-mail transmitted through their systems.
e) E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
f) E-mail can be used to introduce viruses into computer systems.

2. CONDITIONS FOR THE USE OF E-MAIL

The Provider cannot guarantee but will use reasonable means to maintain security and confidentiality of E-mail information sent and received. The Patient and Provider must consent to the following conditions:

a) E-mail is not appropriate for urgent or emergency situations. The Provider cannot guarantee that any particular E-mail will be read and responded to.
b) E-mail must be concise. The Patient should schedule an appointment if the issue is too complex or sensitive to discuss via E-mail.
c) E-mail communications between patient and provider will be filed in the Patient's permanent medical record.
d) The Patient's messages may also be delegated to another provider or staff member for response. Office staff may also receive and read or respond to patient messages.
e) The Provider will not forward patient-identifiable E-mails outside of the URMC healthcare system without the Patient's prior written consent, except as authorized or required by law.
f) The Patient should not use E-mail for communication regarding sensitive medical information.
g) It is the Patient's responsibility to follow up and/or schedule an appointment if warranted.
h) Recommended uses of patient-to-provider e-mail should be limited to:
   a. Appointment requests
   b. Prescription refills
   c. Requests for information
   d. Non-urgent health care questions
   e. Updates to information or exchange of non-critical information such as laboratory values, immunizations, etc.

3. INSTRUCTIONS

To communicate by E-mail, the Patient shall:

a) Avoid use of his/her employer's computer.
b) Put the Patient's name in the body of the E-mail.
c) Put the topic (e.g., medical question, billing question) in the subject line.
d) Inform the Provider of changes in the Patient's E-mail address.
e) Take precautions to preserve the confidentiality of E-mail.
f) Contact the Provider's office via conventional communication methods (phone, fax, etc.) if the patient does not receive a reply within a reasonable period of time.

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of E-mail between the Provider and me. I consent to the conditions and instructions outlined here, as well as any other instructions that the Provider may impose to communicate with me by E-mail. I agree to use only the pre-designated e-mail address specified above. Any questions I may have had were answered.

_____
Patient or Personal Representative Signature

Date _____

_____
Provider or Department Representative signature

Date _____