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 □ Fatigue □ Numbness/Tingling
□ Acid Reflux □ Fibromyalgia □ Osteoarthritis
□ Angina □ Gallbladder Disorder □ Peripheral Vascular Disease
□ Anxiety □ GI Ulcer □ Polycystic Ovarian Syndrome
□ Asthma □ Gout □ Pseudotumor Cerebri
□ Bipolar Disorder □ Headaches □ Rash/Skin Problem
□ Bleeding □ Heart Attack □ Rheumatoid Arthritis
□ Blood Clot □ Hearing Loss □ Scleroderma
□ Blood Transfusion □ High Blood Pressure □ Seizures
□ Cardiomyopathy □ High Cholesterol □ Shortness of Breath/ on Exertion
□ Carpal Tunnel □ Hyperthyroidism □ Sleep Apnea
□ Cirrhosis □ Hypothyroidism □ Snoring
□ Clotting Disorder □ Insomnia □ Leuk Urine when Cough/Sneeze
□ Congestive Heart Failure □ Irritable Bowel Syndrome □ Stroke
□ COPD □ Liver Disease □ Supraventricular Tachycardia
□ Depression □ Low Blood Sugar □ Swelling in Legs
□ Diabetes Type 1 □ Lupus □ Varicose Veins
□ Diabetes Type 2 □ Malignant Hyperthermia □ Vision Problems
□ Difficulty Swallowing □ Metabolic Disorder □ Other ____________________
**Step 2: 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 3: 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:
________________________________________________________________________

□ Yes  □ No  □ Not currently

**Sexually Active?**

Birth Control/Protection (check all that apply)

- □ Abstinence
- □ Implant
- □ IUD
- □ Patch
- □ Surgical
- □ Condom
- □ Injection
- □ Pill
- □ Post-menopausal
- □ None
- □ Other ______________
**Step 4: Medications/Allergies**

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Frequency</th>
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</thead>
<tbody>
<tr>
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</table>

**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?*

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Reaction(s)</th>
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<tbody>
<tr>
<td>Medications:</td>
<td></td>
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<tr>
<td>Foods, type:</td>
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<tr>
<td>Latex</td>
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<tr>
<td>Iodine</td>
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<td>IV Contrast</td>
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<tr>
<td>Adhesives, type:</td>
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<tr>
<td>No Known Allergies</td>
<td></td>
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</tbody>
</table>

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Step 5: 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

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

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

- Accutrim
- Amphetamines
- Anorex
- Belviq
- Byetta
- Contrave
- Dexatrim
- Didrex
- Dexatrim
- Phendiet
- Sanorex
- Didrex
- Phentrol
- Saxenda
- Fastin
- Fen-Phen
- Ionamine/Adipex
- Mezanaor
- Meridia
- Obalan
- Phendiet
- Phentrol
- Fen
- Phen
- Plegine
- Pondimin
- Prozac
- Qsymia
- Redux
- Sanorex
- Saxenda
- Phentermine
- Tenulate
- Teplanole
- Welchless
- Welbutrin
- Xenical
- Other__________

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

Step 7: Weight Loss Diets *Only document your weight loss attempts in the past 5 years.*

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

Step 8: 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 9: 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 10: 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/Crutche  □ Dependent for ADLs
□ Bedridden  □ Other ______________________
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 ________________________________