Banner Health

BARIATRIC CLINIC NEW PATIENT QUESTIONNAIRE

Patient Name: _____ Date: _____

Please answer the following questions so that we can better meet your needs.

DEMOGRAPHICS

Referring Physician: _____ Phone: _____

Practice Name: _____

Address: _____

Primary Care Physician: _____ Phone: _____

Practice Name: _____

Address: _____

Social Security #: _____ Date of Birth *(mm/dd/yyyy):* _____

What is your current: Height *(feet, inches):* _____ Weight *(lbs.):* _____ BMI: _____ (office use)

Duration of Obesity: years: _____ Maximum Weight: _____ lbs. Age: _____ years

Have you had any prior Gastric Surgery (e.g. gastric bypass)? *(check one)* YES NO

If "YES" 1) What was the procedure? _____

2) When was the procedure performed? _____

PERSONAL / SOCIAL HISTORY

Occupation: _____

Tobacco Use: YES NO *If "yes", specify frequency* _____

E-Cigarettes: YES NO *If "yes", does it contain Nicotine?* _____

Alcohol Use: YES NO *If "yes", specify frequency* _____

Marital Status: *(married/single):* _____ Number of Children: _____

Children Overweight: YES NO Family Support for Weight Loss: YES NO

EXERCISE HISTORY

	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
Average total hours per week of exercise:	_____	_____	_____	_____	_____	_____	_____	_____

Exercise preferences *(e.g., walking, running, tennis, swimming):* _____

Barriers to exercise *(e.g., time, pain, fatigue, lack of interest):* _____

DIET HISTORY

Eating habits: *(Please fill in your typical dietary intake (all foods/beverages) in a 24-hour period):*

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____ *Beverages:* _____

Who guys the groceries? _____ How much do you spend a week on groceries? **$** _____

Do you read food ingredient and/or nutrition labels? YES NO

How many restaurant meals per week? _____

List Specific Food Cravings: _____

_____

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Emotional Eating: *(eating in response to stress/anxiety, anger…please specify):* _____

_____

_____

(Please check "YES" or "NO") YES NO

Binge-Eating Disorder:

- Eat more food than others in a 2-hour period
- Unable to stop eating or unable to control what or how much is eaten
- Eat rapidly
- Eat until stuffed
- Eat when NOT hungry
- Eat alone because embarrassed to eat amount in front of others
- Other (candy)
- Frequency (_____ days/week)

Compensatory Behavior:

- Purge
- Fast
- Laxatives
- Excessive exercise
- Other (lays down)

Prior Dieting Methods: *Duration & total weight loss (*Please check off and fill in all the dieting methods you have tried.)*

	Time on program *(months)*	**Weight lost** *(pounds)*	**Weight loss maintained** *(months)*
Self-directed			
Reducing portions			
Decreasing snacks			
Decrease sweets			
Exercise			
Diets			
Atkins			
Carbohydrates			
Cabbage Soup			
Other _____			
Group			
Weight Watchers			
Overeaters			
Jenny Craig			
Other _____			

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Prior Dieting Methods *(continued)*:

	Time on program *(months)*	Weight lost *(pounds)*	Weight loss maintained *(months)*
RX (Physician supervised medication)			
Meridia			
Xenical			
Phen-fen			
Other _____			
Surgery			
Stapling			
VBG			
Roux-N-Y			
Other _____			
Other			
SlimFast			
Other _____			
Other _____			

MEDICAL HISTORY

(Please check "YES" or "NO")	YES	NO	Duration or frequency of disease
Obesity-Related Diseases			
Type II Diabetes			
Hypertension			
Joint Pain ./ Disability Level			
Heart Disease			
Stroke			
Asthma (COPD)			
Sleep Apnea (Dx. By MD) (CPAP/BiPAP)			
GERD (heartburn)			
Elevated Cholesterol/Triglycerides			
Menstrual Irregularity			
Depression/Anxiety (Current Treatment)			
Past Medical History			
Thyroid Disease			
Glaucoma			

Surgery: _____

Surgery 1 _____ Date: _____

Surgery 2 _____ Date: _____

Surgery 3 _____

Surgery 4 _____

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Family History

Obesity _____

Hypertension _____

Type II Diabetes _____

Coronary Artery Disease _____

Other: _____ _____

ALLERGIES

List any allergies and intolerances to **medications, food or the environment.**

Allergy:	**Reaction:**

MEDICATIONS

List any medications you are taking, with dose and how often. Use the back of form for additional medication.

Medication Name:	**Dose:**	**How often?**	**Reason for taking?**

List any Vitamins, Supplements and Over the Counter Medicines

1.	**4.**
2.	**5.**
3.	**6.**

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