

Regional Weight Management Questionnaire

Bariatric Surgery

Optifast/Optitrim

NAME _____ DATE OF BIRTH _____

ADDRESS _____

PHONE NUMBER _____ SS# _____

Insurance Company _____ Policy # _____

Group # _____ Subscriber's Name _____

E-MAIL ADDRESS _____

Weight _____ Height _____ BMI _____

Primary Physician: _____

Employer: _____

Full time Part time Self employed Student

Marital Status: Single Married Remarried Separated Widowed Divorced

How did you hear about our program: Newspaper Radio Family or Friend Physician Referral
 Intranet Other: _____

DIET HISTORY

How long have you been overweight? _____

What have you done to lose weight? _____

Have you tried diet pills? No Yes If yes, what kind? _____

Are you a yo-yo dieter? No Yes

Which diet programs apply to you?

- | | | |
|--|---|--|
| <input type="checkbox"/> Diet Medications | <input type="checkbox"/> Living Well Lady | <input type="checkbox"/> Optifast |
| <input type="checkbox"/> Air Force Diet | <input type="checkbox"/> Medifast | <input type="checkbox"/> Slimfast |
| <input type="checkbox"/> Jenny Craig | <input type="checkbox"/> Weight Watchers | <input type="checkbox"/> TOPS |
| <input type="checkbox"/> Low Calorie Diet | <input type="checkbox"/> Overeaters Anonymous | <input type="checkbox"/> Self Imposed Fast |
| <input type="checkbox"/> Subliminal Tapes | <input type="checkbox"/> Numerous Book Diets | <input type="checkbox"/> Metabolife |
| <input type="checkbox"/> Physician Supervised Diet | <input type="checkbox"/> Nutri-System | <input type="checkbox"/> Magazine Diets |
| <input type="checkbox"/> High Protein | <input type="checkbox"/> Mayo Clinic | <input type="checkbox"/> Liquid Protein |
| <input type="checkbox"/> Herbal Life | <input type="checkbox"/> Rader Institute | <input type="checkbox"/> Over-the-counter preparations |
| <input type="checkbox"/> Hypnosis | <input type="checkbox"/> Other _____ | |

DIET HISTORY (CONT.)

What was your most successful diet program? _____

How much weight did you lose with that program? _____

How quickly did you gain weight afterwards? _____

How many times per day do you eat? _____ times.

What are your favorite foods? _____

Are you a snacker? No Yes If yes, how many times daily? _____

What are your favorite snacks? _____

Do you eat a lot of sweets? No Yes If yes, how often? _____

Why do you think you failed with diet programs? _____

EATING BEHAVIORS

I eat when I am:

Stressed/anxious

Feeling angry

Feeling depressed

Feeling bored

Feeling good or celebrating

I eat out a lot

I tend to nibble

I regularly have second helpings

I rarely eat fruits and vegetables

I rarely steam, bake, broil or grill

I regularly eat desserts, especially sweets

ALCOHOL AND TOBACCO

Smoke

In the past? ___ How Much _____
Start _____ Stop _____

Recreational drugs

What? _____

How often? _____

Drink alcohol

How often? _____

Caffeine

What? _____

How often? _____

EXERCISE

Exercise programs you tried? _____

Do you exercise regularly? Yes No

Type of exercise _____

How often _____

What prevents you from exercising? _____

How many flights of stairs do you climb?

MEDICAL HISTORY (check all that apply):

Heart Disease

- | | |
|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chest Pain/ Heart Attack |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Irregular Heart Rhythm |
| <input type="checkbox"/> Bleed easily | <input type="checkbox"/> DVT (Blood Clots) |
| <input type="checkbox"/> Bruise easily | |
-

Pulmonary

- | | |
|--|---|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pulmonary Hypertension |
| <input type="checkbox"/> Hypoventilation | <input type="checkbox"/> Pulmonary Emboli |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Chronic Cough |
-

Peripheral Vascular Disease

- | | |
|---|--|
| <input type="checkbox"/> Stroke or TIA | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Lower Extremity edema | <input type="checkbox"/> Calf tenderness |
| <input type="checkbox"/> Cramps in legs: <input type="checkbox"/> Walking <input type="checkbox"/> at night | |
-

Sleep

- | | | |
|---|----------------------|-----------------------------------|
| <input type="checkbox"/> Sleep Apnea | Year Diagnosed _____ | |
| <input type="checkbox"/> Daytime drowsiness | | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Waking up short of breath at night | | <input type="checkbox"/> Insomnia |
-

Gastrointestinal

- | | |
|---|--|
| <input type="checkbox"/> Persistent Nausea/Vomiting | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Milk Intolerance | <input type="checkbox"/> Diarrhea/ Constipation |
| <input type="checkbox"/> GERD | <input type="checkbox"/> Reflux Disease |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Gallbladder disease or stones |
| <input type="checkbox"/> Colonoscopy Year: _____ | <input type="checkbox"/> Stomach Ulcers |
-

Endocrine

- | | |
|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> GOUT |
| <input type="checkbox"/> High cholesterol/triglycerides | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Heat/cold intolerance | <input type="checkbox"/> Unusual or excess hair growth or loss |

MEDICAL HISTORY (cont.)

Musculoskeletal

- | | |
|---|---|
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> General muscle pain/Fibromyalgia |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Neck/ Back pain |
| <input type="checkbox"/> Ankle pain | <input type="checkbox"/> Hip/ knee pain |
| <input type="checkbox"/> Osteoarthritis | |
-

Neuro/Psychiatric

- | | |
|--|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> PTSD | <input type="checkbox"/> Psychiatric treatment |
| <input type="checkbox"/> Psychiatric Hospitalization | <input type="checkbox"/> Treated by: _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Seizures/convulsions | <input type="checkbox"/> Numbing/tingling |
-

Reproductive

- | | |
|--|---|
| <input type="checkbox"/> Polycystic ovarian syndrome | <input type="checkbox"/> menstrual irregularity |
| <input type="checkbox"/> Pap smear When: _____ | <input type="checkbox"/> Mammogram When: _____ |
-

Genitourinary

- | | |
|--|---|
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Releasing urine when: | Urinary problems: |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Frequent |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> Night time |
| <input type="checkbox"/> Jumping | <input type="checkbox"/> Urgency |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Infection |
-

LIST OTHER MAJOR ILLNESS (PAST AND PRESENT)

Illness	Date	Treatment	Outcome

Regional Weight Management

Personal Goals

We have found that setting goals is important to keep us on track and identify our commitment level. Please complete the five goals that you would like to accomplish with weight loss surgery. Make these goals specific, measurable, obtainable, realistic and tied to a one year deadline.

1. How does obesity currently affect your life? _____

2. What is your target weight? Why? _____

3. In comparison to your current dietary habits, what changes will you make with surgery? _____

4. People who plan for increased activity are more likely to continue with an exercise regime. Specifically set an activity goal that you feel would fit into your life? _____

5. What would you hope to achieve following weight loss surgery? _____

Periodically we can evaluate and adjust your goals throughout this first year.

“Shoot for the moon and you will be sure to land amongst the stars.”

Patient Signature

Date