DR GREEN
Bariatric Surgery

Bariatric Questionnaire

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The information you provide will help us to plan your treatment, please carefully fill out and sign the last page.

PERSONAL DETAILS

Desired hospital: .....

Desired medical procedure:

- ☐ Sleeve Gastrectomy
- ☐ Gastric Bypass
- ☐ Mini Gastric Bypass
- ☐ Revision Surgery
- ☐ Anti Reflux Surgery
- ☐ Gallblader Removal
- ☐ Sils Sleeve Gastrectomy
  Only candidates with a body mass index of 35 or less

First name: ..... **Last name:** .....

Address: .....

Postal code: ..... Telephone No.(Home): .....

Telephone No.(Business): ..... Mobile No.: .....

Your email address: .....

Date of birth: ..... Age.: ..... **Occupation:** .....

Language spoken:(Example: English) .....

Do you have a passport?: ☐ yes ☐ no

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PRIMARY HEALTHCARE PROVIDER

Name: .....

How long he/she has been treating you?: .....

Conditions treated: .....

Telephone: ..... Any other physician/s?: .....

Address: ..... Telephone: .....

CONTACT PERSONS

This information is often vital to us if we need to contact your family urgently. Occasionally people move or have new phone numbers and do not let us know.

1. NEXT OF KIN:

Name: ..... Relationship: .....

Address: ..... Telephone No.(Home): .....

Telephone No.(Business): ..... Emergency contact No.: .....

2. SOCIAL PROFILE

Civil status: ☐ Married ☐ Unmarried ☐ Divorced ☐ Partnership/relationship

Children / Ages: .....

WEIGHT HISTORY:

Please indicate your weight at the following stages of life. Please indicate whether you consider your weight was below average, average, above average or very heavy in the relevant boxes.

Birth Weight:

- ☐ Below average
- ☐ Average Weight
- ☐ Above Average
- ☐ Very Heavy

Weight at beginning school (10-12 yrs.):

- ☐ Below average
- ☐ Average Weight
- ☐ Above Average
- ☐ Very Heavy

Weight at end of hight school(15-18 yrs.):

- ☐ Below average
- ☐ Average Weight
- ☐ Above Average
- ☐ Very Heavy

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Weight at time of begin work (21 years):

- [ ] Below average
- [ ] Average Weight
- [ ] Above Average

Weight at time of marriage(if applicable):

- [ ] Below average
- [ ] Average Weight
- [ ] Above Average

Current body shape:

- [ ] Apple
- [ ] Pear
- [ ] Don't know
- [ ] Other

Current weight (lbs.):

Current height(ft/in):

Current BMI:

Waist circumference:

WEIGHT LOSS HISTORY

Please check the diet programs that apply to you and indicate de duration

- [ ] Weight watchers / Duration:
- [ ] Jenny Craig / Duration:
- [ ] Gloria Marshall / Duration:
- [ ] Appetite suppressants / Duration:
- [ ] Any other drug treatment / Duration:
- [ ] Others(Please indicate) / Duration:

Were there any particular events that lead to significan weight gain?

- [ ] Yes
- [ ] No

If yes, please explain:

FAMILY MEDICAL HISTORY

DIABETES:	[ ] Parent	[ ] Sibling/ Child	[ ] No family history	[ ] Don´t Know	Other:
HEART DISEASE:	[ ] Parent	[ ] Sibling/ Child	[ ] No family history	[ ] Don´t Know	Other:
HYPERTENSION:	[ ] Parent	[ ] Sibling/ Child	[ ] No family history	[ ] Don´t Know	Other:

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GOUT:	☐ Parent	☐ Sibling/ Child	☐ No family history	☐ Don´t Know	Other:
GALLSTONES:	☐ Parent	☐ Sibling/ Child	☐ No family history	☐ Don´t Know	Other:
OBESITY:	☐ Parent	☐ Sibling/ Child	☐ No family history	☐ Don´t Know	Other:
SNORING/ SLEEP APNEA:	☐ Parent	☐ Sibling/ Child	☐ No family history	☐ Don´t Know	Other:
ASTHMA:	☐ Parent	☐ Sibling/ Child	☐ No family history	☐ Don´t Know	Other:
ALLERGIES:	☐ Parent	☐ Sibling/ Child	☐ No family history	☐ Don´t Know	Other:
HAY FEVER:	☐ Parent	☐ Sibling/ Child	☐ No family history	☐ Don´t Know	Other:
DERMATITIS/ ECZEMA:	☐ Parent	☐ Sibling/ Child	☐ No family history	☐ Don´t Know	Other:
HIGHT CHOLESTEROL:	☐ Parent	☐ Sibling/ Child	☐ No family history	☐ Don´t Know	Other:
OSTEOPOROSIS:	☐ Parent	☐ Sibling/ Child	☐ No family history	☐ Don´t Know	Other:
HIP FRACTURES:	☐ Parent	☐ Sibling/ Child	☐ No family history	☐ Don´t Know	Other:

ANY DRUG/FOOD ALLEGIES?

☐ Yes ☐ No

If yes, list(include food, medication, dressings):

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ALCOHOL: ☐ Never ☐ Rarely ☐ Regularly How often?: How many standard glasses do you drink per day?: ☐

What do you drink?: ☐ Beer ☐ Wne ☐ Spirits

SMOKING: ☐ Yes ☐ No ☐ Never How often?: If yes, how many per day?: ☐

If no, have you smoked in the past?: ☐ Yes ☐ No When did you stop smoking?: If yes, how many years?: ☐

SURGICAL HISTORY

Please give details of any past operations (especially bariatric) or any other abdominal surgery.

SURGERY: Date: Reason:

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PERSONAL MEDICAL HISTORY

Have you ever suffered from any of the following health problems? Please check all that apply and provide details.

ILLNESS/ HEALTH PROBLEM	DETAILS
DIABETES	
DIABETES WHILE PREGNANT	
ASTHMA	

RESPIRATORY / BREATHING PROBLEMS

ARTHRITIS OR JOINT PAIN

BACK PAIN

KIDNEY OR URINARY DISORDER

NEUROLOGICAL

PSYCHOLOGICAL/ NERVOUS DISORDER

GALLSTONES

REFLUX OR HEARTBURN

GASTRIC OR DUODENAL ULCER

HEPATITIS OR LIVER DISEASE

HIGH BLOOD PRESSURE

HEART DISEASE

HIGH CHOLESTEROL

ANEMIA OR BLEEDING DISORDER

THROMBOSIS OR CLOTTING DISORDER

VARICOSE VEINS OR LEG SWELLING

ECZEMA OR SKIN CONDITION

HAYFEVER OR RHINITIS

OTHER

SLEEP HISTORY

How many hours sleep do you get at night?:

Is there anything else that keeps you awake at night?:

☐ Yes ☐ No

If yes, Details?:

SYMPTOMS OF APNEA

How often do you snore?:	Never	Rarely	Ocasionally	Frequently	Always
Do you wake during the night with a choking feeling?:	Never	Rarely	Ocasionally	Frequently	Always
How often would you sleep more than 8 hours in total in a 24 hour period?:	Never	Rarely	Ocasionally	Frequently	Always
Do you feel sleepy during the day?:	Never	Rarely	Ocasionally	Frequently	Always
Has anyone noticed that you momentarily stop breathing during your sleep?:	Never	Rarely	Ocasionally	Frequently	Always
How often do you doze off or fall asleep while driving?:	Never	Rarely	Ocasionally	Frequently	Always

EMPLOYMENT

Are you currently employed?: Yes No

Current Employment:

Are you full-time, part-time or casual?:

If you are unemployed, what is the reason?:

Are you actively looking for work?: Yes No

Has your weight made it difficult to find employment?: Yes No

If employed, please state what level of activity your job involves: Little (sedentary job) Moderately active Very active (Labouring)

MEDICATIONS

Please indicate whether you are now or have previously taken any of the following medications. If yes, please state the name of the medication and how long you have been or were taking it.

NAME OF MEDICATION	DOSE	FREQUENCY	PURPOSE	WHEN USE STARTED

Does being at work ever make your chest tight or wheezy?:

☐ Never ☐ Current ☐ In the past ☐ Don´t know

If yes, Details?:

GASTRO ESOPHAGEAL REFLUX / INDIGESTION

Do you have a history of heartburn or indigestion?:

☐ Yes ☐ No

If yes, how often do you have reflux during the day?:

☐ Many times a day ☐ Everyday ☐ Most day ☐ Most weeks ☐ Occassionally

Do you suffer heart burn / indigestion during the night?:

☐ Yes ☐ No

If yes, how often?:

☐ Many times a day ☐ Everyday ☐ Most day ☐ Most weeks ☐ Occassionally

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Do you have difficulty swallowing?: ☐ Yes ☐ No

If yes, Details?:

What aggravates or causes your reflux?:

Does food or fluid reflux into the mouth?: ☐ Yes ☐ No

If yes, Details?:

Do you vomit with reflux?: ☐ Yes ☐ No

If yes, Details?:

Do you suffer from recurrent sore throats?: ☐ Yes ☐ No

If yes, Details?:

Do you suffer from a hoarse voice?: ☐ Yes ☐ No

If yes, Details?:

Do you suffer from a regular cough at night?: ☐ Yes ☐ No

If yes, Details?:

Please list any treatments you may use for reflux / heartburn or indigestion:

OB/GYN

Please, specify pregnancies, births, abortions:

I understand that full disclosure is necesary for my medical safety. I have filled out this medical history to the best of my knowledge, and I have answered these questions with complete honesty to ensure my health and safety.

Patient's full name:

Signature date: