

The Bariatric Surgery Program of Ireland Army Community Hospital

Medical Questionnaire

Instructions: You were given this questionnaire during your Introductory Seminar to Bariatric Surgery. Please complete this questionnaire and return it at your appointment with the bariatric surgeon. Please note, that this must be completed prior to the appointment, and if you arrive at the appointment without the completed questionnaire, your appointment will be rescheduled.

LAST NAME _____ FIRST NAME _____ MI _____

SSN _____ AGE _____ DATE OF BIRTH _____

ADDRESS _____

HOME PHONE _____ CELL PHONE _____ OTHER _____

MARTIAL STATUS: M__ S__ D__ W__ OCCUPATION _____

HEIGHT _____ WEIGHT _____ GOAL WEIGHT _____ HOW LONG AT CURRENT WT? _____

ARE YOU A SMOKER? _____ IF YES, HOW MANY PER DAY? _____ HOW LONG? _____

DO YOU DRINK? _____ IF YES, HOW MUCH, AND HOW OFTEN? _____

RACE _____ ARE YOU ACTIVE DUTY? _____ RESERVES? _____

RETIRED? _____ SPOUSE/ OR DEPENDENT? _____

SPONSOR'S LAST NAME _____ FIRST NAME _____ MI _____

RANK: _____ SSN _____ UNIT _____

DUTY PHONE NUMBER _____ CELL PHONE _____

PCS DATE _____ ETS DATE _____

IS SPONSOR ACTIVE DUTY? _____ RESERVES? _____ RETIRED? _____

PLEASE NOTE: You are required to submit a copy of the current PCS or ETS date. Bariatric Surgery patients must be at Fort Knox, KY for a minimum of six (6) months after surgery. Please remember there is no EFMP for bariatric surgery.

PRIMARY HEATHCARE PROVIDER INFORMATION

PHYSICANS NAME _____ CLINIC ASSIGNED TO _____

HOW LONG HAS HE/SHE BEEN YOUR PCM? _____

DATE OF LAST PHYSICAL EXAMINATION? _____

CONDITIONS TREATED _____

PLEASE NOTE: All patients must have a Primary Care Manager

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ARE YOU ALLERGIC TO ANY MEDICATIONS? PLEASE LIST MEDICATIONS AND REACTION: _____

DO YOU HAVE A LATEX ALLERGY? YES _____ NO _____

*IF YES, HAS THIS BEEN CONFIRMED BY AN ALLERGIST? YES _____ NO _____

LIST ANY MAJOR ILLNESSES

ILLNESS	DATE	TREATMENT	HAS THIS RESOLVED?

LIST ANY SURGERIES

SURGERY	DATE	WHERE? NAME OF FACILITY

FAMILY HISTORY

MOTHER, FATHER, SIBLINGS	AGE NOW OR AT TIME OF DEATH	CAUSE OF DEATH	WEIGHT: THIN, NORMAL, SLIGHTLY OVERWEIGHT, OBESE	HEALTH PROBLEMS, PLEASE EXPLAIN

What other family members are obese? _____

What other family members have had bariatric surgery? _____

Cancer, what type? _____

Diabetes? _____

Heart attack? _____ High Blood Pressure? _____

Stroke? _____ Arthritis? _____

FERTILITY OR GYNECOLOGIC PROBLEMS

Have you been treated for infertility? Yes _____ No _____ if yes, by whom? _____

Do you have a OB/GYN physician? Yes _____ No _____ if yes, who? _____

Date of most recent exam _____ Date of most recent Mammogram _____

Have you ever had an abnormal pap smear? Yes _____ No _____ if yes, did you complete your follow-up care?
Yes _____ No _____ if yes, with whom and when? _____

Date of last menstrual cycle _____ Current birth control method _____

Are you postmenopausal? Yes _____ No _____ if yes, do you take any type of hormone replacement therapy?

Yes _____ No _____ if yes, what type? _____

Please be advised that pregnancy needs to be avoided for 18 months after bariatric surgery, and it is recommended that female patients with child bearing abilities utilize two (2) forms of birth control after surgery for at least 18 months.

URINARY PROBLEMS

Do you ever involuntarily lose your urine? Yes _____ No _____

What causes you to lose your urine? Coughing _____ Jumping _____ Sneezing _____ Walking _____

Bending Forward _____ Other _____

PSYCHIATRIC HISTORY

Psychiatric treatment? Yes _____ No _____ if yes, by whom? _____

When were you treated? _____

Are you still under treatment? _____

HEARTBURN AND/ OR INDIGESTION

Do you have indigestion or heartburn? Yes _____ No _____ if yes, for how long? _____

Have you ever had an endoscopy? Yes _____ No _____ if yes, date of procedure _____

Have you had a colonoscopy? Yes _____ No _____ if yes, date of procedure _____

Do you ever have any type of pain in your abdomen? Yes _____ No _____ if yes, how long? _____

Type of pain? (dull, sharp, etc) _____

When does the pain begin? (before, during, after eating?) _____

How long does the pain last? _____

Any change in bowel movements? Yes _____ No _____ if yes, please describe _____

Any bloody stools? Yes _____ No _____ if yes, how long? _____

Chronic diarrhea? Yes _____ No _____ if yes, how long? _____

Chronic constipation? Yes _____ No _____ if yes, how long? _____

BREATHING PROBLEMS

Have you ever been treated by a pulmonologist? Yes _____ No _____

If yes, please complete the following:

Name of Physician _____

Address _____

Phone number _____ Date of last visit _____

Do you experience shortness of breath with physical activity? Yes _____ No _____

How long have you been aware of this? Be specific _____

When walking up stairs, how many steps or flights can you climb before you notice shortness of breath? _____

Do you snore? Yes _____ No _____ Have you ever had a sleep study? Yes _____ No _____ if yes, when and where? _____

Have you been diagnosed with sleep apnea? Yes _____ No _____ if yes, when? _____

Do you use a CPAP or Bi-PAP machine? Yes _____ No _____ if yes, what type? _____

Do you ever stop breathing while you sleep? Yes _____ No _____ Do you feel rested when waking? Yes _____ No _____

Do you have asthma? Yes _____ No _____ Do you have chronic bronchitis? Yes _____ No _____

EPWORTH SLEEPINESS SCALE SCORING

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

Choose the most appropriate number for you in each situation below using the following scale:

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 public place (theatre or meeting)	
Lying down to rest in the afternoon	
As a passenger in a car for an hour without a break	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

Total Score _____

BONE OR JOINT PROBLEMS

Do you have any of the following? Please indicate:

LOCATION	SWELLING	PAIN	STIFFNESS	POPPING/ CRACKING
ANKLES				
KNEES				
HIPS				
BACK				
OTHER				

Have you ever been told you have degenerative changes or early changes in your joints? Yes _____ No _____

If yes, please explain _____

Have you ever been treated for joint or bone disease? Yes _____ No _____ if yes, please indicate type of treatment and when _____

REVIEW OF SYMPTOMS

	YES	NO	DETAILS/COMMENTS
HIGH BLOOD PRESSURE READINGS			
ELEVATED BLOOD SUGAR READINGS			
FREQUENT OR SEVERE FATIGUE			
FREQUENT OR SEVERE WEAKNESS			
FEVER, CHILLS, OR NIGHT SWEATS			
ANY HISTORY OF HEAD INJURY			
EYEGASSES OR CONTACTS			
NON-CORRECTABLE VISUAL PROBLEMS			
HEARING PROBLEMS			
EAR PAIN			
CHRONIC SINUS CONGESTION			
FREQUENT NOSE BLEEDS			
DENTAL PROBLEMS			
DENTURES			
WHEEZING			
COUGHING			

BREAST LUMPS, PAIN OR DISCHARGE			
HEART MURMUR			
HISTORY OF HIV INFECTION			
HISTORY OF LIVER PROBLEMS			
HISTORY OF HEPATITIS (STATE TYPE)			
USE OF BIRTH CONTROL			
INFERTILITY			
ANEMIA			
ANY HISTORY OF BLOOD TRANSFUSIONS			
BLEEDING TENDENCY			
CONVULSIONS OR SEIZURE DISORDER			
PARALYSIS			
NUMBNESS OR TINGLING			
DEPRESSION			
ANXIETY			
DRUG OR ALCOHOL USE			
CHRONIC SKIN RADH OR HIVES			
CHRONIC SKIN INFECTION OF LOWER LEGS			
CHRONIC SKIN INFECTION UNDER BREAST			
CHRONIC SKIN INFECTIONS UNDER ABDOMEN SKIN CREASE			
VARICOSE VEINS OF LEGS			
MIGRAINES			
LUPUS			
RHEUMOTIOD ARTHRITIS			
GOUT			
PENILE DISCHARGE OR SORES			
ERECTILE DYSFUNCTION			

Please list any other conditions not listed. Please be specific _____

BEHAVIOR HISTORY

Please mark each question in term of whether you have experienced this behavior in the past or present. Answer each question with a yes or no, and indicate relevant dates.

Have you ever...

1. Been treated for an emotional disorder (depression, anxiety) by a mental health professional or your personal physician? YES / NO DATE _____
2. Been prescribed medication for an emotional or nervous disorder? YES / NO DATE _____
3. Been hospitalized for an emotional disorder? YES / NO DATE _____
4. Had suicidal thoughts or a suicide attempt? YES / NO DATE _____
5. Been treated for an alcohol or substance abuse problem or attended a twelve step program such as AA, or been hospitalized for addiction issues ? YES / NO DATE _____
6. Suffered an eating disorder such as anorexia, bulimia or compulsive eating including the excessive use of laxatives or self-induced vomiting to control your weight? YES / NO DATE _____

- 7. Been placed on disability, or loss of job due to emotional disorder? YES / NO DATE _____
- 8. Been in an abusive relationship? YES / NO DATE _____
- 9. Experienced a significant emotional trauma or stressful event? YES / NO DATE _____

COMPREHENSIVE DIETARY HISTORY

Have you attended one of Ireland Army Community Hospital's 12 week Weight Loss Programs? YES / NO
 Which one? _____

MEDICALLY SUPERVISED DIET PROGRAMS. Please complete, and be as specific as possible.

PROGRAM	SUPERVISED BY:	WHEN, AND FOR HOW LONG	WEIGHT LOST, WEIGHT REGAINED

DIET MEDICATIONS PERSCRIBED IN THE PAST? IF SO, PLEASE LIST _____

SURGICAL WEIGHT LOSS

Have you ever had any type of weight loss surgery in the past? YES / NO If yes, please complete the following:

Surgeons Name _____ Telephone Number _____

Address _____

Date of Surgery _____ Type of surgery _____

Was the surgery done at a military facility? YES / NO if yes, which facility _____

NON-MEDICALLY SUPERVISED DIET PROGRAMS. Please complete, and be as specific as possible.

PROGRAM	WHEN, AND HOW LONG	WEIGHT LOSS	WEIGHT REGAINED

OVER THE COUNTER DIET MEDICATIONS USED IN THE PAST? PLEASE LIST _____

At what age did you first start dieting? _____

What was your greatest single weight loss, and how long did you sustain the weight loss? _____

How did you lose this weight? _____

How many times have you lost over 25 pounds? _____

How long have you been overweight? _____

How long have you been at your current weight? _____

Are you under the care of a physician for weight loss? _____

Physician _____ Telephone Number _____

Please list any other diet information we have not covered, but you feel we need to be aware of: _____

EXERCISE

Do you exercise? YES _____ NO _____

If yes, please complete the following:

How often do you exercise? _____

What type of exercise program are you currently on? _____

What physical activities do you find enjoyable? _____

What type of exercise program are you planning on after surgery? _____

Would you be interested in exercise counseling or working with Physical Therapy? YES _____ NO _____

Patient Signature / Date