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Colorectal, General & Weight Loss Surgery
Minimally Invasive Laparoscopic Surgery
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Weight Loss Surgery Questionnaire

Patient's name: ______________________________ Age: _____ Gender: male/ female (circle one)
Primary physician: _______________________ Referring physician: __________________________

History of present illness:
How long have you had problem with weight? ____
At high school graduation or at 18 years old, how much did you weight? ______________________
How much did you weight at 22 years old? ____
What was your age when you started to gain weight? ______________________________________
What was the cause of your weight gain? ____
What is the highest weight that you ever reached? _______________________________________
When did you reach this highest weight? ____

Please list all the diet plans and medications that you have tried and also the duration of each diet and medications: ____
____
____
____
Have you ever been on Fen-Phen or Redux? _____ If yes, when and for how long? ____________
What was the most weight you have been able to lose? _____________________________________
When and how did you loose this weight? ____

Please describe your typical meals (what do you eat every day?):
Breakfast:
Lunch:
Dinner:
Do you snack between your meals? ______________ How many snacks a day? ______________
What do you snack on? ____
Do you have a craving for sweets? _____ Do you like starchy foods (potatoes, pasta or rice)? _____
Do you eat fast food? ________If yes, what do you eat? __________________________________
How many times a week do you eat fast foods? ____
Do you drink soda? _____________ How many cans daily? _______________________________

What do you do for exercise? ____
How much exercise each day? _______________ How many times per week? ______________

How long have you been contemplating gastric bypass as a way to manage weight?
Have you researched information on weight loss surgery? ________________
Circle all that applied: a. researching on internet b. attending seminar c. reading brochure
d. talking to patients/ friends/ family members who had weight loss surgery

Medical history:

Please list past and current medical illnesses: ____

____

____

Do you have:

Obstructive sleep apnea?	□No	□Yes
Diabetes mellitus type II?	□No	□Yes
High blood pressure?	□No	□Yes
Heart disease?	□No	□Yes
Degenerative joint disease/osteoarthritis?	□No	□Yes
Gastroesophageal reflux disease/ heartburn?	□No	□Yes
High cholesterol problem?	□No	□Yes
Varicose veins?	□No	□Yes
Leg ulcer due to vein disease?	□No	□Yes
Polycystic Ovarian Syndrome?	□No	□Yes
Nonalcoholic steatohepatitis/fatty liver?	□No	□Yes
Pseudotumor cerebri?	□No	□Yes
Urinary incontinence?	□No	□Yes

Please list all surgeries you have had: ____

____

____

Hospitalization (reasons & dates):____

____

____

Medications:

Current medications and dosages: ____

____

____

Allergy to medications:

Please list name of medications and types of reaction: ______________________________

____

Family medical history:

Please list affected member and the medical illnesses/cancer: _________________________

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Habits:

Do you currently smoke cigarette? _____ If no, have you ever smoked cigarette? __________

When did you quit? ___________ How many do or did you smoke daily? __________

How many years have or did you smoked? ______________________________________

Do you drink alcoholic beverage? _____ How many drinks weekly and what type? _________

Have you used illicit drugs? ______ What type? _________ When did you use last? ______

Social history:

Marital status please circle one: single/married/divorced/widow(er)

How many children do you have? ______________________

What city/state do you live in?: ____________ Occupation: __________________

Do you have the following conditions:

Skin:
Rash? □No □Yes
Lump? □No □Yes
Unusual change of a mole? □No □Yes

Head and neck areas:
Visual problem besides needing glasses?□No □Yes
Nose infection? □No □Yes
Nose bleeding? □No □Yes
Sore throat? □No □Yes
Swelling/lump?
-in mouth or oral cavity? □No □Yes
-in neck area? □No □Yes

Cardiovascular/ heart-related:
Short of breath:
-at rest? □No □Yes
-with activity? □No □Yes
-lying flat? □No □Yes
Recent chest pain? □No □Yes
Past heart attack? □No □Yes
Congestive heart failure? □No □Yes
Heart valve disease? □No □Yes
Any leg or calf pain with walking? □No □Yes

Lung:
Breathing problem? □No □Yes
History of asthma? □No □Yes
Any lung disease caused by smoking? □No □Yes
Recurrent pneumonia? □No □Yes
Recurrent bronchitis? □No □Yes
Recent cough? □No □Yes
Coughing blood? □No □Yes
Sleep apnea? □No □Yes

Gastro-intestinal:
History of liver disease? □No □Yes
History of pancreatic disease? □No □Yes
Swallowing problem? □No □Yes
Heart burn? □No □Yes
Nausea/vomiting? □No □Yes
Blood in vomit? □No □Yes
Recent change in appetite? □No □Yes
Abdominal bloating? □No □Yes
Abdominal pain? □No □Yes
Diarrhea? □No □Yes
Constipation? □No □Yes
Recent change in bowel habit? □No □Yes
Blood in stool? □No □Yes

Genitalia/Urinary:
History kidney disease? □No □Yes
History of kidney stone? □No □Yes
Pain with urination? □No □Yes
Blood in urine? □No □Yes
Incomplete emptying of bladder? □No □Yes
Frequent urination? □No □Yes
Incontinence to urine? □No □Yes
Female: abnormal vaginal discharge? □No □Yes
Taking birth control pills? □No □Yes
Male: Testicle lump? □No □Yes

Hematological:
Deep venous thrombosis (clot in veins)?
□No □Yes
Pulmonary embolus (clot in lungs)? □No □Yes
Bleeding disorders? □No □Yes
History of blood transfusion? □No □Yes

Endocrine:
Diabetes? □No □Yes
Thyroid diseases? □No □Yes
High cholesterol or triglyceride? □No □Yes
Pituitary tumor? □No □Yes
Taking steroid? □No □Yes

Neurological:
History of stroke? □No □Yes
Nerve problem? □No □Yes

Musculo-skeletal:
Degenerative or osteoarthritis? □No □Yes
History of neck pain or problem? □No □Yes
History of back pain or problem? □No □Yes
Joint pain?
- shoulder □No □Yes
-hip □No □Yes
-knee □No □Yes
-ankle □No □Yes
Muscle lump or swelling? □No □Yes

Infections:
History of bacterial resistance infection? □No □Yes
History of sexually transmitted disease? □No □Yes
History of HIV/ AIDS? □No □Yes
Histoy of hepatitis B or C infection? □No □Yes

General:
Fever? □No □Yes
Night sweat? □No □Yes
Unexpected weight loss? □No □Yes
Unusually fatigue? □No □Yes

Psychological:
Depression? □No □Yes
Alcohol abuse or drug addiction? □No □Yes
Schizophrenia? □No □Yes

Please list any other symptoms not previuosly listed that you have significant concern with:

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