

Bariatric Surgery Questionnaire

Name: _____ Date of Birth: _____ Phone: _____

Attended Seminar Date: _____

This questionnaire must be completed and returned prior to scheduling your first appointment.

Email: Send to WeightLossSurgery@urmc.rochester.edu. Please include the completed email consent form (last page of this document). The email consent form verifies that you acknowledge any risks associated with using an unsecure email.

Mail: Highland Hospital, Department of Surgery
c/o Bariatric Questionnaire
1000 South Avenue, Box 95, Rochester, NY 14620

Fax: 585-341-0215

Step 1: Medical History

Check any condition that applies to you

- | | | |
|---|---|---|
| <input type="checkbox"/> Problems with Anesthesia | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Gallbladder Disorder | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> GI Ulcer | <input type="checkbox"/> Polycystic Ovarian Syndrome |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Pseudotumor Cerebri |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rash/Skin Problem |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Blood Clot | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Scleroderma |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Shortness of Breath/ on Exertion |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Leak Urine when Cough/Sneeze |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Supraventricular Tachycardia |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Low Blood Sugar | <input type="checkbox"/> Swelling in Legs |
| <input type="checkbox"/> Diabetes Type 1 | <input type="checkbox"/> Lupus | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Diabetes Type 2 | <input type="checkbox"/> Malignant Hyperthermia | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Metabolic Disorder | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dizzy/Loss of Balance | <input type="checkbox"/> Morbid Obesity | |

Step 2: Family History

Indicate any known family history

Anesthesia Problem

- Mother
- Father
- Brother
- Sister
- Son
- Daughter
- Maternal Aunt
- Maternal Uncle
- Paternal Aunt
- Paternal Uncle
- Maternal Grandmother
- Maternal Grandfather
- Paternal Grandmother
- Paternal Grandfather
- No Family History

Arthritis

- Mother
- Father
- Brother
- Sister
- Son
- Daughter
- Maternal Aunt
- Maternal Uncle
- Paternal Aunt
- Paternal Uncle
- Maternal Grandmother
- Maternal Grandfather
- Paternal Grandmother
- Paternal Grandfather
- No Family History

Asthma

- Mother
- Father
- Brother
- Sister
- Son
- Daughter
- Maternal Aunt
- Maternal Uncle
- Paternal Aunt
- Paternal Uncle
- Maternal Grandmother
- Maternal Grandfather
- Paternal Grandmother
- Paternal Grandfather
- No Family History

Cancer

- Mother
- Father
- Brother
- Sister
- Son
- Daughter
- Maternal Aunt
- Maternal Uncle
- Paternal Aunt
- Paternal Uncle
- Maternal Grandmother
- Maternal Grandfather
- Paternal Grandmother
- Paternal Grandfather
- No Family History

COPD

- Mother
- Father
- Brother
- Sister
- Son
- Daughter
- Maternal Aunt
- Maternal Uncle
- Paternal Aunt
- Paternal Uncle
- Maternal Grandmother
- Maternal Grandfather
- Paternal Grandmother
- Paternal Grandfather
- No Family History

Depression

- Mother
- Father
- Brother
- Sister
- Son
- Daughter
- Maternal Aunt
- Maternal Uncle
- Paternal Aunt
- Paternal Uncle
- Maternal Grandmother
- Maternal Grandfather
- Paternal Grandmother
- Paternal Grandfather
- No Family History

Diabetes Type 1

- Mother
- Father
- Brother
- Sister
- Son
- Daughter
- Maternal Aunt
- Maternal Uncle
- Paternal Aunt
- Paternal Uncle
- Maternal Grandmother
- Maternal Grandfather
- Paternal Grandmother
- Paternal Grandfather
- No Family History

Diabetes Type 2

- Mother
- Father
- Brother
- Sister
- Son
- Daughter
- Maternal Aunt
- Maternal Uncle
- Paternal Aunt
- Paternal Uncle
- Maternal Grandmother
- Maternal Grandfather
- Paternal Grandmother
- Paternal Grandfather
- No Family History

Early Death

- Mother
- Father
- Brother
- Sister
- Son
- Daughter
- Maternal Aunt
- Maternal Uncle
- Paternal Aunt
- Paternal Uncle
- Maternal Grandmother
- Maternal Grandfather
- Paternal Grandmother
- Paternal Grandfather
- No Family History

Heart Disease

- Mother
- Father
- Brother
- Sister
- Son
- Daughter
- Maternal Aunt
- Maternal Uncle
- Paternal Aunt
- Paternal Uncle
- Maternal Grandmother
- Maternal Grandfather
- Paternal Grandmother
- Paternal Grandfather
- No Family History

High Blood Pressure

- Mother
- Father
- Brother
- Sister
- Son
- Daughter
- Maternal Aunt
- Maternal Uncle
- Paternal Aunt
- Paternal Uncle
- Maternal Grandmother
- Maternal Grandfather
- Paternal Grandmother
- Paternal Grandfather
- No Family History

High Cholesterol

- Mother
- Father
- Brother
- Sister
- Son
- Daughter
- Maternal Aunt
- Maternal Uncle
- Paternal Aunt
- Paternal Uncle
- Maternal Grandmother
- Maternal Grandfather
- Paternal Grandmother
- Paternal Grandfather
- No Family History

Kidney Disease

- Mother
- Father
- Brother
- Sister
- Son
- Daughter
- Maternal Aunt
- Maternal Uncle
- Paternal Aunt
- Paternal Uncle
- Maternal Grandmother
- Maternal Grandfather
- Paternal Grandmother
- Paternal Grandfather
- No Family History

Mental Illness

- Mother
- Father
- Brother
- Sister
- Son
- Daughter
- Maternal Aunt
- Maternal Uncle
- Paternal Aunt
- Paternal Uncle
- Maternal Grandmother
- Maternal Grandfather
- Paternal Grandmother
- Paternal Grandfather
- No Family History

Morbid Obesity

- Mother
- Father
- Brother
- Sister
- Son
- Daughter
- Maternal Aunt
- Maternal Uncle
- Paternal Aunt
- Paternal Uncle
- Maternal Grandmother
- Maternal Grandfather
- Paternal Grandmother
- Paternal Grandfather
- No Family History

Obesity

- Mother
- Father
- Brother
- Sister
- Son
- Daughter
- Maternal Aunt
- Maternal Uncle
- Paternal Aunt
- Paternal Uncle
- Maternal Grandmother
- Maternal Grandfather
- Paternal Grandmother
- Paternal Grandfather
- No Family History

Stroke

- Mother
- Father
- Brother
- Sister
- Son
- Daughter
- Maternal Aunt
- Maternal Uncle
- Paternal Aunt
- Paternal Uncle
- Maternal Grandmother
- Maternal Grandfather
- Paternal Grandmother
- Paternal Grandfather
- No Family History

Other Conditions _____

- Mother
- Father
- Brother
- Sister
- Son
- Daughter
- Maternal Aunt
- Maternal Uncle
- Paternal Aunt
- Paternal Uncle
- Maternal Grandmother
- Maternal Grandfather
- Paternal Grandmother
- Paternal Grandfather
- No Family History

Step 3: Surgical History

Check any surgery that applies to you.

- | | | |
|--|--|---|
| <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> Colon/Large Intestine Surgery | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Coronary Angioplasty | <input type="checkbox"/> Intestinal Bypass |
| <input type="checkbox"/> Bariatric Surgery | <input type="checkbox"/> C-Section | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Duodenal Switch | <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Pacemaker Insertion |
| <input type="checkbox"/> Gastric Bypass | <input type="checkbox"/> Fracture Surgery | <input type="checkbox"/> Plastic Surgery |
| <input type="checkbox"/> Lap Band | <input type="checkbox"/> Gallbladder Removal | <input type="checkbox"/> Small Intestine Surgery |
| <input type="checkbox"/> Sleeve Gastrectomy | <input type="checkbox"/> Gastric Stimulator Implant | <input type="checkbox"/> Spine Surgery |
| <input type="checkbox"/> Biliopancreatic Diversion | <input type="checkbox"/> Heart Bypass | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Brain Surgery | <input type="checkbox"/> Heart Stents | <input type="checkbox"/> Tubes Tied |
| <input type="checkbox"/> Breast Surgery | <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Vertical Banded Gastroplasty |
| <input type="checkbox"/> Cardio Defibrillator | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Other _____ |

Step 4: Social History

Do you drink alcohol? Yes No

If yes, how many per week?

Glasses of Wine _____

Cans of Beer _____

Shots of Liquor _____

Comments on alcohol use:

Do you currently use illicit/street drugs? Yes No

If yes, how many times per week?

Date Last Used: _____

Marijuana _____ Cocaine _____

Methamphetamines _____

Inhalants _____ IV _____

Other _____

Comments on drug use:

Tobacco use:

- | | |
|--|--|
| <input type="checkbox"/> Current every day smoker | <input type="checkbox"/> Smokeless tobacco user: |
| <input type="checkbox"/> Never a smoker | <input type="checkbox"/> Vape |
| <input type="checkbox"/> Former smoker, quit date: _____ | <input type="checkbox"/> Chew |
| | <input type="checkbox"/> Snuff |

Comments on history with tobacco:

Sexually Active? Yes No Not currently

Birth Control/Protection (check all that apply)

- | | | | | |
|--------------------------------------|------------------------------------|-------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Abstinence | <input type="checkbox"/> Implant | <input type="checkbox"/> IUD | <input type="checkbox"/> Patch | <input type="checkbox"/> Surgical |
| <input type="checkbox"/> Condom | <input type="checkbox"/> Injection | <input type="checkbox"/> Pill | <input type="checkbox"/> Post-menopausal | <input type="checkbox"/> None |
| <input type="checkbox"/> Other _____ | | | | |

Step 6: Bariatric Sleep Assessment

On a scale of 0-3, how likely are you to doze off in these situations?

- 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 a public place (ex. in a movie theater or a meeting)	
As a passenger in a car for an hour or more	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (without alcohol consumption)	
In a car, while stopped for a few minutes in traffic (you're the driver)	

How frequently do you snore or have you been told you snore loud enough to disturb other's sleep?

- Never
- Rarely- less than once a week
- Occasionally- 1-3 times a week
- Frequently- More than 3 times a week
- Unsure

How often have you been told you pause or stop breathing while sleeping?

- Never
- Rarely- less than once a week
- Occasionally- 1-3 times a week
- Frequently- More than 3 times a week
- Unsure

Do you sleep during the day?

- Yes
- No

Do you sleep excessively?

- Yes
- No

Step 7: Weight Loss Medications (Check all that you have taken)

- | | | | |
|---------------------------------------|---|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Accutrim | <input type="checkbox"/> Fastin | <input type="checkbox"/> Phentrol | <input type="checkbox"/> Tenuate |
| <input type="checkbox"/> Amphetamines | <input type="checkbox"/> Fen-Phen | <input type="checkbox"/> Plegine | <input type="checkbox"/> Tepanol |
| <input type="checkbox"/> Anorex | <input type="checkbox"/> Ionamin/Adipex | <input type="checkbox"/> Pondimin | <input type="checkbox"/> Wellbutrin |
| <input type="checkbox"/> Belviq | <input type="checkbox"/> Mezanor | <input type="checkbox"/> Prozac | <input type="checkbox"/> Xenical |
| <input type="checkbox"/> Byetta | <input type="checkbox"/> Meridia | <input type="checkbox"/> Qsymia | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Contrave | <input type="checkbox"/> Obalan | <input type="checkbox"/> Redux | |
| <input type="checkbox"/> Dexatrim | <input type="checkbox"/> Phendiet | <input type="checkbox"/> Sanorex | |
| <input type="checkbox"/> Didrex | <input type="checkbox"/> Phentermine | <input type="checkbox"/> Saxenda | |

If you have taken Fen-Phen, what year and for how long did you use it? _____

Step 8: Weight Loss Diets Only document your weight loss attempts in the past 5 years.

Diet Program	Number of Months	How much weight did you lose?	Physician Supervised? Y/N	Year
Atkins				
Jenny Craig				
LA Weight Loss				
Nutri-System				
Weight Watchers				
South Beach				
Registered Dietitian				
Optifast/Medifast				
Calorie Controlled				
Other:				

Step 9: Morbid Obesity History

- Have you been morbidly obese for greater than 5 years? Yes No
- Have you been obese since childhood? Yes No
- Have you been obese since pregnancy? Yes No

Step 10: DisabilityAre you disabled? Yes No

Years disabled: _____

Reason Disabled (*check all that apply*)

- | | |
|---|--|
| <input type="checkbox"/> Motor Vehicle Accident | <input type="checkbox"/> Work Related Injury |
| <input type="checkbox"/> Illness | <input type="checkbox"/> Other _____ |

Assistive Device (*check all that apply*)

- | | | | |
|-----------------------------------|---------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Cane | <input type="checkbox"/> Walker | <input type="checkbox"/> Wheelchair | Years in wheelchair/ scooter: _____ |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Sling | <input type="checkbox"/> Power Scooter | |

Step 11: Exercise ToleranceCan you independently perform acts of daily living (ADLs)? Yes NoDo you perform any additional exercise? (*Check all that apply*)

- | | |
|--|--|
| <input type="checkbox"/> Walking/Treadmill | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Chair Exercise | <input type="checkbox"/> Stationary Cycling/Biking |
| <input type="checkbox"/> Other _____ | |

How many times per week do you exercise? _____

How long, in minutes, do you exercise each week? _____

Functional Limits (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> None (Can walk 200 ft. without assistance) | <input type="checkbox"/> Require assistance with ADLs |
| <input type="checkbox"/> Require wheelchair | <input type="checkbox"/> Can only perform ADLs |
| <input type="checkbox"/> Cane/Crutch | <input type="checkbox"/> Dependent for ADLs |
| <input type="checkbox"/> Bedridden | <input type="checkbox"/> Other _____ |

PATIENT E-MAIL CONSENT FORM

(E-mail should be used only when a secure EMR messaging portal is not available)

Patient name: _____
 Patient MR#: _____
 Patient E-mail: _____
 Provider: _____
 Provider E-mail: _____
 Personal Representative*:
 Name: _____
 Relationship: _____
 E-Mail: _____

* see HIPAA Policy 0P16 Personal Representative

1. RISK OF USING E-MAIL

Transmitting patient information by E-mail has a number of risks that patients should consider. These include, but are not limited to, the following:

- a) E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- b) E-mail senders can easily misaddress an E-mail.
- c) Backup copies of E-mail may exist even after the sender or the recipient has deleted his or her copy.
- d) Employers and on-line services have a right to inspect E-mail transmitted through their systems.
- e) E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- f) E-mail can be used to introduce viruses into computer systems.

2. CONDITIONS FOR THE USE OF E-MAIL

The Provider cannot guarantee but will use reasonable means to maintain security and confidentiality of E-mail information sent and received. The Patient and Provider must consent to the following conditions:

- a) E-mail is not appropriate for urgent or emergency situations. The Provider cannot guarantee that any particular E-mail will be read and responded to.
- b) E-mail must be concise. The Patient should schedule an appointment if the issue is too complex or sensitive to discuss via E-mail.
- c) E-mail communications between patient and provider will be filed in the Patient's permanent medical record.
- d) The Patient's messages may also be delegated to another provider or staff member for response. Office staff may also receive and read or respond to patient messages.
- e) The Provider will not forward patient-identifiable E-mails outside of the URMHC healthcare system without the Patient's prior written consent, except as authorized or required by law.

- f) The Patient should not use E-mail for communication regarding sensitive medical information.
- g) It is the Patient's responsibility to follow up and/or schedule an appointment if warranted.
- h) Recommended uses of patient-to-provider e-mail should be limited to:
 - a. Appointment requests
 - b. Prescription refills
 - c. Requests for information
 - d. Non-urgent health care questions
 - e. Updates to information or exchange of non-critical information such as laboratory values, immunizations, etc.

3. INSTRUCTIONS

To communicate by E-mail, the Patient shall:

- a) Avoid use of his/her employer's computer.
- b) Put the Patient's name in the body of the E-mail.
- c) Put the topic (e.g., medical question, billing question) in the subject line.
- d) Inform the Provider of changes in the Patient's E-mail address.
- e) Take precautions to preserve the confidentiality of E-mail.
- f) Contact the Provider's office via conventional communication methods (phone, fax, etc.) if the patient does not receive a reply within a reasonable period of time.

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of E-mail between the Provider and me. I consent to the conditions and instructions outlined here, as well as any other instructions that the Provider may impose to communicate with me by E-mail. I agree to use only the pre-designated e-mail address specified above. Any questions I may have had were answered.

 Patient or Personal Representative Signature

Date _____

 Provider or Department Representative signature

Date _____

