**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_**



Division of Bariatric Surgery

**HEALTH ASSESSMENT QUESTIONNAIRE**

**Please circle the procedure type you are interested in: Gastric Bypass Sleeve Gastrectomy**

**What motivates you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Can you walk? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of your support person? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**When did you start battling with your weight? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If disabled, what is the reason for your disability? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***ALLERGIES (please include reaction you get when you take it)***

***CURRENT OVER THE COUNTER AND PRESCRIBED MEDS (please include how much and how often)***

***ENDOCRINE***

⁪ **Yes** ⁪ **No Hypothyroid** ⁪ **Yes** ⁪ **No Hyperthyroid**

⁪ **Yes** ⁪ **No Diabetes If Yes, when were you diagnosed?**

**If yes, is your diabetes controlled by diet?** ⁪ **Yes** ⁪ **No**

**If yes, do you take oral diabetic medication?** ⁪ **Yes** ⁪ **No**

**If yes, do you take insulin? ⁪ Yes ⁪ No**

***PULMONARY***

⁪ **Yes** ⁪ **No Asthma** ⁪ **Yes** ⁪ **No Shortness of Breath with Light Activity**

⁪ **Yes** ⁪ **No Emphysema** ⁪ **Yes** ⁪ **No Chronic Bronchitis**

⁪ **Yes** ⁪ **No Snore** ⁪ **Yes** ⁪ **No Sleep Apnea**

⁪ **Yes** ⁪ **No Use Oxygen at Home (If yes, how much? \_\_\_\_\_\_\_\_\_\_\_\_liters)**

⁪ **Yes** ⁪ **No Use CPAP as instructed**

⁪ **Yes** ⁪ **No Have trouble falling or staying asleep**

⁪ **Yes** ⁪ **No Wake up at night trying to catch your breath**

***CARDIOVASCULAR***

⁪ **Yes** ⁪ **No High Blood Pressure** ⁪ **Yes** ⁪ **No Chest Pain**

⁪ **Yes** ⁪ **No Congestive Heart Failure** ⁪ **Yes** ⁪ **No Heart Disease**

⁪ **Yes** ⁪ **No Irregular Heart Beat** ⁪ **Yes** ⁪ **No Edema**

⁪ **Yes** ⁪ **No Heart Murmurs** ⁪ **Yes** ⁪ **No Blood Clots**

⁪ **Yes** ⁪ **No Heart Attack** ⁪ **Yes** ⁪ **No Stroke**

⁪ **Yes** ⁪ **No High Cholesterol** ⁪ **Yes** ⁪ **No Hyperlipidemia**

⁪ **Yes** ⁪ **No Swelling of legs, feet, or ankles** ⁪ **Yes** ⁪ **No IVC filter**

***HEMATOLOGY***

⁪ **Yes** ⁪ **No Anemia** ⁪ **Yes** ⁪ **No Blood/Bleeding Disorder**

***GASTROINTESTINAL***

⁪ **Yes** ⁪ **No Difficulty Chewing/Swallowing** ⁪ **Yes** ⁪ **No Frequent Nausea**

⁪ **Yes** ⁪ **No Ulcers in the Stomach** ⁪ **Yes** ⁪ **No Frequent Vomiting**

⁪ **Yes** ⁪ **No Acid Reflux Disease (GERD)** ⁪ **Yes** ⁪ **No Hiatal Hernia**

⁪ **Yes** ⁪ **No Crohn’s Disease** ⁪ **Yes** ⁪ **No Irritable Bowel Syndrome**

⁪ **Yes** ⁪ **No Ulcerative Colitis** ⁪ **Yes** ⁪ **No Frequent Diarrhea**

⁪ **Yes** ⁪ **No Frequent Constipation** ⁪ **Yes** ⁪ **No Diverticulosis/Diverticulitis**

***GYNECOLOGICAL***

⁪ **Yes** ⁪ **No Infertility** ⁪ **Yes** ⁪ **No Have Regular Menstrual Cycle**

⁪ **Yes** ⁪ **No Use Birth Control** ⁪ **Yes** ⁪ **No Polycystic Ovarian Syndrome**

**Women ONLY: Number of Pregnancies**

**Number of Children Delivered**

**Number of Living Children**

***RHEUMOTOLOGY***

⁪ **Yes** ⁪ **No Chronic Fatigue Syndrome** ⁪ **Yes** ⁪ **No Chronic Pain Syndrome**

⁪ **Yes** ⁪ **No Autoimmune Disease** ⁪ **Yes** ⁪ **No Lupus**

⁪ **Yes** ⁪ **No Fibromyalgia** ⁪ **Yes** ⁪ **No HIV or AIDS**

⁪ **Yes** ⁪ **No Rheumatoid Arthritis** ⁪ **Yes** ⁪ **No Osteoarthritis**

⁪ **Yes** ⁪ **No Degenerative Disc Disease** ⁪ **Yes** ⁪ **No Back Pain**

⁪ **Yes** ⁪ **No Hip Pain (Which side? \_\_\_\_\_\_\_\_\_\_\_\_\_)**

⁪ **Yes** ⁪ **No Knee pain (Which side? \_\_\_\_\_\_\_\_\_\_\_\_\_)**

⁪ **Yes** ⁪ **No Ankle Pain (Which side? \_\_\_\_\_\_\_\_\_\_\_\_\_)**

***HEPATIC***

⁪ **Yes** ⁪ **No Liver Disease** ⁪ **Yes** ⁪ **No Cirrhosis**

⁪ **Yes** ⁪ **No Hepatitis**

***RENAL/URINARY***

⁪ **Yes** ⁪ **No Protein in Urine** ⁪ **Yes** ⁪ **No Kidney Disease**

⁪ **Yes** ⁪ **No Stress Incontinence** ⁪ **Yes** ⁪ **No Kidney Failure**

⁪ **Yes** ⁪ **No Ever Been on Dialysis (If current, what days? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)**

***PSYCHOLOGICAL***

⁪ **Yes** ⁪ **No Depression** ⁪ **Yes** ⁪ **No Anxiety Attacks**

⁪ **Yes** ⁪ **No Bipolar Disorder** ⁪ **Yes** ⁪ **No Suicidal Attempts (Last attempt \_\_\_\_\_\_\_)**

***SOCIAL HISTORY***

⁪ **Yes** ⁪ **No Consume ANY Nicotine Products (for ex. Cigarettes, snuff, e-cigs, ect.)? If yes, please go ahead and try to stop now. Please note you will be randomly tested during your evaluation period.**

⁪ **Yes** ⁪ **No Use ANY Street Drugs**

⁪ **Yes** ⁪ **No Former Smoker? If yes, when did you quit?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

⁪ **Yes** ⁪ **No Use Alcohol? If yes, how often and how much?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

⁪ **Yes** ⁪ **No Eat Sweets?**

***PAST SURGICAL HISTORY (Please Check and/or List…)***

⁪ **Yes** ⁪ **No Ever had problems with anesthesia?**

**Type of Surgery & Date Performed**

***CANCER HISTORY (Please List…)***

**Type of Cancer & Month and Year Diagnosed**

***FAMILY HISTORY***

**Father’s current age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or age at death:**

**Cause of death**

**Health problems**

**Mother’s present age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or age at death**

**Cause of death**

**Health problems**

**Names and ages of brother(s)/sister(s) and health problems. Please include**

**Stepbrother(s)/stepsister(s).**

***MY CURRENT DOCTORS (Please provide name and phone number)***

**Primary Care Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referring Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cardiologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pulmonologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Psychiatrist/Psychologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Gynecologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Nephrologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Orthopedist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Endocrinologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Gastroenterologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ANY Other Doctor: ­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**The information I have provided in this questionnaire is true to the best of my knowledge.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature Date**

*Revised 8/23/18 mlw*