

THE UNIVERSITY OF TEXAS  
**SOUTHWESTERN MEDICAL CENTER**  
 AT DALLAS

Ambulatory Services  
 Department of Surgery

**Bariatric Patient Questionnaire**

Pt. Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_ City State Zip  
 MRN: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 SSN: \_\_\_\_\_ SEX: \_\_\_\_\_  
 DOS: \_\_\_\_\_

Name: \_\_\_\_\_ Sex:  M  F Age: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone:(\_\_\_\_)\_\_\_\_\_ Work Phone: (\_\_\_\_)\_\_\_\_\_ Cell/Other:(\_\_\_\_)\_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Previous attempts at weight reduction:**

How many years have you been overweight? \_\_\_\_\_

**Diet programs and supplements:** (Please indicate which of the following diets or plans you have attempted)

Program	Dates	Duration	MD Supervised?	Weight Loss
<input type="radio"/> Weight Watchers	_____	_____	_____	_____
<input type="radio"/> Jenny Craig	_____	_____	_____	_____
<input type="radio"/> Metabolife	_____	_____	_____	_____
<input type="radio"/> Medifast	_____	_____	_____	_____
<input type="radio"/> Nutri/System	_____	_____	_____	_____
<input type="radio"/> Atkins Diet	_____	_____	_____	_____
<input type="radio"/> Herbalife	_____	_____	_____	_____
<input type="radio"/> SlimFast	_____	_____	_____	_____
<input type="radio"/> Grapefruit Diet	_____	_____	_____	_____
<input type="radio"/> Liquid Diets	_____	_____	_____	_____
<input type="radio"/> Pritikin Diet	_____	_____	_____	_____
<input type="radio"/> Optifast	_____	_____	_____	_____
<input type="radio"/> T.O.P.S.	_____	_____	_____	_____
<input type="radio"/> Other:	_____	_____	_____	_____

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List any other physician-supervised  
**Weight loss attempts:** \_\_\_\_\_

**Weight-Loss Medication History:** Please indicate if you have taken any of the following medications to lose weight.

Medication:	Dates	Duration	MD Supervised?	Weight Loss
<input type="radio"/> Amphetamines	_____	_____	_____	_____
<input type="radio"/> Phentermine (Adipex, Fastin, Pondimen)	_____	_____	_____	_____
<input type="radio"/> Phen-Fen	_____	_____	_____	_____
<input type="radio"/> Dexfenfluramine (Redux)	_____	_____	_____	_____
<input type="radio"/> Xenical (Orlistat)	_____	_____	_____	_____
<input type="radio"/> Meridia (Sibutramine)	_____	_____	_____	_____

**Other Diet Medications:** \_\_\_\_\_

**Non-Dietary Therapies:** Please indicate if you have tried any of the following weight loss therapies.

Therapy:	Dates	Duration	MD Supervised?	Weight Loss
<input type="radio"/> Exercise	_____	_____	_____	_____
<input type="radio"/> Hypnosis	_____	_____	_____	_____
<input type="radio"/> Behavior Modification	_____	_____	_____	_____
<input type="radio"/> Acupuncture	_____	_____	_____	_____

List any other weight loss  
**methods you have tried:** \_\_\_\_\_

**Previous Weight Loss Surgery:**  No  Yes

Surgery Type	Date	Surgeon	Wt. Loss
_____	_____	_____	_____

**Please bring a chronological diet history to your initial appointment**

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**Obesity Related Medical History:**

**Do you, or have you had, any of the following illnesses or symptoms?**

**Heart Disease**  No  Yes  
 If yes, year of diagnosis: \_\_\_\_\_  
 Do you have, or have you had:  
 Angina  
 M.I. (heart attack, myocardial infarction)  
 Coronary Bypass surgery  
 Coronary Angioplasty  
 Palpitations (abnormal heart beat)

**Congestive Heart Failure**  No  Yes  
 If yes, year of diagnosis: \_\_\_\_\_

**High Blood Pressure**  No  Yes  
 If yes, year of diagnosis: \_\_\_\_\_

**Elevated Cholesterol**  No  Yes  
 If yes, year of diagnosis: \_\_\_\_\_

**Elevated Triglycerides**  No  Yes

**Diabetes**  No  Yes  
 If yes, year of diagnosis: \_\_\_\_\_  
 Juvenile onset  
 Gestational (Pregnancy)  
 Adult onset  
 Diet Controlled  No  Yes  
 Oral Medications  No  Yes  
 Insulin  No  Yes

**Asthma**  No  Yes  
 If yes, year of diagnosis: \_\_\_\_\_

**Shortness of Breath**  No  Yes  
 If yes, can you: walk \_\_\_\_\_ blocks  
 climb \_\_\_\_\_ flights of stairs

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**Sleep Apnea**  No  Yes  
 If yes, do you use a CPAP or BiPAP machine?  No  Yes

**Sleep Difficulties:**

snoring	<input type="radio"/> No	<input type="radio"/> Yes
awakenings at night	<input type="radio"/> No	<input type="radio"/> Yes
daytime drowsiness	<input type="radio"/> No	<input type="radio"/> Yes
observed apnea spells	<input type="radio"/> No	<input type="radio"/> Yes
morning headaches	<input type="radio"/> No	<input type="radio"/> Yes

**Reflux/Heartburn/Esophagitis/Hiatal Hernia**  No  Yes  
 If yes, year of diagnosis: \_\_\_\_\_  
 Prescription medications:  No  Yes  
 Over the counter meds:  No  Yes  
 Frequency of use: \_\_\_\_\_  
 Endoscopy:  No  Yes

**Venous Stasis**  No  Yes  
 Leg or ankle swelling/edema  No  Yes  
 Leg ulceration  No  Yes  
 Leg skin color change or thickening  No  Yes

**Pain or Arthritis of Ankles/Knees/Hips**  No  Yes  
 Limits ability to walk or exercise  No  Yes  
 Prescription medications  No  Yes  
 Over the counter medications  No  Yes

**Low Back Pain / Sciatica**  No  Yes  
 Limits ability to walk or exercise  No  Yes  
 Prescription medications  No  Yes  
 Over the counter medications  No  Yes

**Urinary Incontinence (leakage of urine)**  No  Yes  
 With coughing/sneezing/straining  No  Yes  
 Number of times per week: \_\_\_\_\_

**Migraine Headaches**  No  Yes  
 Frequency: \_\_\_\_\_  
 Prescription medications  No  Yes  
 Over the counter medications  No  Yes

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**Deep Venous Thrombosis (Blood Clots in Legs)**  No  Yes

If yes, year of diagnosis: \_\_\_\_\_

- Pulmonary embolism  No  Yes
- Blood thinning medication  No  Yes

**Abominal Wall Hernia**  No  Yes

- Incisional  No  Yes
- Umbilical (belly button)  No  Yes

Number of hernia repairs and dates: \_\_\_\_\_

Hernia currently present  No  Yes

**Menstrual Irregularities**  No  Yes

Infertility  No  Yes  n/a

**Past Medical History:**

**Please list all other medical conditions or illnesses not previously mentioned:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please list all non-surgical hospitalizations you have experienced as an adult:**

Indication	Hospital	Date





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**Social History:**

**Marital Status:**  **Single**  **Married**  **Divorced**

**Children:**  **No**  **Yes** **Number:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_

**Do you smoke tobacco?**  **No**  **Yes**

If yes, number of packs per day: \_\_\_\_\_ Years of tobacco use: \_\_\_\_\_

**Do you use alcohol?**  **No**  **Yes** Amount and frequency: \_\_\_\_\_

**Have you ever been treated for depression?**  **No**  **Yes**

Are you currently in treatment?  **No**  **Yes**

If yes, please indicate the name of your physician or therapist:  
 \_\_\_\_\_

**Have you ever been hospitalized for mental illness?**  **No**  **Yes**

**System Review:** (Please mark any of the following you experience or have experienced in the past.)

**Constitutional:**  fatigue  tiredness  recent weight loss  
 fever  night sweats  abnormal bleeding

**Head and Neck:**  blurred vision  double vision  loss of vision  loss of hearing  
 dizziness  vertigo  sinus congestion  runny nose  
 sneezing  loss of smell  sinus infections  sore throat  
 difficulty swallowing  pain when swallowing  hoarseness  lump in neck

**Cardiovascular:**  chest pain  pain in arms or neck  heart attack  palpitations  
 heart pounding  abnormal heart beats  heart murmur  stroke  
 high blood pressure  low blood pressure  pain in legs  cold feet  
 loss of pulses

**Respiratory:**  shortness of breath  asthma  wheezing  cough  
 bloody sputum  emphysema  pneumonia  bronchitis  
 difficulty sleeping flat  waking at night short of breath

**Gastrointestinal:**  jaundice  hepatitis  cirrhosis  vomiting  
 nausea  heartburn  abdominal pain  diarrhea  
 constipation  pain with bowel movements  blood in stool  
 change in stool size  hemorrhoids  irritable bowel  colitis

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- Genitourinary:**  blood in urine  frequent urination  leakage of urine  pain with urine  
 trouble starting urine  kidney stones  kidney infection  bladder infection
- Men:**  discharge from penis  loss of erection
- Women:**  vaginal discharge  abnormal vaginal bleeding  irregular periods  
 pelvic examination/PAP smear with past year

- Musculoskeletal:**  pain in joints  muscular aches  swelling of joints  arthritis  
 pain in hips  pain in knees  pain in ankles  pain in feet  
 low back pain  sciatica  herniated disk  
 numbness in feet or legs  abnormal lumps or masses

- Endocrine:**  hyperthyroid  low thyroid  goiter  diabetes  
 previous radiation  adrenal gland tumor  swollen glands  
 previous steroid (corticosteroids, cortisone) use or injections

- Skin/Breast:**  skin cancer  abnormal moles  burns  rash  
 breast mass  nipple discharge  mammogram within the past year

- Neurological:**  seizures  convulsions  fainting  dizziness  
 light headedness  falling  muscle weakness  numbness  
 tremors  loss of consciousness  strokes

- Psychological:**  depression  nervousness  anxiety  
 suicidal thoughts  suicide attempts  hospitalization for emotional problems  
 psychiatric or psychological counseling  schizophrenia  
 anorexia  bulimia  binge eating

I am interested in the gastric  bypass  lap band  undecided

**Physician Attestation:** I have reviewed and verified the above information with:

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Bariatric Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**“PLEASE DO NOT RETURN BY FAX”**