

Medical Record Number

Patient Name

STANFORD HOSPITAL and CLINICS
STANFORD, CALIFORNIA 94305



CLINICS • BARIATRIC SURGERY
PATIENT QUESTIONNAIRE

Addressograph or Label - Patient Name, Medical Record Number

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Bariatric & Metabolic Interdisciplinary Clinic

Stanford Hospital and Clinics

Bariatric & Metabolic Interdisciplinary (BMI) Clinic

900 Blake Wilbur Drive, W0048, MC 5355, Palo Alto, CA 94304

New Patient Coordinator: (650) 736-5800, option 1 Fax: (650) 723-8378



Patient Questionnaire

This questionnaire is required and needs to be completed before an appointment can be made with the physician.

Name: _____ DOB: _____ Age: _____

Address: _____

Phone: Home: _____ Cell: _____ Work: _____

E-Mail: _____

Referring physician and clinic: _____

Physician's address: _____

Physician's phone #: _____ Physician's Fax #: _____

Other physicians that care for you: _____

How did you hear about us? (Internet, primary care physician, friend etc.) _____



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CONSIDERING WEIGHT LOSS SURGERY

How long have you been considering weight loss surgery? _____

What have been your main sources of information about weight loss surgery?

Do you know other people that have had an operation for obesity? Yes No

Have those operations been successful? Yes No

Do you have family and friends supportive of your decision to undergo an operation to help you lose weight? _____

What are your main reasons for considering an operation to help you lose weight?

DIET HISTORY

List major diet programs that you have tried, including dates and amount of weight lost:

Diet program	Approx. date	Number of pounds lost
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Have you used any of the following to control your weight?

Binging and purging Yes No

Binging followed by food restriction Yes No

Vomiting Yes No

Laxatives Yes No

Diuretics Yes No



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WEIGHT HISTORY

What was your lifetime maximum weight? _____ When? _____

Were you obese before puberty? Yes No Current weight _____

Current height _____

Please fill out a timeline of weight during your life as best as you can, include any important personal events (i.e. pregnancy, marriage, etc.):

Age	Maximum Weight	Important Events
0-13		
13-18		
18-30		
30-50		
50+		

CURRENT HABITS

How many carbonated beverages do you drink a day? _____ Diet Regular

How many meals a day do you eat? _____

Do you snack? If yes, describe: _____ How often: _____

Do you eat in the middle of the night? _____

How many calories do you think you eat a typical day? _____

How many times a week do you eat out in a restaurant? _____

How many times a week do you bring home take-out food? _____

How many glasses of water do you drink a day? _____

How many cups of coffee do you drink a day? _____ decaffeinated regular

Do you drink alcoholic beverages? If yes, describe weekly intake: _____

Who does the cooking in your household? _____

Who does the food shopping in your household? _____

You feel that you are overweight because (check all that apply):

- I eat normal amounts of food, but have an abnormal metabolism.
- I eat larger than normal amounts of normal foods.
- I eat larger than normal amounts of normal foods, as well as sweets and snacks.
- I tend to eat mostly sweets and high calorie foods.
- Other: _____



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MEDICAL HISTORY

Have you ever had any of the following medical problems? Please explain in the space below:

Neurological:

- Stroke _____ Year: _____ Any residual now? _____
- Seizures or Epilepsy _____
- Migraine Headaches _____

Cardiac:

- Angina (Chest Pain, Pressure or Tightness) _____
- Heart Attack (Myocardial Infarction) Previous Cardiac Surgery Stent
- Previous Angioplasty or Percutaneous Coronary Intervention (PCI) for Coronary Blockage
- Hypertension (High Blood Pressure) _____
- Number of High Blood Pressure Medications Taken Daily _____
- High Cholesterol Number of Cholesterol Meds Taken Daily _____
- High Triglycerides Number of Triglyceride Meds Taken Daily _____
- Irregular Heart Rhythm Palpitations Rapid Heart Beat
- Congestive Heart Failure (Fluid in the Lungs) _____
- Peripheral Edema (Swelling of the Ankles or Legs) _____

Pulmonary:

- Asthma _____
- Sleep Apnea Use CPAP or BiPap Mask Mask Was Prescribed, But Cannot Tolerate
- Other Lung or Breathing Problems Severe COPD Tuberculosis
- Pulmonary Embolus (Blood Clot to Lung) Use Oxygen At Home

Endocrine:

- Diabetes Oral Medicine Insulin Diet Controlled _____
- Thyroid Problems _____

Gastrointestinal / Liver:

- Gastroesophageal Reflux (GERD) or Frequent Heartburn on GERD Meds Daily
- Gallstones had Gallbladder Removed _____
- Hernia - Umbilical Groin Incisional Ventral/other type of hernia
- Hepatitis or Liver Problems Please list: _____

Renal:

- Kidney or Bladder Problems Renal Insufficiency On Dialysis Treatments
- Stress Incontinence (Leak Urine with Coughing or Laughing)

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Vascular:

- Blood Clot or Embolus Please state body location and date: _____
- Venous Stasis in Legs or Poor Circulation
- Abnormal Bleeding or Bruising
- Blood Transfusion - List Reason: _____ Year _____

Musculoskeletal:

- Low Back Pain Neck Pain Diagnosis? _____
 - Arthritis or Degenerative Joint Disease Hips Knees Ankles Feet
 - Activity is Limited by Pain Pain Requires Daily Pain Medication
 - Use Mobility Device Cane Walker Wheel Chair
 - Surgery for Back Pain or Joint Pain has been done or is planned
- Area of body: _____ Year _____

Functional Health Status in Performing Activities of Daily Living:

- Independent in Caring for Self - Bathing, Dressing, Going to Bathroom
- Partially Dependent on Others for: _____
- Totally Dependent on Others for Help

Psychiatric:

- Depression Treated with Medications Treated with Counseling
- Anxiety General Social Treated with Medications Counseling
- Psychiatric Illness Bipolar Major Depressive Disorder Other: _____
- History of Physical Abuse or Sexual Abuse - When? _____
- Alcoholism How much alcohol consumed daily? _____ If quit, date: _____
- Substance Abuse / Street Drugs What type: _____ If quit, date: _____

Other Pertinent Health Issues:

- Cancer - Year and Treatment: _____
- Gout
- Rheumatic Fever
- Other - Specify: _____

For Women:

- Have you had problems with Anemia (low blood count)? Yes No
- Do you have a family history of Osteoporosis? Yes No
- Are you Post-Menopausal? Yes No
- Are you pregnant? Yes No



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SURGICAL HISTORY

List all the previous operations you have had:

Operation	Year	Type of Anesthesia	Problems?
1.			
2.			
3.			
4.			

HOSPITALIZATIONS

List any hospitalizations you had for an illness or accident, not requiring surgery: Year

1.	
2.	
3.	

MEDICATIONS

List all the medications you take, including those which do not require a prescription:

Medication name	Dosage/ Amount	Number of times taken daily
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Have you taken Steroids (Prednisone or Cortisone) in past 6 months? No Yes: _____

ALLERGIES

List all medications/ medical products that cause an allergic or adverse reaction:

Medication/ Latex / Food / Betadine, etc.	Type of reaction
1.	
2.	
3.	
4.	



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HABITS

Have you ever smoked?

- Never
- Yes, but I quit in _____ (year), and smoked about _____ packs per day for _____ years
- Yes, I currently smoke _____ packs per day and have smoked for _____ years

Do you drink alcoholic beverages now?

- Yes, I drink more than 7 drinks per week
- Yes, I drink less than 7 drinks per week
- I used to drink, but I quit in _____ (year)
- No

Do you currently use recreational or illegal drugs now? No Yes

Type/Frequency: _____

I previously used drugs, but I quit in _____ (year)

SOCIAL HISTORY

With whom do you live?
What is your occupation?
Do you work night shifts?
How many hours a day are you employed outside the home?
How many hours a day do you watch TV?
If you are disabled, it is because:
Could someone help care for you if you became seriously ill?
Are you the primary care giver for someone else? (dependent children, parents, etc)
What hobbies are important to you?

EXERCISE

Do you exercise? If yes, describe _____

If not, what is the most strenuous physical activity that you do in a typical week?

Which of the following activities can you do without stopping to rest?

- Walk to a building from a distant parking space
- Climb one flight of stairs
- Climb two flights of stairs
- None of the above



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EXERCISE (continued)

If you stop to rest during activities, what are the main reasons you stop? (check all that apply)

- Shortness of Breath
- Fatigue
- Chest Pain
- Joint Discomfort - circle which one: hips knees ankles feet
- Back Pain
- Other: _____

FAMILY HISTORY

Do any of your blood relatives have the following problems? Explain which relative and type of problem in the space provided.

- Heart Disease _____
- Diabetes _____
- Lung Disease _____
- Stroke _____
- Kidney Disease _____
- Liver Disease _____
- Cancer _____
- Rheumatoid Arthritis _____
- Alcoholism _____
- Serious Mental Illness _____
- Other illnesses that run in the family _____

Have you or any of your blood relatives had a serious problem with Anesthesia?

- No Yes - list: _____

List the approximate weights of all family members (normal and overweight):

Maternal Grandmother _____ Paternal Grandmother _____
 Maternal Grandfather _____ Paternal Grandfather _____
 Mother _____ Sister(s) _____
 Father _____ Brother(s) _____
 Children _____

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REVIEW OF SYMPTOMS

Do you currently have any of the following symptoms? If yes, please explain:

- Chest Pain _____
- Blackouts or periods of Dizziness _____
- Palpitations or Irregular Heart Beats _____
- Swelling in the Ankles _____
- Shortness of Breath with activity _____
- Shortness of Breath when walking up one flight of stairs _____
- Chronic Cough or sputum (phlegm) production _____
- Excessive Thirst _____
- Blood in your Phlegm _____
- Black or tarry Stools _____
- Diarrhea _____
- Frequent or new Constipation _____
- Temporary Loss or Blurring of Vision _____
- Teeth or Gum problems _____
- Temporary Weakness of one or more Limbs _____
- Facial Weakness or Numbness _____
- Burning with Urination or Frequent Urination _____
- Arthritis or Severe Joint pain _____
- Back Pain _____
- Rash or other Skin conditions _____
- Excessive Bleeding following minor cuts or dental surgery _____
- Fever _____
- Depression/Anxiety _____
- Weight gain or loss greater than 10 pounds in the past 3 months (circle which one)

Patient Signature	Print Name	Date	Time
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Person completing form if other than patient: _____
Relationship

Signature	Print Name	Date	Time
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*Thank you for completing this questionnaire.
This will help your doctor understand your health better.
Please mail or fax the questionnaire back to this address:*

Stanford Hospital and Clinics
Bariatric & Metabolic Interdisciplinary (BMI) Clinic
900 Blake Wilbur Drive, W0048, MC 5355, Palo Alto, CA 94304
Fax: (650) 723-8378

Instructions to Attending Physician:

Your signature below indicates that you have reviewed the information contained in the entire questionnaire and you have reviewed the pertinent or key finding(s) with the patient and/or family. Key finding(s) must be summarized in your progress note; however, the questionnaire may be referenced for additional details.

Key findings = positive responses or pertinent negatives

Attending MD: _____ Print Name: _____ Date: _____ Time: _____