EMORY
BARIATRIC CENTER

New Patient Questionnaire

Name_____ Clinic #:_____ Date: _____
Last First MI

Date of Birth:_____ Age:_____ Sex: ___M___F Ethnicity/Race: _____

How were you referred to us (friend, physician, internet, etc)? _____

Primary Care Physician's Name: _____
Address: _____
Phone/Fax: _____

Past Medical and Surgical History: (please check any medical problems, current or past)

_____ Heart Disease - If yes: a. Have you ever had a heart attack? ___Y ___ N
b. Have you ever had cardiac bypass surgery? ___Y ___ N
c. Have you ever had a stent placed? ___Y ___ N
_____ Congestive Heart Failure
_____ Cardiac arrhythmia (such as atrial fibrillation)
_____ High Blood Pressure/Hypertension (# of BP medications you are taking? ____)
_____ Pre-hypertension
_____ High Cholesterol (On medication for it? ___Y ___ N)
_____ Stroke or TIA (mini-stroke)
_____ Heart Valve Disorder (Type? ____)
_____ Diabetes (On Insulin? ___Y ___ N) or Pre-Diabetes/Borderline Diabetes
_____ Gestational Diabetes
_____ Low Testosterone / Hypogonadism
_____ Polycystic Ovarian Syndrome (PCOS)
_____ Thyroid Disease
_____ Asthma (on oxygen at home? ___ Y ___ N)
_____ COPD (on oxygen at home? ___ Y ___ N)
_____ History of pulmonary embolism
_____ History of DVT (deep venous thrombosis) - blood clot in leg
_____ Gastric Reflux (GERD) / Heartburn (On medication for it? ___Y ___ N)
_____ Stomach Ulcers
_____Gallbladder Disorder
_____ Osteoarthritis / Degenerative Joint Disease (Location? _____)
_____ Osteoporosis
_____ Gout
_____ Sleep Apnea (on CPAP or BiPAP? ___Y ___ N; when was it started?_____)
_____ Cancer (Type:_____)
_____ Anemia
_____ Kidney Disease (Are you on hemodialysis? ___ Y ___ N)
_____ Liver Disease / Fatty Liver
_____ Feet or Leg Swelling / Venous Stasis
_____ Migraines/Headaches
_____ Glaucoma
Others: _____
_____

Medications (Prescription and Non-Prescription):
(including vitamins, minerals, or nutritional/herbal supplements)

Name	Dose (mg)	Frequency (i.e. once daily, twice daily)

Are you on any blood thinners or anticoagulation? ___ Y ___ N
Are you on steroids or other immunosuppressants for a chronic condition? ___ Y ___ N

How often do you ***forget*** to take your medication? _____

Do you have allergies to any medications? No___
If yes, what medication(s)? _____
Pharmacy Name: _____ Address: _____

Social History:

1. Circle the last year of school attended:
   1 2 3 4 5 6 7 8 (Grade School) 9 10 11 12 (High School) 1 2 3 4 (College) _____ (Other/Graduate School)
2. Describe your present occupation: _____
   Full time:___ Part time:___ Work hours: _____
3. Present relationship status (please circle one):
   SINGLE MARRIED PARTNERED DIVORCED SEPARATED WIDOWED
4. Number of persons who live in your household (including yourself):_____

Name	Age	Relationship to you	Supportive (Y/N)	Overweight (Y/N)

5. Do you currently smoke? No___ Yes___, how many years have you been smoking _____ and how many packs per day? _____
6. Have you smoked in the past? No___ Yes ____, how many total years _____, how many packs per day _____, and when did you quit? _____
7. Do you drink alcohol? No___. Yes___ (what, how much, how often?_____)

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Mental Health History: (please check any mental health problems, current or past)

____ Anxiety	____ Alcoholism	____ Anorexia
____ Depression	____ Drug Addiction	____ Binge Eating Disorder
____ Bipolar Disorder	____ Schizophrenia	____ Bulimia
____ Panic Attacks	____ Stress	____ Night Eating Disorder

Surgeries: (including any previous obesity surgeries)

Surgery: _____ Date: _____
Surgery: _____ Date: _____
Surgery: _____ Date: _____
Surgery: _____ Date: _____
Surgery: _____ Date: _____
Surgery: _____ Date: _____

Gynecologic History: (For women only)

Pregnancies: Number: _____ Dates: _____
Natural Delivery or C-Section (specify): _____
Menstrual Periods:
Age of onset: _____ Average length: _____
Are they regular? Yes___ If no, explain _____
Date of last menstrual period: _____
Pain associated with period: Yes___ No___
Have you had a hysterectomy? No___ If yes, why? _____
Hormone replacement therapy: No___ If yes, type: _____
Birth control pills: No___ If yes, type: _____
Date of last pelvic exam and Pap smear: _____

Family History: (please record only persons ***biologically*** related to you):

	Living or Deceased	Current Age or Age Deceased	Current Health or Cause of Death	Overweight(Y/N)
Father:	_____	_____	_____	_____
Mother:	_____	_____	_____	_____
Brother:	_____	_____	_____	_____
Brother:	_____	_____	_____	_____
Sister:	_____	_____	_____	_____
Sister:	_____	_____	_____	_____

Has any ***blood relative*** ever had any of the following?

High Blood Pressure: Yes No Who: _____
Kidney Disease: Yes No Who: _____
Diabetes: Yes No Who: _____
Psychiatric Disorder: Yes No Who: _____
Heart Disease: Yes No Who: _____
Stroke: Yes No Who: _____
Cancer: Yes No Who: _____
Other: Yes No Who: _____

Name:_____ Clinic #:_____

Review of Systems: (Please check any problems you have had over the last month)

_____ Nausea	_____ Heat Intolerance	_____ Painful Urination
_____ Vomiting	_____ Headaches	_____ Bloody Urine
_____ Sinus Pain	_____ Dry Skin	_____ Shortness of Breath
_____ Fever	_____ Brittle Hair or Nails	_____ Snoring
_____ Cough	_____ Irregular Heart Beats	_____ Frequent Urination
_____ Chills	_____ Weakness	_____ Increased Hunger
_____ Chest Pain	_____ Joint Pain	_____ Increased Thirst
_____ Constipation	_____ Arm Pain	_____ Numbness or Tingling
_____ Diarrhea	_____ Leg Pain	_____ Skin Rash
_____ Dizziness	_____ Abdominal Pain	_____ Fatigue
_____ Blurry Vision	_____ Pelvic Pain	_____ Hair loss
_____ Nose Bleeds	_____ Hemorrhoids	_____ Acid reflux/heartburn
_____ Neck stiffness	_____ Rectal Bleeding	_____ Other:_____
_____ Cold Intolerance	_____ Back Pain	_____ Other:_____

Physical Activity:

Do you participate in regular physical activity? ___Yes ___No

If yes, what is your activity Level: **(answer only one)**

___ Inactive - no regular physical activity with a sit-down job
___ Light activity - no organized physical activity during leisure time
___ Moderate activity - occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling
___ Heavy activity - consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week
___ Vigorous activity - participation in extensive physical exercise for at least 60 minutes per session 4 times per week

Type of Activity	How Often	How Long
_____	_____	_____
_____	_____	_____

If no, what obstacles are interfering with activity? _____

Functional Health Status: (check one)

Are you: Independent? ___
Partially Dependent? ___
Fully Dependent? ___

Is your ability to walk limited most or all of the time? ___ Y ___ N

Name:_____ Clinic #:_____

Nutrition History:

1. Are you currently on a diet?
   ___ Yes. Describe diet: _____
   ___ No.

2. Are you currently taking prescription or over-the-counter medications to lose weight or to maintain your current weight?
   ___ Yes. What medication(s): _____
   ___ No.

3. What do you think losing weight will do for you…
   in the next few months: _____
   _____
   in the next year or two: _____
   _____

4.

Typical Breakfast:	**Typical Lunch:**	**Typical Dinner:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
Time eaten: _____	Time eaten: _____	Time eaten: _____
Where: _____	Where: _____	Where: _____
With whom: _____	With whom: _____	With whom: _____

5. Do you drink sodas? _____ Sweet tea? _____
   If so, how much per day?_____

6. Do you drink water? _____ How many cups daily? _____

7. What are your worst food habits? _____

8. Snack Habits: What?_____ How much?_____ When? _____

9. Do you have any food cravings? ___ Yes ___ No
   If yes, what food(s) do you crave and when do you crave them? _____
   _____
   Any specific time of the day? _____

10. Check any that apply:
    ___ My family eats most meals together.
    ___ Family meals are served at regular times on most days.
    ___ My family is supportive of my efforts to lose weight.
    ___ Another member of my family is on special diet or is trying to lose weight.

11. Check the types of food you and your family eat and how many times in a week:

	How often?
____Home-cooked meals:	_____
____Heat and serve meals:	_____
____Fast foods:	_____
____Take out from grocery store or restaurant:	_____

12. What was your lowest adult weight? _____ Age at this weight? _____
    What was your highest adult weight? _____ Age at this weight? _____

13. What is your goal weight? _____
    In what time frame would you like to be at your desired weight? _____

14. Have you tried to lose weight in the past?
    ___ No
    ___ Yes – fill in below:

DIET	MEDICATION	OTHER	DATE(S)	WEIGHT LOSS	WEIGHT GAIN

15. What worked best for you and why? _____
    _____

16. In the past year, have you tried to lose weight by vomiting, taking diet pills, diuretics, laxatives, or not eating? ___ Yes ___ No

17. Do you have any food allergies? ___ Yes ___ No
    If yes, list food and reaction_____

18. Do you have any food intolerances? ___ Yes ___ No
    If yes, list food and symptom(s)_____

19. Who plans meals? _____ Cooks? _____ Shops? _____

20. Do you use a shopping list? ___ Yes ___ No

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Binge Eating Disorder:

Do you eat unusually large amounts of food in one sitting?	___ Yes	___ No
Do you continue eating even when you are full or not hungry?	___ Yes	___ No
Do you feel as if you can't stop eating, out of control?	___ Yes	___ No
Do you eat rapidly during binge episodes?	___ Yes	___ No
Does food occupy your thoughts?	___ Yes	___ No
Do you tend to eat or snack all day long?	___ Yes	___ No
Do you feel depressed, disgusted, ashamed, guilty, or unusually upset about your eating?	___ Yes	___ No
Do you eat in secret?	___ Yes	___ No
Do you frequently eat alone?	___ Yes	___ No
Do you have food hidden in your house, just in case of an "emotional emergency"?	___ Yes	___ No
Are you embarrassed about the amount of food you consume?	___ Yes	___ No
Do you eat more food at home after you have already eaten a meal with family or friends?	___ Yes	___ No
Do you overeat without vomiting?	___ Yes	___ No

Night Eating Syndrome:

Do you have a lack of appetite during the morning?	___ Yes	___ No
Do you eat over half of your daily calories after dinner?	___ Yes	___ No
Do you have an uncontrollable desire to eat during the night?	___ Yes	___ No
Do you awaken hungry during the night?	___ Yes	___ No
Do you have difficulty sleeping?	___ Yes	___ No
Do you binge eat during the night?	___ Yes	___ No
How long have these symptoms been going on?	_____	

Emotional Eating:

1. Do you eat more than you would like to when you have negative feelings such as stress, worry, anxiety, depression, anger, or loneliness?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

2. Do you have trouble controlling your eating when you have positive feelings – do you celebrate feeling good by eating?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

3. When you have unpleasant interactions with others in your life, or after a difficult day at work, do you eat more than you would like?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

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Goals and Attitudes:

1. Put an X on the line to show how ***important*** it is for you to make lifestyle changes:

……..……

0	5	10
Not important	Somewhat important	Very important

2. Put an X on the line to show how ***ready*** you are to make lifestyle changes:

……..……

0	5	10
Not ready	Somewhat ready	Very ready

3. Put an X on the line to show how ***confident*** you are that you can make lifestyle changes.

……..……

0	5	10
Not confident	Somewhat confident	Very confident

4. What lifestyle changes would you be willing to make today? _____

_____

5. How much time would you be willing to spend each day on making lifestyle changes? _____

_____

6. What things might make it hard for you to make lifestyle changes? _____

_____

7. Put an X on the line to show your current level of ***stress***:

……..

0	5	10
Very relaxed	Managing OK	Very stressed

8. What are the main stressors in your life (i.e. work, marriage, family, boredom)? _____

_____

9. What strategies do you use to address these stressors? _____

_____

Obstructive Sleep Apnea Screening Questionnaire:

1. Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
   ___ Yes ___ No
2. Do you often feel tired, fatigued, or sleepy during the daytime?
   ___ Yes ___ No
3. Has anyone observed you stop breathing during your sleep?
   ___ Yes ___ No
4. Do you have or are you being treated for high blood pressure?
   ___ Yes ___ No
5. Is your BMI more than 35 kg/m^2? (can be answered by physician)
   ___ Yes ___ No
6. Is your age greater than 50 years old?
   ___ Yes ___ No
7. Is your neck circumference greater than 17in (male) or 16in (female)?
   (can be answered by physician)
   ___ Yes ___ No
8. Are you a male?
   ___ Yes ___ No