

# UPMC St. Margaret

A Hospital of University of Pittsburgh Medical Center

## PITTSBURGH BARIATRICS @ UPMC ST. MARGARET

100 Delafield Road, Suite 210 • Pittsburgh, PA 15215

Phone: 412-784-5900 • Fax: 412-784-5901

### OFFICE USE ONLY:

SEMINAR DATE: \_\_\_\_\_

BMI: \_\_\_\_\_

CANDIDATE FOR SURGERY?  YES  NO

## WEIGHT LOSS QUESTIONNAIRE

(all questions must be answered and submitted at the end of the sessions)

### DEMOGRAPHICS

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

SS #: \_\_\_\_\_ Sex:  Male  Female

Marital Status:  Married  Single  Divorced  Widowed  Other: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Employer: \_\_\_\_\_ Status:  Full Time  Part Time

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

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Nearest Relative: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ How did you hear about us: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### INSURANCE INFORMATION

Primary Insurance Name: \_\_\_\_\_

Co-Pay; OV: \_\_\_\_\_ Co-Pay; Specialist: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Sex:  Male  Female Date of Birth: \_\_\_\_\_

Subscriber's Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Group: \_\_\_\_\_ Effective Date: \_\_\_\_\_

SS #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Employer: \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_

Co-Pay; OV: \_\_\_\_\_ Co-Pay; Specialist: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Sex:  Male  Female Date of Birth: \_\_\_\_\_

Subscriber's Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Group: \_\_\_\_\_ Effective Date: \_\_\_\_\_

SS #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Employer: \_\_\_\_\_

**MEDICAL INFORMATION**

Current Weight: \_\_\_\_\_ Current Height: \_\_\_\_\_

**1. CHECK ALL MEDICAL ISSUES THAT PERTAIN TO YOU:**

- Heart Disease                       Asthma                                       Gout     Polycystic Ovarian Syndrome
- High Blood Pressure               Thyroid Disorder                       Osteoporosis                               Anemia
- High Cholesterol                       Diabetes                                       Arthritis                                       Clotting/Bleeding Disorder
- Sleep Apnea                               GI Disorder                                       Urinary Incontinence                       Cancer

Other: \_\_\_\_\_

2. Are you currently on a diet for a medical reason?  Yes  No

3. Have you ever been diagnosed with an eating disorder?  Yes  No If yes, please describe: \_\_\_\_\_

4. Have you ever had surgery?  Yes  No If yes, please list all surgical procedures with the approximate date: \_\_\_\_\_

5. Are you receiving any psychiatric/psychological services at this time?  Yes  No If yes, by whom and for what reason: \_\_\_\_\_

6. Please list allergies to medications and your reactions: \_\_\_\_\_

7. What surgery are you interested in?  Gastric Bypass  Lapband  Undecided

8. List your current medications including vitamins, aspirin, and herbal over the counter supplements:

Drug Name	Dose	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



# Pittsburgh Bariatrics at UPMC St. Margaret Health History Questionnaire

Pittsburgh Bariatrics at UPMC St. Margaret  
100 Delafield Road, Suite 210  
Pittsburgh, PA 15215  
412-784-5900  
Fax: 412-784-5901

Name: \_\_\_\_\_ Email: \_\_\_\_\_  
(First, middle initial, last)

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

SS#: \_\_\_\_\_ Gender: \_\_\_\_\_ Male \_\_\_\_\_ Female

### Ethnicity: (Check all that apply)

- African-American                       Hispanic
- Asian     Caucasian
- Native American or Alaska native    Native Hawaiian or Pacific Islander
- Other

### Surgical History

Please check each type of surgery that you have had with an approximate date in which you had the surgery.

#### Bariatric Surgery

- Roux-en-y Gastric Bypass                      Date: \_\_\_\_\_                       Laparoscopic    Open
- Adjustable Band                                      Date: \_\_\_\_\_                       Laparoscopic    Open
- Vertical Banded Gastroplasty (VGB)   Date: \_\_\_\_\_                       Laparoscopic    Open
- Gastric Sleeve                                      Date: \_\_\_\_\_                       Laparoscopic    Open

#### Cardiovascular Surgery

- Open heart surgery                      Date: \_\_\_\_\_
- Angioplasty                                      Date: \_\_\_\_\_
- Stent    Date: \_\_\_\_\_
- Vascular surgery on your legs                      Date: \_\_\_\_\_
- Vascular surgery on your neck                      Date: \_\_\_\_\_
- Vascular surgery on other body part   Date: \_\_\_\_\_
- Pacemaker implant                      Date: \_\_\_\_\_
- Valve repair                                      Date: \_\_\_\_\_

#### Reproductive Surgery

- Hysterectomy                                      Date: \_\_\_\_\_
- Tubal ligation                                      Date: \_\_\_\_\_
- Vasectomy                                      Date: \_\_\_\_\_
- C-Section                                      Date: \_\_\_\_\_
- Breast radiation                                      Date: \_\_\_\_\_
- Breast biopsy                                      Date: \_\_\_\_\_
- Breast lumpectomy                                      Date: \_\_\_\_\_

**Gastrointestinal Surgeries**

Anti reflux Date: \_\_\_\_\_  
 Nissen fundoplication Date: \_\_\_\_\_  
 Hiatal hernia repair Date: \_\_\_\_\_  
 Gallbladder surgery Date: \_\_\_\_\_  
 Appendectomy Date: \_\_\_\_\_  
 Bowel resection Date: \_\_\_\_\_  
 Hemorrhoid surgery Date: \_\_\_\_\_  
 Ulcer surgery Date: \_\_\_\_\_

Type of ulcer surgery: \_\_\_\_\_

**Musculoskeletal Surgery**

Knee replacement Date: \_\_\_\_\_  
 Hip replacement Date: \_\_\_\_\_  
 Knee arthroscopy Date: \_\_\_\_\_  
 Hip arthroscopy Date: \_\_\_\_\_  
 Discectomy Date: \_\_\_\_\_  
 Laminectomy Date: \_\_\_\_\_  
 Hernia repair Date: \_\_\_\_\_

Place a check by each diagnosis or health problem listed below that you have experienced.

**Cardiovascular**

Angina (chest pain)       Congestive heart failure       Coronary artery disease  
 DVT (Deep Vein Thrombosis)       Clotting or bleeding       High blood pressure  
 PVD (Peripheral Vascular Disease)       Stroke       TIA (Mini-stroke)  
 Blockages in legs       Edema/Swelling of legs       Ulceration or discoloration of legs  
 Phlebitis       Cellulitis       Rheumatic Fever  
 Valve Disease

**Gastrointestinal**

Abdominal bleeding       Crohn's disease       Colitis  
 Irritable bowel syndrome       Hemorrhoids       GERD/Reflux  
 C-Difficile       Gallstones       Heartburn  
 Hepatitis       Nash       Cirrhosis  
 Hepatic dysfunction

**Metabolic**

Type II diabetes       Type I diabetes       Elevated blood sugars  
 High cholesterol       Dyslipidemia (low HDL)       Gout  
 Elevated uric acid       Thyroid disorder       Renal failure

**Musculoskeletal**

- |  |                                  |                                  |
|--|----------------------------------|----------------------------------|
| _____ Back Pain  | _____ Degenerative joint disease | _____ Arthritis                  |
| _____ Fibromyalgia                                       | _____ Osteoporosis               | _____ Abdominal hernia           |
| _____ Umbilical hernia                                   | _____ Ventral hernia             | _____ Inguinal hernia            |
| _____ Unable to walk without assistance (cane or crutch) |                                  | _____ Serious accident or injury |

**Neurology**

- |                            |                  |                           |
|----------------------------|------------------|---------------------------|
| _____ Fainting/convulsions | _____ Seizures   | _____ Headaches           |
| _____ Multiple Sclerosis   | _____ Neuropathy | _____ Pseudotumor Cerebri |

**Psychosocial**

- |                        |                   |                            |
|------------------------|-------------------|----------------------------|
| _____ Anxiety          | _____ Bipolar     | _____ Depression           |
| _____ Eating disorders | _____ Nervousness | _____ Personality disorder |
| _____ Psychosis        |                   |                            |

**Pulmonary**

- |                   |                    |                                 |
|-------------------|--------------------|---------------------------------|
| _____ Asthma      | _____ COPD         | _____ Right-sided heart failure |
| _____ Sleep apnea | _____ Tuberculosis |                                 |

**Reproductive**

- |                                |  |
|--------------------------------|--|
| _____ Menstrual irregularities | _____ PCOS (polycystic ovarian syndrome) |
|--------------------------------|--|

**Other**

- |  |  |                         |
|--|--|-------------------------|
| _____ Anemia                               | _____ Cancer   | _____ Eye trouble       |
| _____ Hearing problems                     | _____ Lupus  | _____ Trouble urinating |
| _____ Stress urinary incontinence          | _____ Methicillin resistant staphylococcus aureus (MRSA) |                         |
| _____ Vancomycin resistant enterocci (URE) |  |                         |

**Family History**

Please place a check next to all health problems that run in your family. (Use one check for each person if more than one sibling or child has same condition.)

	Alcohol/ Drug Problem	Alzheimer's	Bleeding Trouble/ Blood Clots	Cancer	Diabetes	Glaucoma	Heart Trouble	High Blood Pressure	Mental Illness	Thyroid Disease
Father										
Mother										
Siblings										
Spouse										
Children										

Immunizations: Mark an "x" next to those you have had and indicate the year.

Mark "x" if yes	Immunization	Year
	Chicken pox vaccine	
	Flu shot	
	Gardasil	
	German Measles	
	Hepatitis A	
	Hepatitis B	
	Measles	
	Mumps	
	Pneumonia	
	Polio	
	Tetanus	
	Zostovax	

**Social History**

Please place a check next to the answer that best describes your alcohol and tobacco use.

Use of Alcohol:    \_\_\_ Never                    \_\_\_ Rarely                    \_\_\_ Moderate                    \_\_\_ Daily

Use of Tobacco:    \_\_\_ Never                    \_\_\_ Previously/Quit                    \_\_\_ Number of packs per day

**Sleep Apnea:**

Sleep apnea is a disorder of breathing during sleep. Apnea during sleep consists of brief periods throughout the night in which breathing stops and is typically associated with loud snoring. People with sleep apnea do not get enough oxygen during sleep, and those who are morbidly obese are at a higher risk for this disorder.

Do you have Sleep Apnea? \_\_\_\_\_Yes \_\_\_\_\_No  
If yes, do you wear a CPAP or Bipap machine at night? \_\_\_\_\_Yes \_\_\_\_\_No

**If you have never been diagnosed with sleep apnea, please answer the questions below. It is important to ensure we diagnosis this condition before your surgery.**

- 1. Have you ever fallen asleep at work? \_\_\_\_\_Yes \_\_\_\_\_No
- 2. Do you snore? \_\_\_\_\_Yes \_\_\_\_\_No
- 3. Has anyone ever told you that stopped breathing at night? \_\_\_\_\_Yes \_\_\_\_\_No
- 4. Do you wake up at night? \_\_\_\_\_Yes \_\_\_\_\_No
- 5. If yes, do you notice that you gasp for breath or feel as if you are smothering? \_\_\_\_\_Yes \_\_\_\_\_No
- 6. Do you awaken at night with any chest discomfort or tightness? \_\_\_\_\_Yes \_\_\_\_\_No

**Using the scale below, choose the best number to rate each situation and your chance of dozing off during these situations.**

**Scale**

- 0=would never doze
- 1=slight change 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 (theater, meeting) \_\_\_\_\_
- As a passenger in a car for an hour without a break \_\_\_\_\_
- Lying down to rest in the afternoon when circumstances permit \_\_\_\_\_
- Sitting and talking to someone \_\_\_\_\_
- Sitting quietly after a lunch without alcohol \_\_\_\_\_
- In a car, while stopped for a few minutes in traffic \_\_\_\_\_

**Total:** \_\_\_\_\_

**Score:** \_\_\_\_\_

**0-10: Normal Range      10-12: Borderline      12-24: Abnormal**

## Diabetes Evaluation

Complete this sheet if you have diabetes, pre-diabetes or borderline diabetes.

1. What type of diabetes do you have?

Type I     Type II     Pre-diabetes     Borderline Diabetes

2. When was your diabetes diagnosed?

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3. Have you received any diabetes education in the past?     Yes     No

4. What were your most recent HgbA1c and the date in which you had done?

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5. Have you ever had hypoglycemia (low blood sugars)?     Yes     No

6. If you have had hypoglycemia, what was the glucose level? \_\_\_\_\_

7. How is your diabetes being currently treated? (Check ALL that apply)

Diet and exercise only

Oral medications

Insulin

Byetta

8. Do you have a meter to test your glucose levels?     Yes     No

9. How often do you check your glucose levels? \_\_\_\_\_

10. List the last three readings and include the date and time the reading was taken

Reading	Date	Time
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Please list all previous weight loss attempts:**

**Diets** (include all, such as Atkins, LA Weight Loss, Jenny Craig, Weight Watchers, Overeaters Anonymous, NutriSystem, Bariatrix, etc). Use other side if necessary.

<b>Name of diet</b>	<b>Year</b>	<b>Length of time</b>	<b>Pounds lost</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Medications** (include all, such as Meridia, Orlistat (Xenical), FenPhen, Adipex, HCG injections, Dexatrim, Trim Spa, Metabolife, Stacker III, etc.). Use other side if necessary.

<b>Name of medication</b>	<b>Year</b>	<b>Length of time</b>	<b>Pounds lost</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Behavioral treatments** (include all, such as hypnosis, counseling, exercise, acupuncture). Use other side if necessary.

<b>Name of treatment</b>	<b>Year</b>	<b>Length of time</b>	<b>Pounds lost</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Medical Weight Loss** (include all, such as dietitian counseling, physician-prescribed diet, Optifast, HMR, gastric bypass, stomach stapling, or banding). Use other side if necessary.

<b>Name of program</b>	<b>Year</b>	<b>Length of time</b>	<b>Pounds lost</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Have any of your relatives had weight reduction surgery?**

No

Yes: Type of surgery: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

**Consumption of beverages containing caffeine, carbonation, calories:**

\_\_\_\_\_ no      \_\_\_\_\_ yes      Type and amount: \_\_\_\_\_

If yes, I agree to eliminate beverages containing caffeine, carbonation, and calories, except for protein supplements and milk, for the first nine (9) months after surgery, or until I can additionally drink at least 64 ounces of appropriate beverages. If I am receiving the band, I will continue not to drink carbonated beverages.

Name/date: \_\_\_\_\_

**Exercise:**

\_\_\_\_\_ no      \_\_\_\_\_ yes      Type and amount: \_\_\_\_\_

If no, I understand that movement is essential for maximum weight loss and maintenance. I understand that increasing movement as my tolerance improves will be necessary to have best results.

Name/date: \_\_\_\_\_

**Weight:**

I understand that weight gain can increase the size of my liver, and that an enlarged liver can make laparoscopic bariatric surgery impossible. I agree to maintain or lose weight from today to the date of my surgery.

Name/date: \_\_\_\_\_

**24 Hour Food Log**

In detail, describe a typical 24 hour day of eating. Note what you drink or eat each hour including typical portions and how the foods are prepared. Identify the hours that you sleep.

Midnight

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

1am

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

2am

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

3am

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

4am

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

5am

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6am

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7am

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8am

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9am

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10am

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11am

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Noon

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1pm

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2pm

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3pm

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4pm

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5pm

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6pm

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7pm

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8pm

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9pm

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10pm

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11pm

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How does your pattern vary on day that you do not work or are non-work day?

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Physician Signature

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Date