THANK YOU FOR CHOOSING

CENTRAL MAINE BARIATRIC SURGERY

We look forward to meeting you at the following appointment:

Office Visit* at Central Maine Bariatric Surgery
12 High Street, Suite 401, Lewiston

Date: _____

Time: _____

You **must** bring this completed packet with you in order to be seen.

Enclosed in this packet please find a personal medical history form and a bariatrics questionnaire which must be completed in full. (Please do not mail or fax these forms; you must bring your completed forms to the first office visit.)

It is very important for you to arrive on time for your scheduled office visits. If you are late, it may be necessary to reschedule.

If you are unable to keep your appointment, please call and notify us at least 24 hours in advance. This will allow us to reschedule with another patient.

Thank you again for choosing Central Maine Bariatric Surgery as you take this step towards improving your health.

*Your office visit consists of a comprehensive evaluation and requires a minimum of (2) two hours. Please arrive 20 minutes early for your office visit.

PATIENT HEALTH HISTORY QUESTIONNAIRE

The following information is very important to your health. Please take time to fully and completely fill out this questionnaire.

Name: _____ Date of Birth: _____

Family Doctor: _____

What is the reason you are seeing the surgeon?

How long have you had this problem?

ALLERGIES & MEDICATIONS

List drug(s) and type of reaction (example: Penicillin caused rash):

List your current medications including Vitamins (continue on page 6):

Medications	Dose	Frequency	For what condition?

List any herbal medications you may be taking:

PAST MEDICAL HISTORY

List all operations and year they were performed:

List all hospitalizations, reason, and year:

Have you had the following?

Seizure, stroke, paralysis	● Yes	● No
High blood pressure or heart attack	● Yes	● No
Asthma, emyphysema, tuberculosis, etc.	● Yes	● No
Ulcers *(stomach/intestinal)*	● Yes	● No
Diabetes	● Yes	● No
Kidney or bladder disease	● Yes	● No
Liver disease *(Includes cirrhosis, hepatitis)*	● Yes	● No
Arthritis	● Yes	● No
Bleeding problems or blood clots	● Yes	● No
Cancer	● Yes	● No
Infectious diseases	● Yes	● No

FAMILY HISTORY

Have there been any of the following diseases in your family? Please indicate if any family members died from these diseases.

Bleeding disorders	● Yes	● No	Who? _____
Stroke or paralysis	● Yes	● No	Who? _____
Cancer	● Yes	● No	Who? _____
Diabetes	● Yes	● No	Who? _____
High blood pressure	● Yes	● No	Who? _____
Lung disease *(Asthma, emphysema, TB)*	● Yes	● No	Who? _____
Other:	● Yes	● No	Who? _____
Other:	● Yes	● No	Who? _____

SOCIAL HISTORY

● Single ● Married ● Divorced ● Widowed How many children do you have?_____

What is your current occupation _____

If retired, what was your occupation? _____

If disabled, what is your disability? _____

Have you ever smoked? ● Yes ● No If yes, packs/day: _____ Number of Years: _____

If you quit smoking, when did you quit? _____

Do you drink alcohol? ● Yes ● No If yes, how much?_____

Have you ever used recreational drugs?	● Yes	● No	If yes, what drugs? _____
IV drugs?	● Yes	● No	
Currently use?	● Yes	● No	

Have you traveled outside the U.S. in the past year? ● Yes ● No

If yes, where? _____

INITIAL HISTORY AND REVIEW OF SYSTEMS

Please Answer Yes or No

Doctor's Use Only

1. Constitutional Symptoms

Fever, chills	● Yes	● No
Weight loss, fatigue, night sweats	● Yes	● No

2. Eyes

Red eyes, poor vision, discharge	● Yes	● No

3. Ear, Nose & Throat

Hearing loss	● Yes	● No
Runny nose, sore throat	● Yes	● No
Dentures, toothache	● Yes	● No

4. Central Nervous System

Frequent headaches	● Yes	● No
Numbness, paralysis	● Yes	● No
Black out, memory loss	● Yes	● No

5. Pulmonary System

Frequent cough, sputum production	● Yes	● No
Cough up blood	● Yes	● No
Trouble breathing	● Yes	● No
Sinusitis, hay fever	● Yes	● No
Changes in your voice	● Yes	● No

6. Cardiovascular System

Chest pain, angina	● Yes	● No
Leg pain at night or while walking	● Yes	● No
Sleep on more than one pillow	● Yes	● No

How far can you walk before getting out of breath? _____

7. Digestive System

Change in appetite	● Yes	● No
Difficulty swallowing	● Yes	● No
Abdominal (stomach) pain	● Yes	● No
Abdominal bloating, distension	● Yes	● No
Frequent nausea or vomitting	● Yes	● No
Vomitting blood	● Yes	● No
Diarrhea or constipation	● Yes	● No
Bloody or tarry bowel movements	● Yes	● No
Recent weight change	● Yes	● No

8. Genito-Urinary System

Any change in urine color	● Yes	● No
Frequent urination	● Yes	● No
Pain or difficulty with urination	● Yes	● No
Urination at night?	● Yes	● No
If yes, How often?_____		
Discharge from penis or vagina	● Yes	● No

9. Musculoskeletal System

Bone pain	● Yes	● No
Weakness	● Yes	● No

10. Skin

Jaundice, itching, rash or infection	● Yes	● No

11. Hematologic and Lymphatic System

Excessive bleeding or easy bruising	● Yes	● No
Ankle or feet swelling	● Yes	● No

12. Endocrine System

Flushing	● Yes	● No
Hot or cold intolerance	● Yes	● No

Female Patients Only

When was your last pelvic exam? _____

When was your last period? _____

Was it normal?	● Yes	● No

How many times have you been pregnant? _____

How many living children do you have? _____

Have you ever had a miscarriage?	● Yes	● No
Have you ever had an abortion?	● Yes	● No
Have you ever had a stillborn baby?	● Yes	● No
Any breast pain, swelling, or lumps?	● Yes	● No

Doctor's Use Only

Patient signature: _____ **Date:**_____

(The above is true and correct to the best of my belief.)

Reviewed by (provider's signature): _____ **Date:** _____

List your current medications including Vitamins (continued from page 2):

Medications	Dose	Frequency	For what condition?

BARIATRIC SURGERY QUESTIONNAIRE

Name: _____ Date of birth:_____

Please check the answers that are correct for you.

1. Have you ever in your life seen a mental health professional (counselor, social worker, psychologist, or psychiatrist) for emotional problems? ● Yes ● No
2. Have you ever been prescribed or taken medications for emotional problems such as depression, nerves, panic, worries, anxiety, hearing voices, or other mental health problems? ● Yes ● No
3. Have you ever in your life stayed overnight in a hospital for emotional reasons or for a mental health problem? ● Yes ● No
4. Has anyone in your family (mother, father, siblings, aunts, uncles, cousins) ever been treated for a mental health problem or been hospitalized for emotional problems? ● Yes ● No
5. Has anyone in your family (mother, father, siblings, aunts, uncles, cousins) ever been prescribed or taken medications for emotional problems such as depression,nerves, panic, worries, anxiety, hearing voices, or other mental health problem? ● Yes ● No

The following questions are about your use of alcohol and other drugs.
Mark the response that fits best for you.

6. Have you ever tried to cut down or quit using alcohol or other drugs? ● Yes ● No
7. Have people ever annoyed you by criticizing your drinking or use of other drugs? ● Yes ● No
8. Have you ever felt guilty about your drinking or use of other drugs? ● Yes ● No
9. Have you ever had a drink or used a drug first thing in the morning to get you started or to take the edge off? ● Yes ● No
10. Have you ever had an OUI? ● Yes ● No

These questions are an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question.

1. Over the last 2 weeks how often have you been bothered by any of the following problems?

a. Little interest or pleasure in doing things	● Not at all ● Several Days	● More than half the days ● Nearly every day
b. Feeling down, depressed, or hopeless	● Not at all ● Several Days	● More than half the days ● Nearly every day
c. Trouble falling or staying asleep, or sleeping too much	● Not at all ● Several Days	● More than half the days ● Nearly every day
d. Feeling tired or having little energy	● Not at all ● Several Days	● More than half the days ● Nearly every day
e. Poor appetite or overeating	● Not at all ● Several Days	● More than half the days ● Nearly every day
f. Feeling bad about yourself, or that you are a failure or have let yourself or your family down	● Not at all ● Several Days	● More than half the days ● Nearly every day
g. Trouble concentrating on things, such as reading the newspaper or watching television	● Not at all ● Several Days	● More than half the days ● Nearly every day
h. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	● Not at all ● Several Days	● More than half the days ● Nearly every day
i. Thoughts that you would be better off dead or of hurting yourself in some way	● Not at all ● Several Days	● More than half the days ● Nearly every day

2. Questions about anxiety

a. In the last 4 weeks have you had an anxiety attack – suddenly feeling fear or panic?	● Yes	● No
b. Has this ever happened before?	● Yes	● No
c. Do some of these attacks come suddenly out of the blue – that is, in situations where you don't expect to be nervous or uncomfortable?	● Yes	● No
d. Do these attacks bother you a lot or are you worried about having another attack?	● Yes	● No

3. Over the last 4 weeks, how often have you been bothered by any of the following problems?

a. Feeling nervous, anxious, on edge or worrying a lot about different things	● Not at all ● Several Days	● More than half the days ● Nearly every day
b. Feeling restless so that it is hard to sit still	● Not at all ● Several Days	● More than half the days ● Nearly every day
c. Getting tired very easily	● Not at all ● Several Days	● More than half the days ● Nearly every day
d. Muscle tension, aches, or soreness	● Not at all ● Several Days	● More than half the days ● Nearly every day
e. Trouble falling asleep or staying asleep	● Not at all ● Several Days	● More than half the days ● Nearly every day
f. Trouble concentrating on things, such as reading a book or watching TV	● Not at all ● Several Days	● More than half the days ● Nearly every day
g. Becoming easily annoyed or irritable	● Not at all ● Several Days	● More than half the days ● Nearly every day

DIET/WEIGHT HISTORY

1. Weight History

Have you ever tried to "go on a diet" to lose weight? ● Yes ● No

How many attempts have been made to lose weight? ● 1-3 ● 3-10 ● 10-25 ● >25

Of these, how many were successful? Please describe the outcome briefly.

At what age did you first have a weight problem? (Circle one) ● 5-10 ● 11-15 ● 16-20 ● 21-30 ● 31-40 ● 41-50

Highest adult weight _____lbs

Lowest adult weight _____lbs

Highest weight 1 yr. ago _____lbs

Highest weight 2 yrs. ago _____lbs

Highest weight 3 yrs. ago _____lbs

How long have you been 100 lbs above your ideal weight? _____ months / years

1. How long have you been considering weight loss surgery?

2. How did you learn about weight loss surgery?

3. Do you know anyone who has had a surgery for weight loss or obesity? ● Yes ● No
   a) If you circled YES, was their operation successful? ● Yes ● No

4. Are your family/friends supportive of your decision to have weight loss surgery? ● Yes ● No

5. What do you think has contributed to your weight gain?

2. Dietary Weight Loss Attempts

Program	Year	Months on Program	Pounds Lost	Pounds Regained	Cost ($)
Fen-Phen (Redux)					
Xenical					
Meridia					
Medifast					
Nutrisystem					
Weight Watchers					
Jenny Craig					
Medilife					
Herbalife					
Richard Simmons					

Program	Year	Months on Program	Pounds Lost	Pounds Regained	Cost ($)
Atkins					
Slim Fast					
Overeaters Anonymous					
Hypnosis					
Acupuncture					
Psychotherapy					
Behavior Modification					
Dietitian					
Other					

3. Exercise Weight Loss Attempts

Program	Year	Months on Program	Pounds Lost	Pounds Regained	Cost ($)
Health Club					
Walking					
Jogging					
Bicycling					
Swimming					
Aerobics					
Home Equipment					
Trainer					
Other					

4. Exercise Habits (Circle all that apply)

- Sedentary
- Minimally Active
- Moderately
- Active
- Very Active

Exercise frequency _____ times/week

Patient signature: _____

Patient Name:_____ **Date:**_____

SLEEP APNEA QUESTIONNAIRE

If you have already been diagnosed with OSA (Obstructive Sleep Apnea), please do not complete.

If you cannot answer some of the questions below, please leave blank.		
Do you **snore** loudly (loud enough to be heard through closed doors?	Yes	No
Do you often feel **tired**, fatigued, or sleepy during the daytime?	Yes	No
Has anyone **observed** you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for **high blood pressure?**	Yes	No
BMI more than 35kg/m?	Yes	No
Age over 50 years old?	Yes	No
Neck circumference > 16 inches or 40 cm?	Yes	No
Gender: Male	Yes	No
For Staff Office Use Only:		
TOTAL SCORE:		
High: 5-8	Medium: 3-4	Low: 0-2

GASTROESOPHAGEAL REFLUX DISEASE HEALTH RELATED QUALITY OF LIFE SCORING SCALE

KEY:

0 = No symptoms
1 = Symptoms noticeable but not bothersome
2 = Symptoms noticeable and bothersome but not every day
3 = Symptoms bothersome everyday
4 = Symptoms affect daily activates
5 = Symptoms are incapacitating – unable to do daily activities

Questions about Symptoms (Circle appropriate number for each question)

1.	How bad is your heartburn?	0	1	2	3	4	5
2.	Heartburn when lying down?	0	1	2	3	4	5
3.	Heartburn when standing up?	0	1	2	3	4	5
4.	Heartburn after meals?	0	1	2	3	4	5
5.	Does heartburn change your diet?	0	1	2	3	4	5
6.	Does heartburn wake you up from sleep?	0	1	2	3	4	5
7.	Do you have difficulty swallowing?	0	1	2	3	4	5
8.	Do you have pain swallowing?	0	1	2	3	4	5
9.	If you take you medications, does this affect your daily life?	0	1	2	3	4	5
10.	How satisfied are you with your present condition?	Satisfied		Neutral		Dissatisfied	

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