

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 | <input type="radio"/> Yes | <input type="radio"/> No |
| High blood pressure or heart attack | <input type="radio"/> Yes | <input type="radio"/> No |
| Asthma, emphysema, tuberculosis, etc. | <input type="radio"/> Yes | <input type="radio"/> No |
| Ulcers (<i>stomach/intestinal</i>) | <input type="radio"/> Yes | <input type="radio"/> No |
| Diabetes | <input type="radio"/> Yes | <input type="radio"/> No |
| Kidney or bladder disease | <input type="radio"/> Yes | <input type="radio"/> No |
| Liver disease (<i>Includes cirrhosis, hepatitis</i>) | <input type="radio"/> Yes | <input type="radio"/> No |
| Arthritis | <input type="radio"/> Yes | <input type="radio"/> No |
| Bleeding problems or blood clots | <input type="radio"/> Yes | <input type="radio"/> No |
| Cancer | <input type="radio"/> Yes | <input type="radio"/> No |
| Infectious diseases | <input type="radio"/> Yes | <input type="radio"/> 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 | <input type="radio"/> Yes | <input type="radio"/> No | Who? _____ |
| Stroke or paralysis | <input type="radio"/> Yes | <input type="radio"/> No | Who? _____ |
| Cancer | <input type="radio"/> Yes | <input type="radio"/> No | Who? _____ |
| Diabetes | <input type="radio"/> Yes | <input type="radio"/> No | Who? _____ |
| High blood pressure | <input type="radio"/> Yes | <input type="radio"/> No | Who? _____ |
| Lung disease
(<i>Asthma, emphysema, TB</i>) | <input type="radio"/> Yes | <input type="radio"/> No | Who? _____ |
| Other: | <input type="radio"/> Yes | <input type="radio"/> No | Who? _____ |
| Other: | <input type="radio"/> Yes | <input type="radio"/> 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

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 vomiting Yes No

Vomiting blood Yes No

Diarrhea or constipation Yes No

Bloody or tarry bowel movements Yes No

Recent weight change Yes No

Doctor's Use Only

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:** _____

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 | <input type="radio"/> Not at all | <input type="radio"/> More than half the days |
| | <input type="radio"/> Several Days | <input type="radio"/> Nearly every day |
| b. Feeling down, depressed, or hopeless | <input type="radio"/> Not at all | <input type="radio"/> More than half the days |
| | <input type="radio"/> Several Days | <input type="radio"/> Nearly every day |
| c. Trouble falling or staying asleep, or sleeping too much | <input type="radio"/> Not at all | <input type="radio"/> More than half the days |
| | <input type="radio"/> Several Days | <input type="radio"/> Nearly every day |
| d. Feeling tired or having little energy | <input type="radio"/> Not at all | <input type="radio"/> More than half the days |
| | <input type="radio"/> Several Days | <input type="radio"/> Nearly every day |
| e. Poor appetite or overeating | <input type="radio"/> Not at all | <input type="radio"/> More than half the days |
| | <input type="radio"/> Several Days | <input type="radio"/> Nearly every day |
| f. Feeling bad about yourself, or that you are a failure or have let yourself or your family down | <input type="radio"/> Not at all | <input type="radio"/> More than half the days |
| | <input type="radio"/> Several Days | <input type="radio"/> Nearly every day |
| g. Trouble concentrating on things, such as reading the newspaper or watching television | <input type="radio"/> Not at all | <input type="radio"/> More than half the days |
| | <input type="radio"/> Several Days | <input type="radio"/> 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 | <input type="radio"/> Not at all | <input type="radio"/> More than half the days |
| | <input type="radio"/> Several Days | <input type="radio"/> Nearly every day |
| i. Thoughts that you would be better off dead or of hurting yourself in some way | <input type="radio"/> Not at all | <input type="radio"/> More than half the days |
| | <input type="radio"/> Several Days | <input type="radio"/> Nearly every day |

2. Questions about anxiety

- | | | |
|---|---------------------------|--------------------------|
| a. In the last 4 weeks have you had an anxiety attack – suddenly feeling fear or panic? | <input type="radio"/> Yes | <input type="radio"/> No |
| b. Has this ever happened before? | <input type="radio"/> Yes | <input type="radio"/> 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? | <input type="radio"/> Yes | <input type="radio"/> No |
| d. Do these attacks bother you a lot or are you worried about having another attack? | <input type="radio"/> Yes | <input type="radio"/> 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 | <input type="radio"/> Not at all
<input type="radio"/> Several Days | <input type="radio"/> More than half the days
<input type="radio"/> Nearly every day |
| b. Feeling restless so that it is hard to sit still | <input type="radio"/> Not at all
<input type="radio"/> Several Days | <input type="radio"/> More than half the days
<input type="radio"/> Nearly every day |
| c. Getting tired very easily | <input type="radio"/> Not at all
<input type="radio"/> Several Days | <input type="radio"/> More than half the days
<input type="radio"/> Nearly every day |
| d. Muscle tension, aches, or soreness | <input type="radio"/> Not at all
<input type="radio"/> Several Days | <input type="radio"/> More than half the days
<input type="radio"/> Nearly every day |
| e. Trouble falling asleep or staying asleep | <input type="radio"/> Not at all
<input type="radio"/> Several Days | <input type="radio"/> More than half the days
<input type="radio"/> Nearly every day |
| f. Trouble concentrating on things, such as reading a book or watching TV | <input type="radio"/> Not at all
<input type="radio"/> Several Days | <input type="radio"/> More than half the days
<input type="radio"/> Nearly every day |
| g. Becoming easily annoyed or irritable | <input type="radio"/> Not at all
<input type="radio"/> Several Days | <input type="radio"/> More than half the days
<input type="radio"/> 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 | 3 = Symptoms bothersome everyday |
| 1 = Symptoms noticeable but not bothersome | 4 = Symptoms affect daily activities |
| 2 = Symptoms noticeable and bothersome but not every day | 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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