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## BARIATRIC PATIENT QUESTIONNAIRE

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In order to better serve you, we need your assistance in obtaining all of the required documentation to submit a request for insurance approval. It is very important that you fill out all of the requested information below. Items in **bold** are *required*. When complete, you may FAX or mail this form to our office.

**IMPORTANT:** We also need copies of your insurance card, front and back.

**Name** \_\_\_\_\_ **Today's Date** \_\_\_\_\_

**Phone (H)** \_\_\_\_\_ **(W)** \_\_\_\_\_ **(Cell)** \_\_\_\_\_

**Email Address** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Sex** \_\_\_\_ **Age** \_\_\_\_ **Height** \_\_\_\_ **Current Weight** \_\_\_\_\_ **Birth Date** \_\_\_\_\_

**Social Security #** \_\_\_\_\_ **Driver's License: State** \_\_\_\_ **#** \_\_\_\_\_

Race (optional):  Caucasian  Black  Asian  Hispanic  Other \_\_\_\_\_

Marital Status (optional):  Single  Married  Separated  
 Divorced  Widowed

**Maximum Weight:** \_\_\_\_\_ **Age first became 75 lbs. or more overweight:** \_\_\_\_\_

**Number of weight loss methods tried pre-op (Please provide a number even if unsure):** \_\_\_\_\_

**How many times have you lost 20 or more pounds? (Please answer even if it is only a guess)** \_\_\_\_\_

**Main reason for wanting treatment for weight loss?** \_\_\_\_\_

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

**Please provide the full name, address and phone number of your primary care physician:**

**Physician Name** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_ **Zip** \_\_\_\_\_ **Phone ( )** \_\_\_\_\_

## EMPLOYMENT INFORMATION

Are you employed?     Yes     No

Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## INSURANCE VERIFICATION

Primary Insurance Company Name \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

IPA/Medical Group \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's SS # \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Insured's Employer \_\_\_\_\_

Insured's Policy Number \_\_\_\_\_ Insured's Group Number \_\_\_\_\_

Secondary Insurance Company Name \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Insured's Name \_\_\_\_\_

Relationship \_\_\_\_\_ Insured's Employer \_\_\_\_\_

Insured's Policy Number \_\_\_\_\_ Insured's Group Number \_\_\_\_\_

## CHOICE OF SURGERY (check one)

Lap-Band

Laparoscopic Gastric Bypass

## CHOICE OF SURGEON (check one)

Dr. Oliak – (Medical Director)

## PATIENT INFORMATION SEMINAR

**Have you attended a patient information seminar?**

Yes I have attended a seminar

Date of seminar \_\_\_\_\_

Location of seminar (check one)

Chapman Medical Center

Other \_\_\_\_\_

## REFERRAL SOURCE

I heard about Chapman Center for Obesity from: (check one and/or write in the information)

Online Search (*website address*) \_\_\_\_\_

Former Patient: Primary Care Physician \_\_\_\_\_ Insurance Company \_\_\_\_\_

Newspaper Ad (*indicate name of paper*) \_\_\_\_\_

Other source \_\_\_\_\_

Name and address (*if you selected Physician or Patient*)

Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

# MEDICAL HISTORY

## LIST PRIOR WEIGHT LOSS OPERATIONS (IF ANY)

- J.I. Bypass                      When? \_\_\_\_\_ Hospital/Clinic Name: \_\_\_\_\_
- Vertical Band Gastroplasty    When? \_\_\_\_\_ Hospital/Clinic Name: \_\_\_\_\_
- Vertical Ring Gastroplasty    When? \_\_\_\_\_ Hospital/Clinic Name: \_\_\_\_\_
- Roux-en-Y Gastric Bypass    When? \_\_\_\_\_ Hospital/Clinic Name: \_\_\_\_\_

## LIST PREVIOUS OPERATIONS

Operation	Date	Type of Anesthesia	Problems (if any)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has any blood relative ever had difficulty or problems with Anesthetics (e.g. malignant hyperthermia)

- Yes    No

## LIST MEDICAL ILLNESSES

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does anyone in the family have Diabetes, High Blood Pressure, Heart Disease or Gallstones?

- Yes    No   Describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## SMOKING AND DRINKING

How many cigarettes (packs) do you smoke a day? \_\_\_\_\_

Do you drink alcohol?

- Never     Rarely (2 times per month or less)     Occasionally (once a week or so)     Daily

## SLEEPING

Has anyone told you that you sometimes hold your breath for a long time while asleep? ...  No     Yes

*For the following questions, answer "Yes" if they occur 2 or more days a week – otherwise answer "No"*

Do you have restless sleep or frequent awakening?.....  No     Yes

Do you have night sweats? .....  No     Yes

Do you snore? .....  No     Yes

Do you have daytime sleepiness? .....  No     Yes

Do you have morning headaches? .....  No     Yes

Do you wake at night with a snort or gasp?.....  No     Yes

## RESPIRATORY

Shortness of breath at rest .....  Never     Past     Now

Pneumonia .....  No     Yes

Bronchitis.....  No     Yes

Emphysema/COPD.....  No     Yes

Have you been diagnosed or treated for asthma?.....  No     Yes

Year of last chest X-ray?..... \_\_\_\_\_

Normal?.....  No     Yes

## CARDIOVASCULAR

Chest pain or angina pectoris? .....  Never     Past     Now

Heart murmur?.....  Never     Past     Now

Have you ever had palpitations/arrhythmia? .....  No     Yes

Have you had a heart attack? .....  No     Yes

Have you been diagnosed or treated for high blood pressure? .....  No     Yes

If yes, were you prescribed medication?

- None     1 medication     2 medications     3 or more medications

Varicose veins?.....  Never     Past     Now

Have you had blood clots or phlebitis (inflammation in the leg vein)?.....  No     Yes

Year of last EKG? \_\_\_\_\_ Normal?.....  No     Yes

Do you have shortness of breath after climbing on flight of stairs? .....  No     Yes

How many blocks can you walk without having to stop for breath? \_\_\_\_\_

How many days a week do you exercise on average? \_\_\_\_\_

### GASTROINTESTINAL

- Have you been told that you have Gallstones? .....  No  Yes
- Do you have heartburn or acid indigestion? .....  No  Yes
- Tarry black stool or blood in bowel movements? .....  Never  Past  Now
- Trouble swallowing or persistent abdominal pain? .....  Never  Past  Now
- Do you frequently regurgitate (burp up) your food?.....  Never  Past  Now
- Crampy abdominal pain? .....  Never  Past  Now
- Chronic constipation? .....  Never  Past  Now
- Frequent diarrhea? .....  Never  Past  Now
- Change in bowel habits? .....  Never  Past  Now
- Hemorrhoids or piles?.....  Never  Past  Now
- Have you been diagnosed as having stomach or intestinal ulcers or other disorders of the gastrointestinal system?.....  Never  Past  Now
- Have you pain or difficulty swallowing?.....  Never  Past  Now
- Have you had hepatitis or liver problems?.....  Never  Past  Now
- Ever vomit blood?.....  Never  Past  Now

### GENITOURINARY

- Menstrual difficulties?  None  Irregular periods  Heavy period  Painful period
- Have you had gynecologic (female) problems?.....  Never  Past  Now
- Are you or might you be pregnant? .....  Never  Past  Now
- Do you lose small amounts of urine with coughing or straining?.....  No  Yes
- Have you had kidney problems?.....  Never  Past  Now
- Burning or pain urination? .....  Never  Past  Now
- Frequent urination? .....  Never  Past  Now
- Feeling you must go immediately? .....  Never  Past  Now
- Blood in urine?.....  Never  Past  Now
- Kidney Stones? .....  Never  Past  Now

### MUSCULOSKELETAL

- Arthritis, swollen or painful joints? .....  Never  Past  Now
- Pain in calves or buttocks when walking, relieved by rest?.....  Never  Past  Now
- Do you have swelling of ankles? .....  No  Yes
- Do you have joint pain – back?.....  No  Yes

Do you have joint pain – hip?.....  No  Yes  
 Do you have joint pain – knee?.....  No  Yes  
 Do you have joint pain – ankle?.....  No  Yes  
 Do you have joint pain – foot?.....  No  Yes

### SKIN

Frequent infections?.....  Never  Past  Now  
 Unusual moles or lumps?.....  Never  Past  Now  
 Describe \_\_\_\_\_

### NEUROLOGICAL

Eye disease or injury?.....  Never  Past  Now  
 Double vision? .....  Never  Past  Now  
 Headaches? (also, check one box in each group below).....  Never  Past  Now  
      rarely                       occasionally               frequently  
      minimal                       moderate                       severe  
 Epilepsy or Seizures?.....  Never  Past  Now  
 Brain disease or Strokes?.....  Never  Past  Now

### EMOTIONAL

Are you satisfied with your social life? .....  No  Yes  
 Were you ever severely, **emotionally, physically** and/or **sexually** abused?.....  No  Yes  
 Are you satisfied with your sex life? .....  No  Yes  
 How would you rate your self esteem level? .....  Low  Med  High  
 How would you rate your energy level? .....  Low  Med  High  
 Do you have trouble sleeping?.....  Never  Past  Now  
 Are you usually tired?.....  Never  Past  Now  
 Are you often depressed?.....  Never  Past  Now  
 Are you often anxious or nervous? .....  Never  Past  Now  
 Do you ever wish you were dead and away from it all? .....  Never  Past  Now  
 Have you ever seen a psychiatrist? .....  No  Yes

If seen by a Psychiatrist, please provide their name, address and phone number:

Psychiatrist Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Have you ever been hospitalized for psychiatric reasons?.....  No  Yes

## HEMATOLOGICAL

- Anemia? .....  Never  Past  Now  
Excessive bleeding or abnormal bruising?.....  Never  Past  Now  
Have you ever received a blood transfusion? .....  Never  Past  Now  
If yes, when? \_\_\_\_\_

## ENDOCRINE

- Hormone therapy?.....  Never  Past  Now  
Thyroid problems?.....  Never  Past  Now  
Have you been diagnosed or treated for Diabetes?.....  No  Yes  
If yes, were you prescribed medication?  None  Oral Medication  Insulin

## METHODS OF WEIGHT CONTROL USED IN THE PAST

### Doctor Supervised Programs

- Rader Institute .....When? \_\_\_\_\_ Program: \_\_\_\_\_  
 Lindora .....When? \_\_\_\_\_ Program: \_\_\_\_\_  
 Fasting .....When? \_\_\_\_\_ Program: \_\_\_\_\_  
 B-6.....When? \_\_\_\_\_ Program: \_\_\_\_\_  
 Amphetamines .....When? \_\_\_\_\_ Program: \_\_\_\_\_  
 Opti-Fast.....When? \_\_\_\_\_ Program: \_\_\_\_\_  
 Schick Center .....When? \_\_\_\_\_ Program: \_\_\_\_\_  
 Medifast .....When? \_\_\_\_\_ Program: \_\_\_\_\_  
 HCG Shots .....When? \_\_\_\_\_ Program: \_\_\_\_\_  
 B-12.....When? \_\_\_\_\_ Program: \_\_\_\_\_  
 Other weight loss pills.....When? \_\_\_\_\_ Program: \_\_\_\_\_  
 Other.....When? \_\_\_\_\_ Program: \_\_\_\_\_

### Traditional Weight Loss Programs:

- Jenny Craig .....When? \_\_\_\_\_ Program: \_\_\_\_\_  
 Over Eater's Anonymous.....When? \_\_\_\_\_ Program: \_\_\_\_\_  
 Weight Watchers.....When? \_\_\_\_\_ Program: \_\_\_\_\_  
 Nutri System.....When? \_\_\_\_\_ Program: \_\_\_\_\_  
 "Fat Farms" .....When? \_\_\_\_\_ Program: \_\_\_\_\_  
 Exercise program .....When? \_\_\_\_\_ Program: \_\_\_\_\_  
 Other.....When? \_\_\_\_\_ Program: \_\_\_\_\_

**Non-traditional Weight Loss Programs**

- Gastric Bubble.....When? \_\_\_\_\_ Program: \_\_\_\_\_
- Acupuncture .....When? \_\_\_\_\_ Program: \_\_\_\_\_
- Jaw wiring .....When? \_\_\_\_\_ Program: \_\_\_\_\_
- Hypnosis.....When? \_\_\_\_\_ Program: \_\_\_\_\_
- Other.....When? \_\_\_\_\_ Program: \_\_\_\_\_

**Self Diets**

- Slim Fast .....When? \_\_\_\_\_ Program: \_\_\_\_\_
- Dieter’s tea .....When? \_\_\_\_\_ Program: \_\_\_\_\_
- Xenadrine .....When? \_\_\_\_\_ Program: \_\_\_\_\_
- Metabolife .....When? \_\_\_\_\_ Program: \_\_\_\_\_
- Accutrim.....When? \_\_\_\_\_ Program: \_\_\_\_\_
- Dexatrim.....When? \_\_\_\_\_ Program: \_\_\_\_\_
- Cal Ban 3000.....When? \_\_\_\_\_ Program: \_\_\_\_\_
- Fasting .....When? \_\_\_\_\_ Program: \_\_\_\_\_
- Other.....When? \_\_\_\_\_ Program: \_\_\_\_\_

**Popular Diet Programs**

- Atkins Diet .....When? \_\_\_\_\_ Program: \_\_\_\_\_
- Bahamian Diet.....When? \_\_\_\_\_ Program: \_\_\_\_\_
- Beverly Hills Diet .....When? \_\_\_\_\_ Program: \_\_\_\_\_
- Cambridge Diet .....When? \_\_\_\_\_ Program: \_\_\_\_\_
- Herbal Life .....When? \_\_\_\_\_ Program: \_\_\_\_\_
- Hollywood Diet.....When? \_\_\_\_\_ Program: \_\_\_\_\_
- Pritikin Diet.....When? \_\_\_\_\_ Program: \_\_\_\_\_
- Scarsdale Diet.....When? \_\_\_\_\_ Program: \_\_\_\_\_
- R. Simmons’ Deal-A-Meal .....When? \_\_\_\_\_ Program: \_\_\_\_\_
- South Beach Diet.....When? \_\_\_\_\_ Program: \_\_\_\_\_
- Other.....When? \_\_\_\_\_ Program: \_\_\_\_\_

**NUTRITIONAL PROGRAMS**

- In-Hospital.....When? \_\_\_\_\_ Program: \_\_\_\_\_  
Hospital/Clinic Name: \_\_\_\_\_
- Out-Patient .....When? \_\_\_\_\_ Program: \_\_\_\_\_  
Hospital/Clinic Name: \_\_\_\_\_