UPMC LIFE CHANGING MEDICINE

UPMC Jameson Bariatric Center

Patient Name: Date of Birth:

FOR OFFICE USE ONLY:

Date: _____ Ht: _____ Wt: _____ BMI: _____ Initials: _____

Date: _____ Ht: _____ Wt: _____ BMI: _____ Initials: _____

BP: _____ T: _____ P: _____ R: _____

☐ **RGB**	**Referrals:**	**Orders:**	
☐ **Sleeve**	☐**PCP**	☐**Bariatric Labs**	☐**Sleep Study**
☐Other_____	☐**Pulm**	☐**UGI**	☐_____
	☐**Cardio**	☐**EGD**	☐_____
	☐**Endo**	☐**Colonoscopy**	
	☐**Dietary**	☐**PFT**	
	☐**Psyche**	☐**Nicotine**	
	☐**Anesthesia**	☐**Drug profile**	

Email (for Support Group Updates): _____

PATIENT HISTORY QUESTIONNAIRE

The information requested in this questionnaire is very important. To give you the best care, and to obtain your insurance approval, you must complete all answers. Please be thorough and complete this at a time that you can focus on your health history and your future goals as you embark upon a new journey of weight loss surgery.

Please list all the physicians whose care you are under:

	Name	Address (Street, City, State, ZIP)	Phone
Primary Care			
Internist			
Cardiologist (Heart doctor)			
Pulmonologist (Lung doctor)			
Endocrine			
Gastroenterologist			
Psychologist/ Psychiatrist			
Other:			
Other:			

MEDICATIONS: Please list below all medications you currently use, including any over-the-counter medications

MEDICATION	DOSE	HOW OFTEN?

HERBAL MEDICINE/SUPPLEMENTS:

NAME	DOSE	HOW OFTEN?

ALLERGIES: *Please list any allergies to medications, surgical tape and/or Latex

WHAT ARE YOU ALLERGIC TO?	REACTION:

SURGICAL HISTORY: Please list any surgical procedures you have had performed

SURGERY	DATE	OPEN OR LAPROSCOPIC	COMPLICATIONS

SYSTEM REVIEW

Please check all symptoms you CURRENTLY are experiencing.

General	Eyes	Ears/Nose/Throat
□ Fever □ Chills □ Anorexia □ Fatigue □ Lack of energy □ Weight loss □ No Issues	□ Blurring □ Double vision □ Irritation □ Discharge □ Vision loss □ Eye pain □ Sensitivity to light □ No Issues	□ Earache □ Ear discharge □ Ringing in ears □ Hearing loss □ Nasal Congestion □ Nosebleeds □ Sore throat/□ Hoarseness □ Difficulty swallowing □ Snoring □ No issues
Cardiovascular	**Respiratory**	**Gastroenterology**
□ Chest pains □ Palpitations □ Fainting □ Shortness of breath □ Difficulty breathing □ Swelling in extremities □ No issues	□ Cough □ Shortness of breath □ Excessive sputum □ Spitting up blood □ Wheezing □ No issues	□ Nausea/ □ Vomiting □ Diarrhea/ □ Constipation □ Change in bowel habits □ Abdominal pain □ Dark stools □ Bloody stool (bright red) □ Jaundice □ Heartburn □ No issues
Genitourinary	**Musculoskeletal**	**SKIN**
□ Vaginal/penile discharge □ Loss of erection □ Incontinence □ Pain upon urination □ Blood in urine □ Frequent urination □ Absence of menstruation □ Normal menstruation □ Abnormal vaginal bleeding □ Irregular periods □ Painful intercourse □ Pelvic pain □ No issues	□ Back pain □ Joint pain □ Joint swelling □ Muscle cramps □ Muscle weakness □ Stiffness □ Arthritis □ No issues	□ Rash □ Itching □ Dryness □ Suspicious lesions □ No issues
Neurologic	**Psychiatric**	**Endocrine**
□ Weakness □ Paralysis □ Numbness or tingling □ Seizures □ Fainting □ Tremors □ Vertigo □ No issues	□ Depression □ Anxiety □ Memory loss □ Mental disturbance □ Suicidal thoughts □ Hallucinations □ Paranoia □ No issues	□ Cold intolerance □ Heat intolerance □ Fatigue □ Frequent urination □ Weight change □ Increased appetite □ No issues
Heme/Lymphatic	**Allergic/Immunologic**	
□ Abnormal bruising □ Bleeding □ Enlarged lymph nodes □ Deep vein thrombosis □ No issues	□ Hives □ Hay fever □ Persistent infections □ HIV exposure □ No issues	

HEALTH HISTORY/FAMILY HISTORY (For family history please indicate if deceased with ↓and age)

Patient and Family:	You	Mother	Father	Brother (s)	Sister (s)	Staff Comments
Heart attack						
Coronary Artery Bypass Graft-CABG						
Heart Disease						
Heart Arrhythmia						

Hypertension						
Stroke/TIA						
High Cholesterol						
Diabetes						
Cancer						
Kidney Problems						
Liver Problems						
Lung Disease						
Blood Clot/Bleeding Issues						
Obesity						
Patient Only:		————	————	————	————	
Depression/Anxiety		————	————	————	————	
Psychological Disorders		————	————	————	————	
Suicide Attempts		————	————	————	————	
Arthritis		————	————	————	————	
Shortness of breath		————	————	————	————	
Sleep Apnea		————	————	————	————	
Have CPAP/BiPAP?		————	————	————	————	
Snoring		————	————	————	————	
Anemia		————	————	————	————	
Thyroid Disease		————	————	————	————	
Vascular Disease		————	————	————	————	
Edema		————	————	————	————	
Heartburn/Reflux		————	————	————	————	
Difficulty Swallowing		————	————	————	————	
Ulcers		————	————	————	————	
Barrett's Esophagus		————	————	————	————	
Crohn's Disease		————	————	————	————	
Diverticulitis		————	————	————	————	
Irritable Bowel		————	————	————	————	
Hernia		————	————	————	————	
Bowel/Urinary Incontinence		————	————	————	————	
Headaches		————	————	————	————	
PCOS		————	————	————	————	
Infertility		————	————	————	————	
Other:						

SLEEP APNEA QUESTIONAIRE: Based on STOP BANG Screening Tool

***Do not complete if you have been diagnosed with sleep apnea**

Do you snore loudly?	**Yes No**
Do you feel tired, fatigued, or sleepy during the day?	**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**
Age over 50 yrs old?	**Yes No**
Male Gender?	**Yes No**
Below staff use only	
BMI > 35g/m2?	**Yes**
Neck circumference >16 inches (40cm)? _____ in.	**Yes No**
Scoring: 1 point for each yes answer	**Total =**
5-8 Yes = High Risk 3-4 Yes = Intermediate Risk	**0-2 Yes = Low Risk OSA**

PERSONAL EVALUATION OF STRENGTHS/BODY IMAGE:

Please list a personal strength: _____

Please list an area of weakness (not weight, eating or lack of exercise): _____

How do you think and feel about your body: _____

What word or phrase would you use to describe your body? _____

How do you rate your current health state (1 = poor, 10 = best): _____

Do you avoid looking at yourself in a mirror? _____

Why have you decided to seek bariatric surgery at this time? _____

What can't you do because of your obesity?_____

How do you think bariatric surgery will help you medically, psychologically or personally**?** _____

LIFESTYLE HISTORY

	Yes	No	Past/Quit date	Type	Frequency?
Tobacco Use				**(Circle) Cigarettes Chewing Tobacco**	**Packs per day:**
Are you willing to quit?					
Alcohol Use				**(Circle) Beer Wine Liquor**	**Drinks per week:**
Are you willing to quit?					
History of Alcohol Abuse			**Please explain:**		

Drug Use/ Substance Abuse			Past/Quit date?	Type & Date Last Used	How long have you used each substance?
Do you receive medicinal marijuana?	Yes	No	MM Card?	Medical Reason Prescribed?	Name and Location of facility:
Are you on Methadone/ Suboxone?			For how long?		Name and Location of facility:
Caffeine				(Circle) Coffee/Tea Pills	Amt/day:

Did you previously start a Bariatric program either with us or another facility? Yes____ or no_____

If yes, where and when? _____

Briefly describe why you did not complete the process.

_____

Weight Loss Surgery yes ☐ no ☐ If Yes, what surgery?_____Date/Location?_____

Longest attempt at weight loss? (ex. time in a program) _____

PERSONAL/SOCIAL FUNCTIONING:

In what way does your weight impact your daily activities? (please circle all that apply)

Decreased Stamina Exacerbation of Pain Increased Fatigue Joint Pain
Mobility Personal Hygiene Public Seating
Sexual Relations Self-Esteem Other: _____

What do you do in your down time?

TV Computer Read Shop Family Friends Eat Other_____

- **SUPPORT SYSTEM**:
  - ☐ Single ☐ Divorced ☐ Widowed ☐ Other
  - ☐ In a relationship? For how long? _____
  - ☐ Married? For how long? _____
  - ☐ Children? How many? _____Healthy?_____
  - ☐ Do you live in a group home/personal care home/assisted living?_____If yes, where?_____
- **EDUCATION/EMPLOYMENT:**

Highest level of education: _____

- ☐ Occupation: _____ ☐ Full time ☐ Part time
- ☐ Disabled ☐ Homemaker ☐ Unemployed ☐ Other: _____

Do you have any difficulty reading or writing? _____

Do you have any language barriers? _____

- **MOBILITY:**

Do you use a wheelchair? Yes or No. If yes, how many hours per day? _____

How far do you walk in a normal day? _____

How many steps can you climb? _____ How many steps do you do daily? _____

Do you exercise? Yes or No. If yes, type and how often? _____

DIETARY HISTORY

Please circle program type(s) you have used in the past. If you have lost 50 pounds or more please indicate below with amount lost, what program and dates.

PROGRAM:

Jenny Craig Nutri-System Weight Watchers LA Weight Loss Opti/Medi Fast Keto Whole 30

TOPS OA 21 Day Fix Atkins South Beach Zone Cabbage Soup Grapefruit Dietitian Counseling

Exercise Portion Control Low Fat/Low Carb Intermittent Fasting Slimfast/Meal Replacement

Other:_____

MEDS:

Fen/Phen/Redux Meridia Adipex Xenical Other RX diet meds "Over The Counter" diet meds:

Type_____Date Last Taken_____

Loss of 50 pounds or greater please explain:

_____

_____

Weight Related History:

Onset of obesity: (circle one) Childhood Adolescence Adulthood

Earliest attempt at weight loss (age you started to focus on weight loss as a priority)? _____

Lowest Adult Weight? _____ Highest Adult Weight? _____

Possible life events and triggers that may have led to weight gain:

- ☐Emotional Eating
- ☐Hours of sleep
- ☐Weight Promoting Medications
- ☐ Smoking Cessation
- ☐Pregnancy
- ☐Post-Partum
- ☐Work Schedule
- ☐Menopause
- ☐Other_____
- ☐Other_____

Current Food Intake and Eating Patterns

Who shops and prepares food in your household? _____

Are you able to shop for yourself?_____If no please explain?_____

Are you able to cook for yourself?_____If no please explain?_____

Feeling After a Meal: (circle) Comfortable Stuffed Can Eat More

Do you skip meals? Yes _____ No _____ If yes, which meals? _____

Second Helpings? (circle) Sometimes Always Never

Dessert? (circle) Usually Sometimes Rarely

Do you have unplanned snacking? Yes _____ No _____ If yes, what times? _____

Circle the snack items you enjoy: (circle) cake cookies ice cream pie candy chocolate pretzels popcorn chips nuts fruit vegetables bread cereal fast food pizza meat other____

Do you wake during the night to eat? Yes _____ No _____ Explain: _____

Do you feel "out of control" when eating? (circle) Sometimes Always Never

What factors play a part in deciding what you will eat? (circle all that apply)

Financial Health Convenience Pleasure Not sure what is healthy

Typical Beverages: _____

Eating Outside of the Home: How often per day, per week, per month?

Fast-Food Restaurants: _____
Take-Out: _____
Restaurants: _____

Food Allergies/Intolerance: _____

Foods Avoided for Other Reasons: _____

What sources of protein are in your diet? _____

What diet restrictions you have been told to follow or special diet that you have yourself on? _____
_____

Do you foresee any financial concerns/hardship after surgery with purchasing healthy foods, protein supplements or vitamin/mineral supplements? Yes or No.
If yes, please explain. _____

Have you ever had or been treated for an eating disorder such as: anorexia/bulimia/binge eating? Yes ___ No ___If so please share _____

Have you ever: (circle all that apply) thrown up food on purpose used laxatives for weight control

exercised excessively hidden food stolen food

What is your weight goal or personal goals (related to weight and health)? _____

How long do you think it will take to achieve this goal?_____

How many times have you lost 20 pounds or more and then gained it back? (circle)

Never 1-2 times 3-4 times 5 or more times

Please record what you might typically eat including type and amount of food.

Meal Time	Beverage, Food Eaten and Amount
Breakfast	
Time	
Snack	
Time	
Lunch	
Time	
Snack	
Time	
Dinner	
Time	
Snack	
Time	