Banner Health

NEW PATIENT MEDICAL HISTORY - BARIATRIC ADDENDUM

Patient Name: _____ DOB: _____ Date: _____

Please answer the following questions so that we can better meet your needs.

What is bothering you most about your weight? _____

What has caused or triggered weight gain in the past? _____

	Patient Measurement (Please Complete)		Age	Weight
Height		**Birth Weight**		
Initial Body Weight		**After Undergoing Puberty**		
Ideal Body Weight		**High School Graduation**		
Excess Body Weight				
Target Weight		**Lowest Weight in Past 5 Years**		
Body Frame (circle one) Small Medium Large		**Highest Weight in Past 5 Years**		

Energy Patterns

(Please check the answer that applies)

What is your energy level in the morning: Very Low Low Moderate High Very High

What is your energy level in the evening: Very Low Low Moderate High Very High

Do you work the afternoon or evening shift at work? YES NO

Do you shift from days to nights? YES NO

Do you consider yourself a morning person (Lark) or an evening person (Owl)? _____

Dietary History

Please give us an idea of your eating habits and patterns:

General Food Questions

Who does the majority of the cooking? _____

Is your home cooked food of a particular ethnic influence? (If so, please check)

Latino Middle Eastern East Indian Kosher Asian African Other

Do you get food through WIC or Food Assistance? YES NO

Banner Health

NEW PATIENT MEDICAL HISTORY - BARIATRIC ADDENDUM

Dietary History (continued)

Please give us an idea of your personal eating patterns:

Personal Eating Habits

How much processed food do you eat? ¯ Everyday Seldom ¯ Rarely Never
Do you buy your fruits and vegetables at a farmers market? YES NO
Do you get coffee drinks in the morning? ¯ YES ¯ NO
If so, what do you add to your coffee (ex: flavored creamer, sugar, sugar substitutes, etc.) _____
Do you drink sugar-sweetened beverages like soda or sports drinks? YES NO
If so, what type? _____ How many ounces per day? _____

Social Eating

Describe the last time you got together with friends? _____
_____
Who prepared the food? _____
What did you eat? _____

Was there any exercise involved? YES NO

Lifestyle Analysis

These questions give us an idea of what lifestyle issues are important to you and may be related to weight.
Specific question about *alcohol* use (the CAGE review):

Do you ever feel the need to **Cut** down? YES NO
Have you ever felt **Annoyed** by criticism of drinking? YES ¯ NO
Have you ever had **Guilty** Feelings? YES NO
Have you ever taken a morning **Eye** opener? YES NO

STRESS RELATED

Have you been hospitalized in the last year?	YES	NO
Have you been hospitalized for more than 7 days in your lifetime?	YES	NO
How many hours do you work per week?	YES	NO
Are you satisfied with your work?	YES	NO
Do you feel under pressure at work?	YES	NO
Do you get along with your colleagues at work?	YES	NO
Do you get along with your spouse or partner?	YES	NO
Do you get along with other relatives?	YES	NO
Have any close relative been seriously ill in the past year?	YES	NO
Do you feel tension at home?	YES	NO
Do you feel lonely?	YES	NO
Do you have anyone whom you can trust and confide in?	YES	NO
Do you get along well with people?	YES	NO
Do you often feel overwhelmed by the demands of every day life?	YES	NO
Do you tend to be influenced by people with strong opinions?	YES	NO

5100-0057
(04/2018)

Banner Health

NEW PATIENT MEDICAL HISTORY - BARIATRIC ADDENDUM

STRESS RELATED (continued)

Do you tend to worry about what other people think of you?				YES	NO
Do you have difficulty breathing or feel you cannot get enough air?				YES	NO
Do you feel tired and lack energy?				YES	NO
Are you irritable?				YES	NO
Do you feel sad or depressed?				YES	NO
Do you feel tense or “wound up”?				YES	NO
Have you lost interest in most things?				YES	NO
Do you get “panic” attacks?				YES	NO
How would you rate your level of stress?	LOW	MEDIUM	HIGH	INTERMITTENT	HIGH
How do you rate the quality of your life?	EXCELLENT	GOOD	FAIR	POOR	AWFUL

Pregnancy/Infertility

Age of first menstrual period? _____ Date of last period: _____
Total # of pregnancies? _____ # of Live Births? _____ # of Miscarriages/abortions? _____

Did you have gestational diabetes?	YES	NO
Preeclampsia?	YES	NO
HELP Syndrome?	YES	NO
Hypertension during Pregnancy?	YES	NO
Did your doctor put you at bed rest during your pregnancy?	YES	NO
Did you have other obstetric complications?	YES	NO
What were the birth weights of your children? _____		
Do you consider yourself infertile?	YES	NO
Have you undergone any treatment for infertility?	YES	NO
Do you presently use Birth Control Pills?	YES	NO
Are you on hormonal replacement therapy?	YES	NO

Sleep History

Sleep plays a major role in overweight and obesity.
How much sleep do you get each night on average? 4-5 Hours 6-8 hours More than 8 hours

Do you have restless sleep?	YES	NO
Does it take a long time to fall asleep? How long on average? _____	YES	NO
Do you wake up early and have trouble falling back asleep?	YES	NO
Do you feel tired when you wake up in the morning?	YES	NO
What is your sleep environment like?	YES	NO
Dark Room:	YES	NO
Sleep with Dogs:	YES	NO
Do you have insomnia?	YES	NO
Do you take any sleep aid medications? If yes, what type? _____	YES	NO
Do you snore at night?	YES	NO
Has your sleep partner ever told you that you stop breathing while you are sleeping?	YES	NO

5100-0057
(04/2018)

Banner Health

NEW PATIENT MEDICAL HISTORY - BARIATRIC ADDENDUM

Please rate how likely you would be to actually *doze* off during each situation. Score your rating by circling a number from 0 to 3 points which best describes each situation and total your answers. Even if you have not done some of these things recently, try to recall how they would likely affect you.

0 points = Would never fall asleep
1 point = Slight chance of falling asleep
2 points = Moderate chance of falling asleep
3 points = High chance of falling asleep

	SITUATION				
A.	Sitting and reading	**0**	**1**	**2**	**3**
B.	Watching TV	**0**	**1**	**2**	**3**
C.	Sitting, inactive in a public place (e.g., theater or meeting)	**0**	**1**	**2**	**3**
D.	As a passenger in a car for an hour without a break	**0**	**1**	**2**	**3**
E.	Lying down to rest in the afternoon when circumstances permit	**0**	**1**	**2**	**3**
F.	Sitting down and talking to someone	**0**	**1**	**2**	**3**
G.	Sitting quietly after a lunch	**0**	**1**	**2**	**3**
H.	In a car, while stopped for a few minutes in traffic	**0**	**1**	**2**	**3**
	Totals				
			TOTAL		

Total up Score:
0-7 No abnormality; 8-9 Average Daytime Sleepiness; 10-15 Excessively sleepy and 16-24 Very Excessively sleepy.

The last two categories mean that further evaluation should be done.

(Johns MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. 1991;14(6):540-5).

Psychosocial History

Screening Questions Psychosocial History –

Have you ever had:

Suicide attempt?	YES	NO
Family history of suicide?	YES	NO
History of Bipolar Disorder?	YES	NO
Obsessive Compulsive Disorder?	YES	NO
A phobia or avoidance of specific things or situations?	YES	NO
Post Traumatic Stress Disorder?	YES	NO

Over the last two weeks have you experienced any of the following:

Loss of interest in activities that you formerly enjoyed?	YES	NO
Guilt worthlessness/helplessness/hopelessness?	YES	NO
Reduced Energy?	YES	NO
Lack of concentration?	YES	NO
Appetite disturbance increased or decreased agitation?	YES	NO
Death of close family member or friend?	YES	NO

Abuse Assessment:

In the past year have you been hit, kicked, or physically hurt by another person?	YES	NO
Have you ever been in a relationship with someone who threatens or physically harms you?	YES	NO
Have you ever been forced to have sexual contact that you were not comfortable with?	YES	NO
Have you ever been abused? If yes, describe by whom, when and how: _____ _____	YES	NO

5100-0057
(04/2018)

Banner Health

NEW PATIENT MEDICAL HISTORY - BARIATRIC ADDENDUM

Previous Bariatric Surgery

***Please complete this information if you have had a previous weight loss surgery procedure:**

Are you having problems with a previous procedure? YES NO

Are you interested in having a revision of a previous weight loss procedure? YES NO

Date of Procedure _____

Name of Surgeon who did the procedure? _____

How much did you weigh prior to the procedure? _____

What was your lowest weight after the procedure? How many months after the primary procedure was your lowest weight? _____

Did you have any readmissions to the hospital after surgery? YES NO

Why? _____

Did you have to go back to surgery for any reason after the original procedure? YES NO

Why? _____

What medical problems did you have prior to surgery? Please give a complete list _____

_____

Adjustable Gastric Band

What type of Band did you have placed? _____

Did you go for regular follow up and get fills? _____

How much fluid do you think is in your band? _____

Do you have a feeling of fullness? _____

Are you throwing up after meals? _____

When you get filled do you feel like you cannot eat? _____

When was your last fill? _____ How much fluid did they put in the band? _____

Have you had any complications of the band? Erosion? Slip or Prolapse? Problems with your Port? _____

_____

Do you want to have the band removed? _____

Do you want a secondary bariatric procedure? YES NO Sleeve Gastrectomy Gastric Bypass Duodenal Switch

Have you had a recent Upper Gastrointestinal Series? YES NO

Where did you have it done? _____

Have you had a scope (EGD) done to look at your surgery from the inside? YES NO

What physician did the EGD? _____

Do you have a copy of your operative report? YES NO _____

5100-0057
(04/2018)