Texas Surgery Associates

2540 North Galloway Avenue #101
Mesquite, Texas 75150

Patient Bariatric Questionaire

Michel K. Stephan, M.D., F.A.C.S.

Name:_____ Sex: ◯ M ◯ F Age:_____

Street Address:_____

City/State/Zip:_____

Home Phone:(____)_____ Work Phone: (____)_____ Cell/Other:(____)_____

Weight:_____ Height:_____ Date of Birth:_____

Previous attempts at weight reduction:

How many years have you been overweight? _____

Diet programs and supplements: (Please indicate which of the following diets or plans you have attempted)

Program	Dates	Duration	MD Supervised?	Weight Loss
◯ Weight Watchers				
◯ Jenny Craig				
◯ Metabolife				
◯ Medifast				
◯ Nutri/System				
◯ Atkins Diet				
◯ Herbalife				
◯ SlimFast				
◯ Grapefruit Diet				
◯ Liquid Diets				
◯ Pritikin Diet				
◯ Optifast				
◯ T.O.P.S.				
◯ Other:				

Texas Surgery Associates

2540 North Galloway Avenue #101
Mesquite, Texas 75150

Bariatric Patient Questionaire

Michel K. Stephan, M.D., F.A.C.S.

List any other physician-supervised Weight loss attempts: _____

_____

Weight-Loss Medication History: Please indicate if you have taken any of the following medications to lose weight.

Medication:	Dates	Duration	MD Supervised?	Weight Loss
◯ Amphetamines				
◯ Phentermine (Adipex, Fastin, Pondimen)				
◯ Phen-Fen				
◯ Dexfenfluramine (Redux)				
◯ Xenical (Orlistat)				
◯ Meridia (Sibutramine)				

Other Diet Medications: _____

Non-Dietary Therapies: Please indicate if you have tried any of the following weight loss therapies.

Therapy:	Dates	Duration	MD Supervised?	Weight Loss
◯ Exercise				
◯ Hypnosis				
◯ Behavior Modification				
◯ Acupuncture				

List any other weight loss methods you have tried: _____

_____

Previous Weight Loss Surgery: ◯ No ◯ Yes

Surgery Type	Date	Surgeon	Wt. Loss

Please bring a chronological diet history to your initial appointment

Texas Surgery Associates

2540 North Galloway Avenue #101
Mesquite, Texas 75150

Bariatric Patient Questionaire

Michel K. Stephan, M.D., F.A.C.S.

Obesity Related Medical History:

Do you, or have you had, any of the following illnesses or symptoms?

Heart Disease ◯ **No** ◯ **Yes**

If yes, year of diagnosis: _____

Do you have, or have you had:

◯ Angina
◯ M.I. (heart attack, myocardial infarction)
◯ Coronary Bypass surgery
◯ Coronary Angioplasty
◯ Palpitations (abnormal heart beat)

Congestive Heart Failure ◯ **No** ◯ **Yes**

If yes, year of diagnosis: _____

High Blood Pressure ◯ **No** ◯ **Yes**

If yes, year of diagnosis: _____

Elevated Cholesterol ◯ **No** ◯ **Yes** **Elevated Triglycerides** ◯ **No** ◯ **Yes**

If yes, year of diagnosis: _____

Diabetes ◯ **No** ◯ **Yes**

If yes, year of diagnosis: _____

◯ Juvenile onset
◯ Gestational (Pregnancy)
◯ Adult onset

Diet Controlled ◯ No ◯ Yes
Oral Medications ◯ No ◯ Yes
Insulin ◯ No ◯ Yes

Asthma ◯ **No** ◯ **Yes**

If yes, year of diagnosis: _____

Shortness of Breath ◯ **No** ◯ **Yes**

If yes, can you: walk _____ blocks
climb_____ flights of stairs

Texas Surgery Associates

2540 North Galloway Avenue #101
Mesquite, Texas 75150

Michel K. Stephan, M.D., F.A.C.S.

Bariatric Patient Questionaire

Sleep Apnea ◯ **No** ◯ **Yes**

If yes, do you use a CPAP or BiPAP machine? ◯ No ◯ Yes

Sleep Difficulties:

snoring	◯ No	◯ Yes
awakenings at night	◯ No	◯ Yes
daytime drowsiness	◯ No	◯ Yes
observed apnea spells	◯ No	◯ Yes
morning headaches	◯ No	◯ Yes

Reflux/Heartburn/Esophagitis/Hiatal Hernia ◯ **No** ◯ **Yes**

If yes, year of diagnosis: _____

Prescription medications:	◯ No	◯ Yes
Over the counter meds:	◯ No	◯ Yes

Frequency of use:_____

Endoscopy: ◯ No ◯ Yes

Venous Stasis	◯ **No**	◯ **Yes**
Leg or ankle swelling/edema	◯ No	◯ Yes
Leg ulceration	◯ No	◯ Yes
Leg skin color change or thickening	◯ No	◯ Yes
Pain or Arthritis of Ankles/Knees/Hips	◯ **No**	◯ **Yes**
Limits ability to walk or exercise	◯ No	◯ Yes
Prescription medications	◯ No	◯ Yes
Over the counter medications	◯ No	◯ Yes
Low Back Pain / Sciatica	◯ **No**	◯ **Yes**
Limits ability to walk or exercise	◯ No	◯ Yes
Prescription medications	◯ No	◯ Yes
Over the counter medications	◯ No	◯ Yes
Urinary Incontinence (leakage of urine)	◯ **No**	◯ **Yes**
With coughing/sneezing/straining	◯ No	◯ Yes

Number of times per week: _____

Migraine Headaches	◯ **No**	◯ **Yes**

Frequency: _____

Prescription medications	◯ No	◯ Yes
Over the counter medications	◯ No	◯ Yes

Texas Surgery Associates

2540 North Galloway Avenue #101
Mesquite, Texas 75150

Bariatric Patient Questionaire

Michel K. Stephan, M.D., F.A.C.S.

Deep Venous Thrombosis (Blood Clots in Legs) ◯ **No** ◯ **Yes**

If yes, year of diagnosis: _____

Pulmonary embolism ◯ No ◯ Yes

Blood thinning medication ◯ No ◯ Yes

Abominal Wall Hernia ◯ **No** ◯ **Yes**

Incisional ◯ No ◯ Yes

Umbilical (belly button) ◯ No ◯ Yes

Number of hernia repairs and dates: _____

Hernia currently present ◯ No ◯ Yes

Menstrual Irregularities ◯ **No** ◯ **Yes**

Infertility ◯ No ◯ Yes ◯ n/a

Past Medical History:

Please list all other medical conditions or illnesses not previously mentioned:

_____

_____

_____

_____

Please list all non-surgical hospitalizations you have experienced as an adult:

Indication	**Hospital**	**Date**

Texas Surgery Associates

2540 North Galloway Avenue #101
Mesquite, Texas 75150

Bariatric Patient Questionaire

Michel K. Stephan, M.D., F.A.C.S.

Past Surgical History:

Please list all surgical procedures or operations:

Procedure	Indication	Hospital	Date

Do you have allergies to any medications? ◯ **No** ◯ **Yes**

If yes, please list medications and reactions (e.g., rash, breathing difficulty, shock, etc):

Have you ever received a blood transfusion? ◯ **No** ◯ **Yes**

Have you ever had hepatitis? ◯ **No** ◯ **Yes**

Have you ever been exposed to HIV/AIDS ◯ **No** ◯ **Yes**

Have you ever abused intravenous drugs? ◯ **No** ◯ **Yes**

Texas Surgery Associates

2540 North Galloway Avenue #101
Mesquite, Texas 75150

Bariatric Patient Questionaire

Michel K. Stephan, M.D., F.A.C.S.

Medications: (Please list all medications you currently use)

Name	Dosage	Frequency	Indication

Family History: (Please indicate if family members have any of the following illnesses)

- ◯ Obesity
- ◯ High Blood Pressure
- ◯ Heart Disease
- ◯ Stroke
- ◯ Lung disease or emphysema
- ◯ High Cholesterol
- ◯ Breast Cancer
- ◯ Other Cancers
- ◯ Kidney Disease
- ◯ Diabetes
- ◯ Blood Disorder
- ◯ Bleeding Tendency

Texas Surgery Associates

2540 North Galloway Avenue #101
Mesquite, Texas 75150

Bariatric Patient Questionaire

Michel K. Stephan, M.D., F.A.C.S.

Social History:

Marital Status: ◯ **Single** ◯ **Married** ◯ **Divorced**

Children: ◯ **No** ◯ **Yes** **Number:**_____

Occupation: _____

Do you smoke tobacco? ◯ **No** ◯ **Yes**

If yes, number of packs per day:_____ Years of tobacco use:_____

Do you use alcohol? ◯ **No** ◯ **Yes** Amount and frequency:_____

Have you ever been treated for depression? ◯ **No** ◯ **Yes**

Are you currently in treatment? ◯ **No** ◯ **Yes**

If yes, please indicate the name of your physician or therapist:

_____

Have you ever been hospitalized for mental illness? ◯ **No** ◯ **Yes**

System Review: (Please mark any of the following you experience or have experienced in the past.)

Constitutional: ◯ fatigue ◯ tiredness ◯ recent weight loss
◯ fever ◯ night sweats ◯ abnormal bleeding

Head and Neck: ◯ blurred vision ◯ double vision ◯ loss of vision ◯ loss of hearing
◯ dizziness ◯ vertigo ◯ sinus congestion ◯ runny nose
◯ sneezing ◯ loss of smell ◯ sinus infections ◯ sore throat
◯ difficulty swallowing ◯ pain when swallowing ◯ hoarseness ◯ lump in neck

Cardiovascular: ◯ chest pain ◯ pain in arms or neck ◯ heart attack ◯ palpitations
◯ heart pounding ◯ abnormal heart beats ◯ heart murmur ◯ stroke
◯ high blood pressure ◯ low blood pressure ◯ pain in legs ◯ cold feet
◯ loss of pulses

Respiratory: ◯ shortness of breath ◯ asthma ◯ wheezing ◯ cough
◯ bloody sputum ◯ emphysema ◯ pneumonia ◯ bronchitis
◯ difficulty sleeping flat ◯ waking at night short of breath

Gastrointestinal: ◯ jaundice ◯ hepatitis ◯ cirrhosis ◯ vomiting
◯ nausea ◯ heartburn ◯ abdominal pain ◯ diarrhea
◯ constipation ◯ pain with bowel movements ◯ blood in stool
◯ change in stool size ◯ hemorrhoids ◯ irritable bowel ◯ colitis

Texas Surgery Associates

2540 North Galloway Avenue #101
Mesquite, Texas 75150

Bariatric Patient Questionaire

Michel K. Stephan, M.D., F.A.C.S.

Genitourinary: ◯ blood in urine ◯ frequent urination ◯ leakage of urine ◯ pain with urine
◯ trouble starting urine ◯ kidney stones ◯ kidney infection ◯ bladder infection

Men: ◯ discharge from penis ◯ loss of erection
Women: ◯ vaginal discharge ◯ abnormal vaginal bleeding ◯ irregular periods
◯ pelvic examination/PAP smear with past year

Musculoskeletal: ◯ pain in joints ◯ muscular aches ◯ swelling of joints ◯ arthritis
◯ pain in hips ◯ pain in knees ◯ pain in ankles ◯ pain in feet
◯ low back pain ◯ sciatica ◯ herniated disk
◯ numbness in feet or legs ◯ abnormal lumps or masses

Endocrine: ◯ hyperthyroid ◯ low thyroid ◯ goiter ◯ diabetes
◯ previous radiation ◯ adrenal gland tumor ◯ swollen glands
◯ previous steroid (corticosteroids, cortisone) use or injections

Skin/Breast: ◯ skin cancer ◯ abnormal moles ◯ burns ◯ rash
◯ breast mass ◯ nipple discharge ◯ mammogram within the past year

Neurological: ◯ seizures ◯ convulsions ◯ fainting ◯ dizziness
◯ light headedness ◯ falling ◯ muscle weakness ◯ numbness
◯ tremors ◯ loss of consciousness ◯ strokes

Psychological: ◯ depression ◯ nervousness ◯ anxiety
◯ suicidal thoughts ◯ suicide attempts ◯ hospitalization for emotional problems
◯ psychiatric or psychological counseling ◯ schizophrenia
◯ anorexia ◯ bulemia ◯ binge eating

I am interested in the gastric ◯ lap band ◯ bypass ◯ lap bypass ◯ undecided

Physician Attestation: I have reviewed and verified the above information with:

Patient Signature: _____ Date: _____

Bariatric Physician Signature: _____ Date: _____