



# Bariatric Surgery Program Questionnaire

**Dr. Timothy Ehrlich, MD, FACS**

In order to provide insurance companies with the maximum information to assist them in determining the medical necessity for bariatric surgery, we ask that you complete this form and bring this with you when you come for your initial appointment. **Please answer all the questions in the space provided.**

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Race: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ (home)  okay to leave message

Phone: \_\_\_\_\_ (mobile)  okay to leave message

e-mail: \_\_\_\_\_

I would like to receive periodic e-mails regarding bariatric surgery and upcoming support services

**How did you hear about us?** (Please rate the choices from 1 to 6, 1 being the most important, 6 the least important)

Family member/friend is a patient of this program \_\_\_\_\_

Internet search  Google  Yahoo!  Bing  \_\_\_\_\_

TV Show \_\_\_\_\_

Newspaper advertisement Name of newspaper: \_\_\_\_\_

Saw information about seminar at Griffin hospital

My physician referred me



I was referred to this program by my physician

Physician: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Primary Care Physician Information:**  same as referring physician

Physician: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Which, if any, of your physicians do you feel would write letters of support for bariatric surgery to your insurance company?**

Referring Physician  Primary Care Physician  Other (please complete below)

Physician: \_\_\_\_\_

Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_



## History of Obesity

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Body Mass Index (BMI): \_\_\_\_\_

How long have you been overweight? \_\_\_\_\_ years Since the age of: \_\_\_\_\_

What is your highest adult weight? \_\_\_\_\_

What is your lowest adult weight? \_\_\_\_\_

Why are you pursuing a surgical attempt at weight loss?

---

---

---

---

---

Please list your goals and/or expectations following bariatric surgery:

---

---

---

---

---

When you lose weight, do you always regain it?  yes  no

Do you usually gain back more than you lost?  yes  no

What was the most amount of weight you lost? \_\_\_\_\_ pounds

How long did it take for the weight to come back? \_\_\_\_\_

Please describe your most successful weight loss attempt and why you feel it was a success. Please include the date and duration of the program.

---

---

---

---

In what ways was the above mentioned weight loss attempt unsuccessful?

---

---



Insurance companies want to know that efforts have been made to reduce/modify weight. Many demand the dates of medically supervised programs including the doctors' and/or nutritionists' names and the resulting weight loss.

Have you participated in a medically supervised weight loss program?  yes  no

If yes, please provide the following information:

Doctors or Nutritionists	Year	Length of Program	Weight Loss Result	Duration of weight loss maintenance

Have you ever participated in commercial weight loss programs?  yes  no

If yes, please provide the following information:

Program	Year	Length of Program	Weight Loss Result	Duration of weight loss maintenance
Weight Watchers				
Tops				
Richard Simmons				
Physician's Weight Loss				
Slimfast				
Jenny Craig				
Health Spa(s)				
Atkins				
Liquid Protein				
Medifast/Optifast				
Nutrisystem				
South Beach Diet				



Have you tried various calorie and/or fat reduction diets, “fad” diets, or diets which required the purchase of books or videos?  yes  no

If yes, please list all diets:

---



---



---

Have you taken weight loss medications like Phen-Fen, Redux or Orlistat?  yes  no

If yes, please provide the following information:

Drug	Duration	Weight loss	Reason for stopping the drug

### Activity/Exercise

Has your weight negatively impacted any of the following (Please check all that apply):

- Ordinary chores/activities of daily life
- Ability to work for a living
- Relationships with family and friends
- Participating in recreational activities
- Difficulty with airline seats
- Climbing stairs
- Difficulty playing with children
- Lifting objects from floor
- Use of public seating
- Tying shoes
- Caring for personal hygiene

Do you exercise currently?  yes  no

Type of activity: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_



### System Review

Do you have (or have you ever had) the following:

**Heart Disease:**

yes  no

- Chest Pain (angina)
- Heart Attack \_\_\_\_\_ (date(s), how many times)
- Coronary Artery Disease
- Arrhythmia
- Atrial Fibrillation
- Pacemaker
- High Cholesterol
- Pulmonary Embolism (blood clot in lung)
- CVA (Stroke)
- High Blood Pressure
- Stress test ⇨ date: \_\_\_\_\_

Cardiologist: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Varicose veins, feet numbness

Blood Clots in veins

**Breathing Problems:**  yes  no

- Asthma
- Shortness of Breath
- COPD
- Emphysema
- \_\_\_\_\_

What precipitates your breathing problems:

- Walking (number of blocks \_\_\_\_\_)
- Climbing stairs (number of steps \_\_\_\_\_)
- \_\_\_\_\_

Pulmonologist: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**Sleep Problems:**  yes  no

- Sleep Apnea
- CPAP ⇨ Do you wear it every night?  yes  no
- Snoring
- Insomnia
- \_\_\_\_\_

⇨ How many times to you get up at night? \_\_\_\_\_

⇨ Have you ever had a sleep study?  yes  no

If yes, where and when? \_\_\_\_\_



**Diabetes:**  yes  no

If yes, how many years? \_\_\_\_\_

Type of diabetes:

Type I (childhood)  Type II (adult onset)  Gestational Diabetes (pregnancy induced)

How is your diabetes controlled? (Please check all that apply)

Diet  Medication  Insulin

What was your last HbA1c? \_\_\_\_\_

Endocrinologist: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

**Thyroid Problems:**  yes  no

Hyperthyroid

Hypothyroid

**Muscle and Joint Pain:**  yes  no

Foot and ankle pain  Knee pain  Hip pain  Back pain

Leg and foot swelling  \_\_\_\_\_

⇒ Do you take Vitamin D?  yes  no

⇒ Are you Vitamin D deficient?  yes  no

⇒ Do you take daily Calcium supplements?  yes  no

⇒ Have you had a bone density test?  yes  no

If yes, where and what were the results? \_\_\_\_\_

**Arthritis:**  yes  no

Osteoarthritis  Rheumatoid arthritis

Are you taking medication for this condition?  yes  no

Name of medication: \_\_\_\_\_

**Cancer:**  yes  no

If yes, please specify type: \_\_\_\_\_

Are you in remission?  yes  no \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**Gastrointestinal Problems:**     yes    no

- Heartburn or reflux    Hiatal Hernia             Infected Gallbladder    Barrett’s Disease
- Gallstones                     Peptic Ulcer Disease (Stomach Ulcers)             Pancreatitis
- Fatty Liver                     Hepatitis
- Endoscopy \_\_\_\_\_(date)

**Gastroenterologist:** \_\_\_\_\_

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

**Phone:** \_\_\_\_\_

**Colon Problems:**     yes    no

- Hemorrhoids             Rectal Bleeding             Polyps             Stool Incontinence
- Family history of colon cancer             Colonoscopy \_\_\_\_\_(date)

**Urinary Incontinence:**     yes    no

If yes, how often: \_\_\_\_\_

Do you wear incontinence pads?             yes    no

Do you take medication for this condition?             yes    no

**Do you have or have you ever had any of following:**

- History of cellulitis     Pseudotumor cerebra             Substance abuse and/or tobacco
- Meningitis in childhood             Encephalitis in childhood

**Women only:**

**Gynecological Problems:**     yes    no

- Difficulty achieving pregnancy             Fibroids/tumor in uterus             Ovarian cyst
- Painful menstrual periods             Heavy menstrual periods             Post-menopausal
- Cessation of menstrual periods             Frequent Urinary Tract Infections
- PCOS     Total Abdominal Hysterectomy (both ovaries removed)
- Miscarriage                                     Extra-uterine pregnancies             C-Section

⇒ Are you pregnant?    yes    no

Total number of pregnancies: \_\_\_\_\_            Total number of living children: \_\_\_\_\_

⇒ date of last mammogram: \_\_\_\_\_

⇒ date of last PAP smear: \_\_\_\_\_



### Surgical History

Please check all that apply and write in the year of the procedure.

- C-Section \_\_\_\_\_
- Gallbladder Surgery \_\_\_\_\_
- Cosmetic Surgery \_\_\_\_\_
- Groin Hernia Repair \_\_\_\_\_
- Ventral or Umbilical Hernia Repair \_\_\_\_\_
- Tonsils \_\_\_\_\_
- Breast Biopsy \_\_\_\_\_
- Diverticulitis Surgery \_\_\_\_\_
- Incisional Hernia Repair \_\_\_\_\_
- Appendix \_\_\_\_\_
- Carpel Tunnel \_\_\_\_\_
- Colon Surgery \_\_\_\_\_

Orthopedic Surgeries: \_\_\_\_\_

Other Surgeries: \_\_\_\_\_

Do you have a history of complications from anesthesia? (Please be specific)

Do you have a family history of complications from anesthesia? (Please be specific)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Psychological History

Are you currently depressed?  yes  no

If yes, are you being treated?  yes  no

Please describe how your depression is being treated and list medicines, if any.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever felt depressed for 2 or more weeks at a time?  yes  no

Are you currently taking any other psychiatric medications?  yes  no



Have you ever had psychological or psychiatric counseling for weight loss or problems associated with weight loss?  yes  no

If yes, please describe:

---

---

---

---

---

Have you ever experienced any suicidal episodes?  yes  no

Have you ever been hospitalized for psychiatric reasons?  yes  no

If yes, what was the reason for the hospitalization and what was the duration of your stay?

---

---

---

---

Have you ever been addicted to drugs or alcohol?  yes  no

If yes, please specify:

---

---

---

---

Do you (or have you ever):

Force yourself to vomit  Go extended periods of time without eating

Exercise excessively  Use laxatives excessively

Binge eat  feel addicted to sweets  have emotional eating

⇒ Do you find yourself discriminated against at work?  yes  no

⇒ Is your life more stable than it was a year ago?  yes  no

⇒ Do you over-eat in reaction to feelings?  yes  no

⇒ If yes, please check all that apply:

sadness  loneliness  anxiety  anger  stress  \_\_\_\_\_

Is your spouse/significant other supportive?  yes  no

Is your family supportive?  yes  no

Do you have a history of physical or sexual abuse?  yes  no



## Social History

Marital status:

Single     Married     Partner     Divorced     Separated     Widowed

⇒ If in a committed relationship, is your partner overweight?     yes     no

⇒ Do you drink alcohol?     yes     no

How many drinks/day? \_\_\_\_\_ How many drinks/week? \_\_\_\_\_

⇒ Do you smoke cigarettes?     yes     no    When did you quit? \_\_\_\_\_     N/A

How many packs/day? \_\_\_\_\_ How long have you been smoking? \_\_\_\_\_

## Family History

Please complete the chart if you have a family history of any of the following medical conditions:

	Obesity	Stroke	Diabetes	Heart Disease	High Blood Pressure
<b>Mother</b>					
<b>Father</b>					
<b>Sibling(s)</b>					
<b>Paternal Aunt(s)</b>					
<b>Paternal Uncle(s)</b>					
<b>Maternal Aunt(s)</b>					
<b>Maternal Uncle(s)</b>					



Please complete the charts in regards to the cause of death and age of death of family members

<b>Family Member</b>	<b>Cause of Death</b>	<b>Age at death</b>
<b>Mother</b>		
<b>Father</b>		
<b>Sibling(s)</b>		
<b>Paternal Aunt(s)</b>		
<b>Paternal Uncle(s)</b>		
<b>Maternal Aunt(s)</b>		
<b>Maternal Uncles(s)</b>		

I agree that all of the above information is truthful to the best of my knowledge.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

