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Patient Health History Questionnaire BARIATRIC SURGERY

The information requested in this questionnaire is very important. To give you the best care, and to obtain your insurance approval, we must have complete answers. Please be thorough.

PATIENT: _____ / _____ / _____ DATE: _____ / _____ / _____
LAST NAME FIRST MIDDLE

_____/_____/_____
BIRTH DATE AGE SOCIAL SECURITY NO.

HOME PHONE NO. CELL PHONE NO.

Ht: _____ Current Weight: _____

WEIGHT RELATED ILLNESSES

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

CARDIOVASCULAR DISEASE:

- | | | |
|--|--|-------------|
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Palpitations (irregular and/or forceful heartbeat) | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Varicose Veins | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Swelling of Ankles/Feet | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Blood clot (Deep Vein Thrombosis- DVT) | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Pulmonary Embolism | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | High Cholesterol | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | High Triglycerides | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | High Blood Pressure | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Angina (chest pain) | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | M.I. (myocardial infarction, heart attack) | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | CABG (coronary artery bypass graft, known as open heart surgery) | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Abnormal EKG | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Shortness of breath | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Stress test to rule out cardiac problems | Date: _____ |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Echocardiogram (heart ultrasound) | Date: _____ |

DIABETES:

- | | |
|--|---------------------|
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Diabetes |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Do you take Insulin |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Oral Medication |

ASTHMA

- Yes No Asthma
Yes No Hospitalization in last 2 years
Yes No Steroid use in last 2 years

SLEEP APNEA SYNDROME

- Yes No Sleep Apnea
Yes No CPAP or BiPAP
Year diagnosed: _____
Last sleep study: _____

Yes No **HEARTBURN/ HIATUS HERNIA**

GALLBLADDER

- Yes No Gallbladder disease
Yes No Gallbladder removed
Yes No Ultrasound performed

GENITO-URINARY:

- Yes No Leakage of urine with laughing/ coughing/ sneezing
Yes No Wear pads frequently

MUSCULOSKELETAL:

- Yes No Arthritis
Yes No Low back strain/pain/sciatica
Yes No Pain in hips/knees/ankles/feet
Yes No Assistance to ambulate
Exercise limitation: None / Minimal / Severe
(CIRCLE ONE)

Yes No **CANCER**

- Yes No Breast
Yes No Endometrial
Yes No Uterine
Yes No Prostrate

Other: _____

Treatment: _____

Remission: _____

- Yes No **WEIGHT RELATED INJURIES AND TRAUMA**
- Yes No **VENOUS STASIS DISEASE**
- Yes No **COLITIS**
- Yes No **LIVER DISEASE**
- Yes No **ULCERS / GASTRITIS**
- Yes No **RECTAL BLEEDING**
- Yes No **THYROID DISEASE**
- Yes No **EATING DISORDER**

If Yes, have you been seen by a specialist? Yes No

PAST MEDICAL HISTORY

Please identify which of the following childhood illnesses and operations you have experienced.

- | | | | |
|---|-------------|---|-------------|
| <input type="checkbox"/> Rheumatic fever | Year: _____ | <input type="checkbox"/> Heart murmur | Year: _____ |
| <input type="checkbox"/> Obesity | Year: _____ | <input type="checkbox"/> Bleeding disorders | Year: _____ |
| <input type="checkbox"/> Bleeding disorders | Year: _____ | <input type="checkbox"/> Appendectomy | Year: _____ |
| <input type="checkbox"/> Asthma | Year: _____ | <input type="checkbox"/> Tonsillectomy | Year: _____ |
-

For female patients only

Currently pregnant: Yes No

Number of pregnancies: _____ Age at first period: _____

Number of live births: _____ Date of last period: _____

Miscarriages/abortions: _____

Obstetric complications:

Do you presently use:

- Birth control pills Yes No List Type: _____
- Estrogens Yes No List Type: _____
-

Please list below all serious illnesses and hospitalizations you have experienced in adulthood.

Major Illness	Date	Treatment

Major Surgery

	Year
	Year
	Year

Allergy to surgical tape/latex Yes No

Drug Allergies	Drug	Reaction	_____√ Here if NONE

Current Medications:

Drug	Dosage	Frequency	Reason Prescribed

Aspirin Yes No

Non-Steroidal Anti-Inflammatory Drug (NSAID) Yes No

Blood Thinner (Coumadin, Plavix, Lovenox) Yes No

SYSTEM REVIEW

Check all symptoms which you have, or have had. Write in any additional problems.

HEAD, EYE, EAR, NOSE & THROAT:

- | | | |
|---|---|--|
| <input type="checkbox"/> STUFFY NOSE | <input type="checkbox"/> RUNNY NOSE | <input type="checkbox"/> HAY FEVER |
| <input type="checkbox"/> SINUS TROUBLE | <input type="checkbox"/> EARACHE | <input type="checkbox"/> HEADACHE |
| <input type="checkbox"/> BLURRY VISION | <input type="checkbox"/> DOUBLE VISION | <input type="checkbox"/> HALOS AROUND LIGHTS |
| <input type="checkbox"/> LOSS OF NIGHT VISION | <input type="checkbox"/> BUZZING IN EARS | <input type="checkbox"/> RINGING IN EARS |
| <input type="checkbox"/> DISCHARGE FROM EAR | <input type="checkbox"/> LOSS OF HEARING | <input type="checkbox"/> DIZZINESS |
| <input type="checkbox"/> VERTIGO | <input type="checkbox"/> LOSS OF BALANCE | <input type="checkbox"/> SORE THROAT |
| <input type="checkbox"/> LUMP IN THROAT | <input type="checkbox"/> TROUBLE SWALLOWING | <input type="checkbox"/> HOARSENESS |
| <input type="checkbox"/> PAIN WITH SWALLOWING | | |

RESPIRATORY:

- | | | |
|--|--|--|
| <input type="checkbox"/> BRONCHITIS | <input type="checkbox"/> WHEEZING | <input type="checkbox"/> ASTHMA |
| <input type="checkbox"/> USE TWO PILLOWS | <input type="checkbox"/> BLOOD IN SPUTUM | <input type="checkbox"/> OUT OF BREATH WITH EXERTION |
| <input type="checkbox"/> COUGH | <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> SHORTNESS OF BREATH AT NIGHT |
| <input type="checkbox"/> WAKE UP AT NIGHT COUGHING
OR CHOKING | | <input type="checkbox"/> WAKE UP AT NIGHT SHORT
OF BREATH |

CARDIOVASCULAR:

- | | | |
|--|--|---|
| <input type="checkbox"/> PALPITATIONS | <input type="checkbox"/> POUNDING OF HEART | <input type="checkbox"/> SKIPPING OF HEARTBEAT |
| <input type="checkbox"/> PAINS IN CHEST | <input type="checkbox"/> PAINS IN NECK | <input type="checkbox"/> PAINS IN ARMS |
| <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> SQUEEZING OF CHEST |
| <input type="checkbox"/> COLD FEET | <input type="checkbox"/> LOSS OF PULSES | <input type="checkbox"/> ABNORMAL ELECTROCARDIOGRAM |
| <input type="checkbox"/> IRREGULAR HEARTBEAT | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> PAIN IN LEGS |
| <input type="checkbox"/> BLUE TOES | <input type="checkbox"/> BLUE FINGER | |

GASTROINTESTINAL:

- | | | |
|---|---|---|
| <input type="checkbox"/> HEARTBURN | <input type="checkbox"/> NAUSEA | <input type="checkbox"/> VOMITING |
| <input type="checkbox"/> GASSINESS | <input type="checkbox"/> ACID STOMACH | <input type="checkbox"/> DIARRHEA |
| <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> HEMORRHOIDS | <input type="checkbox"/> BELCHING FLUID IN THROAT |
| <input type="checkbox"/> BURNING IN THROAT | <input type="checkbox"/> PAINS IN STOMACH | <input type="checkbox"/> FOOD STICKING IN CHEST |
| <input type="checkbox"/> BURNING IN STOMACH | <input type="checkbox"/> BLOOD IN STOOLS | <input type="checkbox"/> PAIN WITH BOWEL MOVEMENT |
| <input type="checkbox"/> FISSURES | <input type="checkbox"/> CRAMPS | <input type="checkbox"/> IRRITABLE COLON COLITIS |

GENITOURINARY:

- | | | |
|--|---|---|
| <input type="checkbox"/> PAIN WITH URINATION | <input type="checkbox"/> TROUBLE STARTING URINE | <input type="checkbox"/> TROUBLE STOPPING URINE |
| <input type="checkbox"/> SMALL URINE STREAM | <input type="checkbox"/> BLOOD IN URINE | <input type="checkbox"/> KIDNEY FAILURE |
| <input type="checkbox"/> NEPHRITIS | <input type="checkbox"/> FREQUENT URINATION | <input type="checkbox"/> URINARY TRACT INFECTIONS |
| <input type="checkbox"/> KIDNEY STONES | <input type="checkbox"/> GETTING UP AT NIGHT TO URINATE | |
| <input type="checkbox"/> LEAKAGE OF URINE WITH COUGH OR SNEEZE | | |

MEN:

- DISCHARGE FROM PENIS
- LOSS OF ERECTION
- PAINFUL ERECTION

OB/GYN:

- VAGINAL DISCHARGE
- VAGINAL BLEEDING
- PAIN WITH INTERCOURSE
- IRREGULAR PERIODS

ENDOCRINE (GLANDULAR):

- LOW THYROID
- HYPERTHYROID
- GOITER
- GRAVE'S DISEASE
- THYROID NODULES
- DIABETES
- ADRENAL GLAND TUMOR
- FREQUENT FLUSHING
- FREQUENT HEAVY SWEATING

MUSCULOSKELETAL:

- PAIN IN JOINTS
- SWELLING OF JOINTS
- WARM JOINTS
- FLUID IN JOINTS
- ARTHRITIS
- BROKEN BONES
- SPRAINS
- LOW BACK PAIN
- SCIATICA
- HIP PAIN
- KNEE PAIN
- ANKLE PAIN
- FOOT PAIN
- FLATFEET
- SLIPPED DISK
- HERNIATED DISK
- REDNESS OF SKIN OVER JOINTS

NEUROLOGICAL:

- DIZZINESS
- VERTIGO
- FALLING TO THE SIDE
- FALLING AT NIGHT
- NUMBNESS
- TINGLING
- SHAKINESS
- PINS & NEEDLES FEELINGS
- WEAKNESS OF ANY MUSCLES
- TWITCHING OF MUSCLES
- WEAKNESS OF GRIP
- TREMOR
- FAINTING
- CONVULSIONS
- FITS
- LOSS OF CONSCIOUSNESS

PSYCHOLOGICAL:

- NERVOUSNESS
- DEPRESSION
- PSYCHOLOGICAL COUNSELING
- THOUGHTS OF SUICIDE
- SUICIDE ATTEMPTS
- PSYCHIATRIC TREATMENT
- HOSPITALIZATIONS FOR EMOTIONAL PROBLEM
- ANXIETY

FAMILY HISTORY

Family Member	Living?	Age	Age at Demise	Illness/Cause of death	Ht	Wt
Mother						
Father						
Maternal Grandmother						
Maternal Grandfather						
Fraternal Grandmother						
Fraternal Grandfather						
Sibling						
Sibling						
Sibling						
Sibling						

Please indicate if there is a family history of:

- | | |
|---|--|
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Lung disease, asthma or emphysema |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Bleeding tendency or blood disorder |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Breast cancer |
| <input type="checkbox"/> High blood cholesterol | <input type="checkbox"/> Colon cancer |

Please list all the physicians whose care you are under.

	Name	Location	Telephone
Primary Care / Internist Physician			
Gynecologist			
Orthopedist			
Psychiatrist/Psychologist			
Physical Therapist			
Other			

SOCIAL HISTORY

Marital Status: S: ___ M: ___ D: ___ W: ___ Religion: _____

Level of Education: _____

Persons Living in the Home: _____

Smoking History: Never Former Smoker Year Quit: _____

CURRENTLY Smoking: Yes No

 Number of packs per day: _____ Number of years: _____

 Are you willing to quit? Yes No

Recreational Drug Use: Yes No Describe: _____

Alcohol Intake Yes No

 Frequency of alcoholic beverages: None Light Moderate Heavy

WEIGHT HISTORY

Please estimate as closely as possible for all that applies.

Life Event	Age	Weight
Birth Weight		
Start of High School		
High School Graduation		
Marriage		
Lowest Weight in Past 5 Years		
Highest Weight in Past 5 Years		
1 st Pregnancy		
Last Pregnancy		

Please list any food allergies or intolerances you may have:

Weight Loss Attempts

Method	Yes	# Months	Year	# of Pounds Lost	Wt Regained
Weight Watchers					
Jenny Craig					
Nutri-Systems					
Opti/Medi Fast					
Phen Fen/Redux					
Phentarmine					
Meridia					
Xenical / Orlistat					
Ephedra					
Metabolife					
Nutritionist					
Slim Fast					
Atkins					
South Beach					
Overeaters Anonymous					
Weight Loss Camp					
Medically Supervised Wt Loss					
Doctor Prescribed Diet					
Hypnosis					
Acupuncture					
List any other wt loss attempt(s)					

Previous weight loss surgery Yes No

Date of Surgery: _____ Name of Surgeon: _____

Name of operation: _____ Wt at Operation: _____ Max Amt Wt Lost: _____

Please list any other information you feel is important for your surgeon:

The above information is true to the best of my knowledge:

Print Patient Name: _____ **Patient Signature:** _____

Date: _____

Surgeon: _____

Date Reviewed with Patient: _____

Surgeon Signature: _____

NUTRITIONAL HISTORY

Name: _____ Age: _____ DOB: _____

Occupation: _____

Ht: _____ Wt: _____ BMI: _____ IBW: _____

What were the 2 most effective diets and why?	
1. _____	2. _____
Why: _____	
Have you seen a nutritionist in the past? Yes <input type="checkbox"/> No <input type="checkbox"/>	
What is the most weight lost on a diet? _____	
How? _____	

Exercise History Please list exercise level below:

	Describe	Frequency	Duration	Time
<input type="checkbox"/> None				
<input type="checkbox"/> Moderate				
<input type="checkbox"/> Average				
<input type="checkbox"/> Strong				

FOOD PREFERENCES

Indicate which foods you prefer (which foods would most likely make you go off a diet).

Rank each selection from 1 - like very much to 4 - can take it or leave it

Candy _____	Chips/Snacks _____	Seafood _____
Chocolate _____	Fried Food _____	Dairy _____
Cakes/Pies _____	Fast Food _____	Red Meat _____
Cookies _____	Pizza _____	Poultry _____
Ice Cream _____	Bread/rice/pasta _____	Vegetables _____
	Cold Cereal _____	Fruit _____

Cravings/ Favorite Foods:

FOOD PATTERN:

Number of meals per day: _____

Eat between meals: Yes No

TYPICAL DIET – when NOT dieting- Current?: Yes/NO

**Include time, amount, brand, condiments added (sugar/cream/ mayo etc), beverages.*

<u>Breakfast-time:</u>	<u>Snack Time:</u>	<u>Lunch Time:</u>	<u>Snack Time:</u>	<u>Dinner Time:</u>	<u>Snacks Time:</u>

2nd/3rd helping?

TYPICAL DIET- while dieting- Current? Yes/ NO

<u>Breakfast Time:</u>	<u>Snack Time:</u>	<u>Lunch Time:</u>	<u>Snack Time:</u>	<u>Dinner Time:</u>	<u>Snacks Time:</u>

***Circle & add others where appropriate:**

Beverages #/day: water ____, coffee/tea ____, soda ____, diet soda ____, fruit juice ____, alcohol ____, milk ____, sport drinks ____, flavored coffees ____, smoothies ____

Dairy foods: *low-fat or whole milk-* cottage cheese, milk, yogurt, cheese

Protein foods: poultry, fish, seafood, beef, pork/ pork products, eggs, burgers, veggie/soy burgers/meats, peanut butter, beans

Starches/Grains: *whole grain wheat/oat or white-* bread, rolls, English Muffin, bagels, rice, pasta, cereal name _____, Pancakes, waffles, French toast, muffins, breakfast pastry, hot cereal, bialy

Fat added to food: cream, butter; oil, salad dressing, mayonnaise, PAM, butter substitute, sugar/ sugar sub, creamy soups or sauces

Vegetable: d/wk: broccoli/cauliflower, spinach/green leafy; salads; string beans; corn; peas/ carrots; squash; potatoes/ French fries/ mashed potato; yams; plantains

Fruits: d/wk: Tropical fruit, seasonal fruit, banana, berries, apples, oranges, grapefruit, grapes, melon

Sweet snacks/ Desserts: ice cream, cookies, chocolate candy, gummy/hard candy, pastry, cakes, pie

Salty/crunch snacks: nuts, seeds, crackers and cheese, chips, pretzels, popcorn

Fast Food/ Restaurants: _____ **#/wk:** Give an example of a typical meal if you order from:

Chinese/Asian cuisine:
Spanish/ Mexican:
French/Italian/ Pizza:
Steakhouse/seafood:
American/Diner/ Deli/ Cafeteria:
McDonalds/Burger King/Wendy's:
Other:

Binges/ Trigger foods/ Environmental triggers:

Eating habit & emotional eating self- assessment:		Eat in response to:
<input type="checkbox"/> Skip meals/ erratic meal times	<input type="checkbox"/> Dine Out > 2x per week	<input type="checkbox"/> Depression
<input type="checkbox"/> Secret eating	<input type="checkbox"/> Large Portions	<input type="checkbox"/> Anger
<input type="checkbox"/> Binge eating (feel out of control/guilt)	<input type="checkbox"/> Frequent Snacks/ grazing	<input type="checkbox"/> Habit/ "Time to eat"
<input type="checkbox"/> Night eating	<input type="checkbox"/> Eat until stuffed/ uncomfortable	<input type="checkbox"/> Bored/ "because its there"
<input type="checkbox"/> Eat while doing/ TV/ cooking/ work	<input type="checkbox"/> Usually hungry at meals/ snacks	<input type="checkbox"/> Lonely
<input type="checkbox"/> Eat fast/ don't chew well	<input type="checkbox"/> Rarely hungry at meals/ snacks	<input type="checkbox"/> Worried/ stressed/ anxious/ nervous
<input type="checkbox"/> Clean plate	<input type="checkbox"/> Not satisfied after meals- still hungry	<input type="checkbox"/> Reward/ celebratory
<input type="checkbox"/> 2 nd helpings often	<input type="checkbox"/> Sweets/ baked goods	<input type="checkbox"/> Relaxation/ Escape
<input type="checkbox"/> Meal Eater	<input type="checkbox"/> Salty, crunchy snacks	<input type="checkbox"/> Hunger
<input type="checkbox"/> Grazer/snacker btw/ @ meals	<input type="checkbox"/> Savory meals/ foods	<input type="checkbox"/> Craving w/o hunger

What do you feel are your personal diet and behavioral obstacles for losing weight and maintaining weight loss: _____

How much weight would you like to lose from WLS? What do you feel is your ideal weight?

Diet and Behavioral Self Recommendations:

1. Read food labels/ practice portion control
2. Make lower fat choices: Avoid fried/fast foods- alt. cooking methods/ food choices
3. Avoid beverages with calories and carbonation; reduce caffeine intake
4. Exercise 30 minutes brisk walking most days of the week
5. Time management and meal planning
6. Avoid bringing trigger/ binge foods into the home or workplace
7. Other: _____

The above information is true to the best of my knowledge. Print Patient Name: _____

Patient Signature: _____

Date: _____

Nutritionist: _____

Date Reviewed with Patient: _____

Nutritionist Signature: _____