Danbury Hospital
Western Connecticut Health Network

The Center for Weight Loss Surgery
111 Osborne Street
Danbury, CT, 06810
203.739.7131 / 203.739.1669 fax

Bariatric Surgery Program Patient Health Questionnaire

Name: _____ DOB: _____

Please answer the following questions in their entirety. This information will assist us in proving medical necessity to your insurance company for approval of your weight loss surgery.

This form must be completed and returned at your Bariatric Education Class.

Weight Loss History

1. How long have you been overweight? _____ years/months Since what age? _____

2. What are the highest and lowest adult weights you have achieved? _____lbs. (highest)

_____ lbs. (lowest)

3. Have you participated in a commercial weight loss program? ☐ NO ☐ YES

If yes, please provide the following information:

Program	Duration	Date (year)	Total Weight Loss	Wt Loss maintained for how long
Weight Watchers				
Jenny Craig				
Atkins				
Medifast/Optifast				
Slim-Fast				
Other:				

4. Do you follow any special diet restrictions currently? ☐ NO ☐ YES

If yes, please describe: _____

5. Are you or have you ever been treated for an eating disorder? (Anorexia, bulimia, binge eating, etc.)

☐ NO ☐ YES If yes, please describe: _____

Mental Health:

1. Are you currently receiving any psychological services at this time? ☐ NO ☐ YES

If yes, please list treating physician: _____

2. Have you been treated in the past for depression/ psychiatric condition? ☐ NO ☐ YES

If yes, please list treating physician and date(s) of treatment: _____

Name: _____ **DOB:** _____

Active Lifestyle:

1. Are you currently exercising: ☐ NO ☐ YES: if yes, how often: _____
2. What type(s) of exercise to you enjoy? _____

Pregnancy History: ☐ N/A

**A patient must wait 9 months after giving birth to begin the Program.*

Total Number of Pregnancies: _____ Date of most recent birth*: _____

Total Number of C-sections: _____ Total Number of Natural Births: _____

Medical Providers:

Primary Care Physician: _____

Address: _____

Phone / Fax: _____

Cardiologist: _____

Address: _____

Phone / Fax: _____

Gastroenterologist: _____

Address: _____

Phone / Fax: _____

EGD (endoscopy): ☐ NO ☐ YES: date/location: _____

Psychiatrist / Mental Health Provider: _____

Address: _____

Phone / Fax: _____

Pulmonologist: _____

Address: _____

Phone / Fax : _____

Chest x-ray: ☐ NO ☐ YES: date/location: _____

Sleep Study: ☐ NO ☐ YES: date/location: _____

Other Specialty Provider: _____

Address: _____

Phone / Fax: _____

Name: _____ **DOB:** _____

○ **Past Medical History:** Please check all that apply: O **NO PAST MEDICAL HISTORY**

○ Acid Reflux / GERD	○ COPD	○ IBS (Irritable Bowel Syndrome)
○ Alcohol abuse / Alcoholism	○ Coronary Heart Disease	○ Kidney Disease / Dialysis
○ Anemia	○ Crohns Disease / Ulcerative Colitis	○ Liver Disease
○ Angina	○ Depression	○ Menstrual Irregularities
○ Anxiety	○ Diabetes: type: _____	○ Migraine
○ Arthritis/Joint Disease	○ DVT / Blood Clot	○ MI (Heart Attack)
○ Asthma	○ IVC Filter: yes no	○ MVA (motor vehicle accident) /
○ Atrial Fibrillation	○ Epilepsy/Seizure	TBI (traumatic Brain Injury)
○ BPH	○ Gall Bladder disease	○ Neurological disorder: please
○ Bleeding Disorder: please	○ Heart Murmur	Specify: _____
specify: _____	○ Hemophilia	○ Osteoarthritis
○ Cancer (Type: _____)	○ Hepatitis _____	○ Osteoporosis
○ Cardiac arrhythmias	○ HIV / AIDS	○ Peptic Ulcer Disease
○ Congestive Heart Failure	○ Hyperlipidemia	○ Sleep Apnea
○ CVA (stroke)	○ Hypertension	○ Thyroid Disease
	○ IBD (Inflammatory Bowel Disease)	○ Other: _____

Family History: Please check if you have a family history of any of the following medical conditions.

Disease	Mother	Father	Brother/Sister	Grandfather	Grandmother
Obesity					
Hypertension					
Heart Disease					
Diabetes					
Other					

1. Total Number of Siblings: _____
2. Please note if the following family members are deceased, providing cause of death/age, if known.

- Mother: Cause & Age: _____
- Father: Cause & Age: _____
- Brother(s)/Sister(s): Cause & Age: _____
- Maternal Grandparents: Cause & Age: _____
- Paternal Grandparents: Cause & Age: _____

Current Medications: Please list all of your medications, including herbal and over the counter medications

Name of Medication	Dose & Frequency	Reason for the Medication	Prescribing MD

Social History:

1. Have you ever smoked? ☐ NO ☐ YES ☐ Quit Date: _____

If yes, how many years have you been smoking? _____ Packs per day? _____

2. Do you drink alcohol on a regular basis? ☐ NO ☐ YES ☐ QUIT Date: _____

If yes, how many drinks do you drink per day: _____

Past Surgical History: (procedure / date)

- _____ Date: _____
- _____ Date: _____
- _____ Date: _____
- _____ Date: _____

Allergies:

Do you have any allergies?

Medications: ☐ NO ☐ YES if yes, please list medication and reaction: _____

Foods: ☐ NO ☐ YES if yes, please list: _____

If you are over 65 years of age:

Have you fallen in the last year? ☐ NO ☐ YES If yes, how many times: _____

Patient Signature: _____ Date: _____

Name: _____ DOB: _____

Name: _____ **DOB:** _____

Nutrition History:

1. Have you ever been advised by your physician to follow a special diet? **YES** **NO**
    a. If yes, please describe: _____
2. Do you have any food allergies or intolerances? **YES** **NO**
    a. If yes, please specify: _____
3. Fluid intake:
    a. How much fluid do you drink daily? _____
    b. If that total, how much is water? _____
    c. Do you drink alcohol? **YES** **NO** if yes, how many drinks weekly? _____
    d. Do you drink fluids during your meal? **YES** **NO**
4. Do you eat quickly? **YES** **NO** if yes, how long is your meal? _____

Exercise and Activity

1. Do you currently follow a consistent exercise program? **YES** **NO**
    a. If yes, please describe: _____
2. Do you feel that your life/schedule often conflicts with your exercising? **YES** **NO**
    a. If yes, please explain: _____

Eating Patterns

1. Do you skip meals? _____ If yes, which ones do you skip and why? _____
   _____
2. How often do you snack? _____
3. How many times per week do you eat out? _____ Usual Choice? _____
4. Do you eat standing up? ____ yes ____ no
5. Do you eat in the car? ____ yes ____ no
6. Do you eat at the table? ____ yes ____ no
7. Do you eat with others? ____ yes ____ no
8. Do you engage in other activities when you eat? ____ yes ____ no
9. Who usually prepares the food at home? _____
10. Do you read food/nutrition labels? ____ yes ____ no
11. Do you travel and/or entertain for business? ____ yes _____ no
    a. How often? Never Weekly Monthly Occasionally
12. Does your meal and snack pattern vary on the weekend vs. during the week? _____

Comments:

_____
_____
_____
_____

Name: _____ DOB: _____

Food Record Log: Please use the following forms to record your food intake for 2 days

Time / Meal	Food or beverage	Portion / Amount

Patient Signature: _____ Date: _____

Name: _____ DOB: _____