BARIATRIC SURGERY QUESTIONNAIRE

University of Iowa Hospitals & Clinics
Bariatric Surgery Program - Attn Christine Melichar
200 Hawkins Drive Iowa City, Iowa 52242-1086
Tel: 800-777-8442 Fax: 319-353-6192
Email: obesitysurgery@uiowa.edu

Office use only:

MRN _____

BMI _____

Please complete and return this form to be considered for evaluation

Name _____ **Date** _____

Age _____ **Date of Birth** _____/_____/_____ **Sex** ☐ M ☐ F

Address _____ **City** _____ **State** ____ **Zip code** _____

Preferred Daytime Phone: (_____) _____-_____

Do you have email that is checked regularly? Can we use it to contact you with appointment information?
☐ No ☐ Yes – **If Yes, Please take a moment to sign up for secure messaging through MyChart at https://mychart.uihealthcare.org/mychart/. Should you need further assistance in the setup process, contact UI Health Access at 800-777-8442 or 319-384-8442.**

Have you previously had bariatric surgery? ☐ NO ☐ YES*

When: _____ Where: _____ Type: _____

Reason(s) for seeking a revision: _____

*please provide original bariatric surgery op report and recent testing with this questionnaire

Primary Insurance: _____ **ID#** _____ Group# _____
Policy holder _____ Relationship_____ **Customer Service Phone#** _____

Secondary Insurance: _____ **ID#** _____ Group# _____
Policy holder _____ Relationship_____ **Customer Service Phone#** _____

☐ **Self-Referred**

☐ **Physician Referred - Name** _____ **Phone (_____) _____-_____**

Current Height: ____feet ____ inches

Current Weight _____

NOTE: Education regarding bariatric surgery is done in a group setting format due to the number of people requesting bariatric surgery. Please know that all personal information is kept private during these classes. It will be your decision to share personal information or ask individual questions during the group sessions.
Our staff will be available to answer individual questions following the group class.

OBESITY RELATED COMPLAINTS: (please X all that apply)
Have you EVER had…

Past / Now	Condition	Medication/Treatment needed (name and dosage)
☐ ☐	High blood pressure	
☐ ☐	Diabetes	
☐ ☐ ☐ ☐ ☐ ☐	Sleep Apnea w/ sleep study Daytime Sleepiness Snoring	
☐ ☐	Reflux (heartburn)	
☐ ☐	Heart disease	
☐ ☐ ☐ ☐	High Cholesterol High Triglycerides	
☐ ☐	Joint pain	
☐ ☐	Back pain	
☐ ☐	Hip pain	
☐ ☐	Knee pain	
☐ ☐	Ankle & foot pain	
☐ ☐	Swelling of feet	
☐ ☐	Urinary stress incontinence	
☐ ☐ ☐ ☐ ☐ ☐	Blood clots Deep vein thrombosis DVT Pulmonary embolism PE	
☐ ☐	Stroke	
☐ ☐	Shortness of breath	
☐ ☐	Asthma	
☐ ☐	Emphysema	
☐ ☐	Headaches	
☐ ☐	Migraines	
☐ ☐	Kidney disease	
☐ ☐	Seizures	
☐ ☐	Rashes	
☐ ☐	Arthritis / Osteoarthritis	
☐ ☐	Cancer	
☐ ☐	Irregular periods	
☐ ☐	Eating disorder	
☐ ☐	Non-Alcoholic Fatty Liver or Non-Alcoholic Steatohepatitis	
☐ ☐	Other (please specify) Additional space - next page	

Past / Now	Psychiatric History	Medications	Hospitalized for mental health	Dates hospitalized for mental health
☐ ☐	Depression		☐Yes	
☐ ☐	Severe depression		☐Yes	
☐ ☐	Schizophrenia		☐Yes	
☐ ☐	Bipolar		☐Yes	
☐ ☐	Anorexia		☐Yes	
☐ ☐	Bulimia		☐Yes	
☐ ☐	Treated by a mental health provider		☐Yes	

Mental Health History – explanations:

_____

_____

_____

MEDICAL HISTORY: (list any other conditions not addressed on previous page)

Condition: _____ Medication: _____ Dosage: _____

Condition: _____ Medication: _____ Dosage: _____

Condition: _____ Medication: _____ Dosage: _____

SURGICAL HISTORY:

Type: _____ (Lap or open) Reason _____ Date _____

Type: _____ (Lap or open) Reason _____ Date _____

Type: _____ (Lap or open) Reason _____ Date _____

Type: _____ (Lap or open) Reason _____ Date _____

Type: _____ (Lap or open) Reason _____ Date _____

SOCIAL AND PERSONAL HISTORY:

Highest level of education: _____

Occupation: _____

Employer name: (for our records only) _____

Do you use tobacco/nicotine products? (chew, cigarettes, cigars, e-cig, pipes, etc)?

☐ Never

☐ Past - When quit? _____

☐ Currently - How Much? _____

Do you have a history of either alcohol, drug/substance abuse? ☐ No ☐ Yes*

*If Yes do you currently use?

☐ No. What type did you use? _____ When did you quit? _____

☐ Yes. What type do you use? _____ How often? _____

EXERCISE HISTORY: What is your exercise program?

☐ I am unable to exercise due to - ☐ severe joint pain ☐ shortness of breath ☐ wheelchair/bed

☐ I can exercise but I do not have a regular routine

☐ I currently exercise by doing: _____

☐ Other – (please explain) _____

DIETARY HISTORY:

Do you follow a special diet: **Currently?** ☐ no ☐ yes

Name/type of diet attempt_____

Date started (**month/year**) _____/_____

Beginning weight_____ pounds lost _____ pounds gained_____

Previous diets (Most recent attempts only) ☐ no ☐ yes

Name/type of diet attempt_____

Dates on diet (**month/year**) _____/_____ to _____/_____ (# of months_____)

Beginning weight_____ pounds lost _____ pounds gained_____

Name/type of diet attempt_____

Dates on diet (**month/year**) _____/_____ to _____/_____ (# of months_____)

Beginning weight_____ pounds lost _____ pounds gained_____

Which meals do you eat each day? ☐ Breakfast ☐ Lunch ☐ Supper

Do you snack? ☐ no ☐ yes How often? ☐ mid-morning ☐ afternoon ☐ evening ☐ just before bed

What do you typically eat for snacks?_____

Do you drink milk? ☐ no ☐ yes What kind?_____

Do you drink plain water? ☐ no ☐ yes How much? _____

Do you drink pop? ☐ no ☐ yes How often? _____

Do you drink juice? ☐ no ☐ yes How often? _____

Do you consume alcoholic beverages? ☐ No ☐ Yes - If yes, how many drinks per week? _____

What other beverages do you drink? (tea sweet-unsweet, carbonated/sparkling water, energy, etc)

_____

Do you have food allergies? ☐ no ☐ yes What? _____

The following questions ask about your eating patterns and behaviors within the last 3 months.

For each question choose the answer that best applies to you within the last 3 months.

1. During the last 3 months, did you have any episodes of excessive overeating (i.e., eating significantly more than what most people would eat in a similar period of time)?	Yes	No

If you answered "NO" to question 1, you may STOP. The remaining questions do not apply to you. If you answered "YES" to question 1, please continue.

2. Do you ever feel distressed about your episodes of excessive overeating?	Yes	No

Within the past 3 months…	Never or Rarely	Sometimes	Often	Always
3. During your episodes of excessive overeating, how often did you feel like you had no control over your eating (e.g., not being able to stop eating, feel compelled to eat, or going back and forth for more food)?				
4. During your episodes of excessive overeating, how often did you continue eating even though you were not hungry?				
5. During your episodes of excessive overeating, how often were you embarrassed by how much you ate?				
6. During your episodes of excessive overeating, how often did you feel disgusted with yourself or guilty afterward?				
7. During the last 3 months, how often did you make yourself vomit to control your weight or shape?				

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THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM
PLEASE RETURN IT FOR OUR REVIEW BEFORE AN EVALUATION CAN BE CONSIDERED