

SEVERE OBESITY HISTORY QUESTIONNAIRE
UI OBESITY SURGERY PROGRAM - Attn Chris Melichar
200 Hawkins Drive Iowa City Iowa 52242-1086
Tel: 319-356-1887 Fax: 319-353-6192
Email: obesitysurgery@uiowa.edu

(Please complete and return this form to be considered for appointment)

Name _____ Date: _____

Age _____ Date of Birth ____/____/____ Sex M F

Phone (list all)

Home (____) _____ - _____ Work (____) _____ - _____ Cell (____) _____ - _____

Address _____ City _____ State ____ Zip code _____

Email _____ Can we use this as a way to contact you? Yes No

African/American Caucasian (white) Hispanic Native American Asian Other

I am interested in being educated on the following procedures: (X all that apply)

- Laparoscopic adjustable gastric band
 Laparoscopic Roux-en-Y gastric bypass
 Revision of bariatric surgery* (Must provide initial op-report and test results showing complication)

Insurance/Medical coverage information:

Insurance #1 _____ ID# _____ Group# _____

Policy holder _____ Relationship _____ Customer Service Phone# _____

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How did you hear of our program? (Please check all that apply):

- Web TV Radio News Paper Seminar UIHC Noon News/UI employee
 Family/Friend From UIHC bariatric surgery patient (name) _____
 I had bariatric surgery at UIHC Insurance Company Self Referred Physician _____

Do you currently smoke: Yes No

OBESITY HISTORY: Height: _____

Weight: (current) _____ (highest) _____ (lowest since age 18) _____

Age at onset of obesity: _____

OBESITY RELATED COMPLAINTS: (please X all that apply) **Have you ever had...**

Past / Now	Condition	Medication/Treatment needed (name and dosage)		Notes (office use)
<input type="checkbox"/> <input type="checkbox"/>	High blood pressure			
<input type="checkbox"/> <input type="checkbox"/>	Diabetes			
<input type="checkbox"/> <input type="checkbox"/>	Sleep Apnea			
<input type="checkbox"/> <input type="checkbox"/>	Daytime Sleepiness			
<input type="checkbox"/> <input type="checkbox"/>	Snoring			
<input type="checkbox"/> <input type="checkbox"/>	Reflux (heartburn)			
<input type="checkbox"/> <input type="checkbox"/>	Heart disease			
<input type="checkbox"/> <input type="checkbox"/>	High Cholesterol			
<input type="checkbox"/> <input type="checkbox"/>	High Triglycerides			
<input type="checkbox"/> <input type="checkbox"/>	Joint pain			
<input type="checkbox"/> <input type="checkbox"/>	Back pain			
<input type="checkbox"/> <input type="checkbox"/>	Hip pain			
<input type="checkbox"/> <input type="checkbox"/>	Knee pain			
<input type="checkbox"/> <input type="checkbox"/>	Ankle & foot pain			
<input type="checkbox"/> <input type="checkbox"/>	Swelling of feet			
<input type="checkbox"/> <input type="checkbox"/>	Urinary stress incontinence			
<input type="checkbox"/> <input type="checkbox"/>	Blood clots			
<input type="checkbox"/> <input type="checkbox"/>	Stroke			
<input type="checkbox"/> <input type="checkbox"/>	Shortness of breath			
<input type="checkbox"/> <input type="checkbox"/>	Asthma			
<input type="checkbox"/> <input type="checkbox"/>	Emphysema			
<input type="checkbox"/> <input type="checkbox"/>	Headaches			
<input type="checkbox"/> <input type="checkbox"/>	Migraines			
<input type="checkbox"/> <input type="checkbox"/>	Kidney disease			
<input type="checkbox"/> <input type="checkbox"/>	Seizures			
<input type="checkbox"/> <input type="checkbox"/>	Rashes			
<input type="checkbox"/> <input type="checkbox"/>	Arthritis			
<input type="checkbox"/> <input type="checkbox"/>	Cancer			
<input type="checkbox"/> <input type="checkbox"/>	Irregular periods			
<input type="checkbox"/> <input type="checkbox"/>	Eating disorder			
<input type="checkbox"/> <input type="checkbox"/>	Other (please specify) Additional space - next page			
Past / Now	Psychiatric History	Medications	Hospitalized* Dates	Explain (next page)
<input type="checkbox"/> <input type="checkbox"/>	Depression		<input type="checkbox"/> No <input type="checkbox"/> Yes	
<input type="checkbox"/> <input type="checkbox"/>	Severe depression		<input type="checkbox"/> No <input type="checkbox"/> Yes	
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Schizophrenia/ <input type="checkbox"/> Bipolar		<input type="checkbox"/> No <input type="checkbox"/> Yes	
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Anorexia / <input type="checkbox"/> Bulimia		<input type="checkbox"/> No <input type="checkbox"/> Yes	

***If you currently see a psychiatric doctor or have been hospitalized due to psychiatric illness, please provide us with a current psychiatric evaluation.**

Continued Psychiatric History – explanations:

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

Condition: _____ Medication: _____ Dosage: _____

Condition: _____ Medication: _____ Dosage: _____

Condition: _____ Medication: _____ Dosage: _____

SURGICAL HISTORY: (If you've had bariatric surgery provide initial op-report and test results/complications)

Type: _____ Reason _____ Date _____

Type: _____ Reason _____ Date _____

Type: _____ Reason _____ Date _____

Type: _____ Reason _____ Date _____

Type: _____ Reason _____ Date _____

DRUG ALLERGIES:

Drug: _____ Reaction: _____

Drug: _____ Reaction: _____

FAMILY HISTORY – (Please X all appropriate boxes)

	Severe Obesity	Heavy	Normal Weight	Bariatric Surgery	Diabetes	Heart Problems
Father						
Paternal Grandfather						
Paternal Grandmother						
Father's brothers						
Father's sisters						
Mother						
Maternal Grandfather						
Maternal Grandmother						
Mother's brothers						
Mother's sisters						
Your brothers						
Your sisters						
Your sons						
Your daughters						

PROGRESSION OF WEIGHT GAIN PATTERN (AGE 18 TO CURRENT):

- No pattern
- Steady, gradual increase of weight over the years
- Sudden increases of weight with pregnancies
- Variable weight gain/loss due to intermittent diet and exercise (regained weight when stopped program)

EXERCISE HISTORY: What is your exercise program?

- I am unable to exercise due to - severe joint pain shortness of breath wheelchair/bed
- I am able to exercise but I do not have a regular routine
- I walk / run ___ times per week for ___ minutes
- I swim ___ times per week for ___ minutes
- I lift weights ___ times per week for ___ minutes
- Other – (please explain) _____

DIETARY HISTORY: What do you consider to be your daily eating pattern? (✓ **all that apply**)

- Less than normal Normal Overeat Binge Serious eating disorder Excessive snacking

Do you eat/snack just before bedtime? No Yes

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

What and how much do you usually eat for breakfast? _____

What and how much do you usually eat for lunch? _____

What and how much do you usually eat for supper? _____

What are your favorite snacks? _____

How much of them do you eat per sitting? _____

Do you drink pop? No Yes – How many 12oz servings per day? DIET ____ REGULAR ____

Do you drink Juice? No Yes - What kind? _____ How much per day? _____

SOCIAL AND PERSONAL HISTORY:

Highest level of education: _____

Occupation: _____ Part time Full time

Employer name: (for our records only) _____

Do you have children? No Yes - How many? _____

Marital status: Single Married Separated Divorced

Have you **ever** smoked tobacco (cigarettes, cigars, pipes, etc)? No Yes

If YES, do you currently smoke?

No - When did you quit? _____ How many packs per day _____

Yes – Year you started? _____ How many packs per day _____

Have you **ever** used chewing tobacco? No Yes

If YES, do you currently “chew”?

No - When did you quit? _____ How many times/cans per day _____

Yes – Year you started? _____ How many times/cans per day _____

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

Have you used drugs in the past (other than prescribed medication)? No Yes

If YES, do you currently use drugs?

No. What drug(s) did you use? _____ When did you quit? _____

Yes. What type of drug(s) are you using? _____

Female reproductive history:

Current method of birth control: _____

Number of: Pregnancies _____ Normal vaginal deliveries _____ C-Sections _____

1st pregnancy: _____ (year) _____ pounds gained

2nd pregnancy: _____ (year) _____ pounds gained

3rd pregnancy: _____ (year) _____ pounds gained

SUMMARY DOCUMENT OF PATIENTS WEIGHT LOSS ATTEMPTS

PATIENT NAME: _____

Please list most recent supervised diet attempts first - then list other diets within the past 7 years

Name/type of diet attempt _____
Dates on diet (**month/year**) ____/____ to ____/____ (# of months _____)
Beginning weight _____ pounds lost _____ pounds gained _____
Supervised by a physician, dietician or weight management program Yes No

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ACKNOWLEDGEMENT OF GROUP TEACHING FORMAT

We would like to inform you that due to the number of people requiring instruction on our UI Obesity Surgery Program, education is done in a group setting format. We will keep your personal information 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.

I acknowledge that I have received the above information.

(Patient signature)

(Date)

Please sign and return with your questionnaire.