

Bariatric Patient History

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Date Completed: _____ / _____ / 20_____

Last Name: _____ Suffix: _____

First Name: _____ Middle initial: _____ Preferred Name or Nickname: _____

Date of Birth: _____ / _____ / _____ Age: _____

How did you find us?: (choose one)

1. Someone you know – Friend Family Patient Hospital or Premier employee
2. Physician – Primary care Specialist Other bariatric surgeon. Who? _____
3. Newspaper – Which one? _____
4. Internet – Search web site. Which one? _____
 Hospital website Obesityhelp.com Premiersurgical.com WATE.com
 Other. Which one? _____
5. Expo – Healthy Living Expo Womens Expo Other _____
6. TV – Commercial Live interview Other _____
7. Insurance company. Which one? _____
8. Other _____

Medical History:

What is your chief complaint? (the primary reason that you want to have bariatric surgery)

Current illnesses/diseases:

(check all that apply)	How long? (years)	First diagnosed (year)	Other information
<input type="checkbox"/> Diabetes			How long on insulin? _____ yrs.
<input type="checkbox"/> Hypertension			
<input type="checkbox"/> Hyperlipidemia (high cholesterol)			
<input type="checkbox"/> Arthritis			
<input type="checkbox"/> Sleep apnea			CPAP/BIPAP pressure? _____
<input type="checkbox"/> Gout			
<input type="checkbox"/> Hypothyroidism (low thyroid)			
<input type="checkbox"/> GERD (esophageal reflux)			
<input type="checkbox"/> COPD / Emphysema			
<input type="checkbox"/> Asthma			
<input type="checkbox"/> Pulmonary hypertension			
<input type="checkbox"/> Congestive heart failure			
<input type="checkbox"/> Coronary artery disease			
<input type="checkbox"/> Varicose veins			
<input type="checkbox"/> Depression			
<input type="checkbox"/> Anxiety			
<input type="checkbox"/> Bipolar disease			
<input type="checkbox"/> Stroke			How long ago?
<input type="checkbox"/> Skin fold rash			Location:
<input type="checkbox"/> Neuropathy			
<input type="checkbox"/> Pseudo Tumor Cerebri			
<input type="checkbox"/> Cancer			Type?
<input type="checkbox"/> Fibromyalgia			
<input type="checkbox"/> Hemorrhoids			
<input type="checkbox"/> Blood clots in leg or lungs			
<input type="checkbox"/> Other			

Surgical History: (List all surgeries including dates. Attach additional page if necessary.)

Surgery	Date	Hospital

Previous Bariatric Surgery Yes No

If yes, what procedure: _____

When: _____ Surgeon: _____

Address: _____ City: _____ Hospital: _____

Phone number: (_____) _____ - _____

Original weight _____ lbs. Lowest weight achieved _____ lbs.

Where there any complications? Yes No

If yes, explain: _____

Allergies:

Medication:	Reaction:
Latex? Yes <input type="checkbox"/> No <input type="checkbox"/> Iodine? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Family History: (check all that apply)

Disease:	Relationship:	Age at onset of disease:
<input type="checkbox"/> Obesity		
<input type="checkbox"/> Diabetes		
<input type="checkbox"/> Cancer		
<input type="checkbox"/> Heart disease		
<input type="checkbox"/> Hypertension		
<input type="checkbox"/> Stroke		
<input type="checkbox"/> Other		

Do you have any family or friends who have had bariatric surgery? If so, who are they and what procedure did they have? : _____

Social History:**Habits:**

Smoking Yes (packs per day? _____) Never Quit (when?) _____ months / _____ years ago.

Alcohol Yes No If yes, how much? _____ per week/month

Illicit or recreational drug use? Yes No if yes, name of drug and last use. _____

Limitations/Disabilities:

Disabled Yes No If yes, for how long _____ yrs.

Cause of disability _____

Limitations: _____

Weight History: Current weight: _____ lbs. Current height _____ feet, _____ inches

Your weight at 18 years old: _____ lbs.

Your heaviest weight: _____ lbs. At what age? _____

Weight gain in the last 6 months? _____ lbs.

Weight loss in the last 6 months? _____ lbs.

System review: (If you have had any of the following symptoms in the last 6 months, place a check next to it)

- General: Fever Chills Weight loss Fatigue
- Head & Neck: Blurred vision Loss of vision Loss of hearing Bleeding gums
- Respiratory: Cough Wheezing Short of breath
 Snoring, if yes, do you wear CPAP or BIPAP
- Circulatory: Chest pain Fast heart rate Leg cramps Ankle swelling
- Gastrointestinal: Black or bloody stools Vomiting Nausea Hemorrhoids
 Constipation Diarrhea Reflux or heartburn Abdominal pain
 Yellow skin or eyes Trouble swallowing
- Musculoskeletal: Joint pain Joint swelling
- Neurologic: Dizziness Numbness Confusion
- Urologic: Bloody urine Burning with urination Frequent urination
- Skin: Skin fold rashes Infections Lesions or sores Unusual moles
- Breasts: Pain Nipple discharge Lump
- Psychiatric: Mood swings Memory loss Anxiety Depression
- Gynecology : Vaginal Discharge Unusual Bleeding Pregnancy
- Endocrine: Heat intolerance Cold intolerance
- Hematological : Easy bleeding Easy bruising Swollen glands or lymph nodes

Diet History: (include self monitored, physician monitored and commercial diets, list most recent first)

Name of diet or Physician name:	When (year):	Months on diet:	Weight lost:	Weight regained:

Exercise History: (be honest)

Type: (walking, weights, etc.)	How often: (daily, weekly, etc.)	Date of last exercise:

Do you own exercise equipment? [] Yes [] No

What sports have you played? : _____

Do you have a gym membership? [] Yes [] No

What keeps you from being able to exercise? _____

Psychiatric History:

To the best of your ability, please list any psychological or psychiatric treatments received in the past.

A. List any psychological medications taken by prescription (dates and dosages).

B. List any talk therapy or counseling you have had. (duration + dates).

C. List any benefits that you perceive yourself as receiving and any adversity that you perceive resulted from the above treatments.

Bariatric Behavior Questionnaire[®] Actual (BBQA)

Answer All Questions. Read each item carefully and rate the Actual behaviors being expressed by you to achieve weight loss and good health. Rate whether the behaviors are expressed **Rarely (R)**, **Sometimes (S)**, **Often (O)** or **N/A** (not applicable because of stage of progress toward surgery). Please be very thoughtful and take time with this survey. The information is very important to long term success of weight loss with bariatric surgery. **Make a circle around your choices.**

NOTE: we will ask you from time to time to repeat this survey and also might ask people who support you and know you well to complete the survey about you from their viewpoint. We do this to help get accurate information about your compliance behaviors. We want you to be very happy with your outcome in the long term.

1. Eats food that offer good nutrition.	Rarely	Sometimes	Often	
2. Eats and chews slowly; savors food to enjoy it.	Rarely	Sometimes	Often	
3. Eats in secret, not letting others see.	Rarely	Sometimes	Often	
4. Eats small meals, 4-6 per day.	Rarely	Sometimes	Often	N/A
5. Eats sufficient protein 60-80 grams per day.	Rarely	Sometimes	Often	
6. Eats correct quantity of food, not too much and not too little.	Rarely	Sometimes	Often	
7. Drinks mostly water and gets about 4 pints of water a day.	Rarely	Sometimes	Often	
8. Eats sweets, starchy carbohydrates or both.	Rarely	Sometimes	Often	
9. Takes proper vitamins and supplements to insure proper nutrition	Rarely	Sometimes	Often	
10. Eats quickly, chewing and swallowing quickly	Rarely	Sometimes	Often	
11. Exercises or moves with vigor at least 60 minutes per day	Rarely	Sometimes	Often	
12. Makes excuses for not moving or exercising	Rarely	Sometimes	Often	
13. Shows long term commitment to exercise	Rarely	Sometimes	Often	
14. Has positive vision for personal future	Rarely	Sometimes	Often	
15. Mindful and makes deliberate choices to have better health	Rarely	Sometimes	Often	
16. When faced with negative thoughts, chooses positive thoughts instead	Rarely	Sometimes	Often	
17. Memories of past failures disrupt current good health practices	Rarely	Sometimes	Often	

18. Works to eliminate controllable stress and strain	Rarely	Sometimes	Often	
19. When faced with adversity, gives in or gives up	Rarely	Sometimes	Often	
20. Complains about pains and problems	Rarely	Sometimes	Often	
Bariatric Behavior Questionnaire[®] Actual (BBQA) (cont.)				
21. Optimistic about life's possibilities and the future	Rarely	Sometimes	Often	
22. Provides encouragement to others; shares knowledge and wisdom	Rarely	Sometimes	Often	N/A
23. Sees self as deprived of food enjoyment	Rarely	Sometimes	Often	
24. Grateful for blessings of life	Rarely	Sometimes	Often	
25. Sees self as victim of circumstance and bad luck	Rarely	Sometimes	Often	
26. Engages in activities that add meaning and richness to life	Rarely	Sometimes	Often	
27. Changes mental picture of body to match actual weight loss	Rarely	Sometimes	Often	
28. Accepts positive comments about changing body	Rarely	Sometimes	Often	N/A
29. Shows understanding that PERFECT weight or shape is unattainable	Rarely	Sometimes	Often	
30. Gets restorative sleep (7-10 hours of sleep each 24 hour period)	Rarely	Sometimes	Often	
31. Takes prescribed medications on time and in proper dosage	Rarely	Sometimes	Often	
32. Keeps appointments with weight loss surgeon and other weight loss professionals	Rarely	Sometimes	Often	N/A
33. When seriously off track, seeks professional help	Rarely	Sometimes	Often	N/A
34. Attends bariatric support groups regularly	Rarely	Sometimes	Often	N/A
35. Takes personal responsibility for own health	Rarely	Sometimes	Often	

