Weight Loss - Patient Questionnaire

In order to increase the efficiency of your visit and the probability that you can have the type of operation you desire, please take a few minutes to complete this information sheet. Please bring this form and the Health Assessment form to your first visit.

Patient's Name: _____ Date of Birth: _____

Height: _____ft _____in Weight: _____ pounds

Abdominal Surgery History (Please bring reports for all of the abdominal surgeries you have had, if possible)

1. Surgery performed: _____
   a. When: _____ Where _____ Surgeon _____
   b. Complications? _____
2. Surgery performed: _____
   a. When: _____ Where _____ Surgeon _____
   b. Complications? _____
3. Surgery performed: _____
   a. When: _____ Where _____ Surgeon _____
   b. Complications? _____

Most insurance plans, including Medicare and Medicaid, require prior efforts at weight loss before they will consider authorizing a bariatric weight loss surgery as a means for the treatment of obesity.

Weight Loss History (List each program and the approximate dates of participation)

1. Program _____ Dates: _____ Amt Lost: _____
2. Program _____ Dates: _____ Amt Lost: _____
3. Program _____ Dates: _____ Amt Lost: _____
4. Program _____ Dates: _____ Amt Lost: _____
5. Program _____ Dates: _____ Amt Lost: _____
6. Program _____ Dates: _____ Amt Lost: _____

Most weight ever lost? _____ When? _____

Is your weight stable now? ☐ Yes ☐ No Increasing? ☐ Yes ☐ No Decreasing? ☐ Yes ☐ No

PLACE PATIENT LABEL HERE

Evaluation for pre-operative Physical Therapy and/or Occupational Therapy:

Please circle Yes or No.

1.	I am able to walk one city block with or without an assistive device.	Yes	No
2.	I am able to go up and down one flight of stairs with one railing without help.	Yes	No
3.	I am able to get in and out of bed without help.	Yes	No
4.	I am able to sit and stand from a regular height chair without help without using my arms to push off.	Yes	No
5.	I am able to get on and off the toilet without help.	Yes	No
6.	I am able to perform my toilet hygiene without help.	Yes	No
7.	I am able to put on and take off a pair of pants and shoes without help.	Yes	No
8.	If you circle **yes** to the above questions, please circle yes if you would like an appointment with Physical Therapy.	Yes	No

Additional Questions:

Please circle Yes or No. If yes, please explain in the space provided or on a separate sheet of paper.

Do you have a history of Abdominal wall hernias?	Yes	No
Do you have a history of Peptic/Stomach Ulcers?	Yes	No
Do you have a history of Fibromyalgia?	Yes	No
Do you have a history of Gallstones or other gallbladder problems?	Yes	No
Do you have a history of any kind of Cancer?	Yes	No
Do you have a history of Urinary Incontinence?	Yes	No
Do you have a history of Eating Disorders (e.g., Bulimia, anorexia)?	Yes	No
Do you have a history of any Nutritional Deficiencies	Yes	No
Do you have a history of high cholesterol?	Yes	No

PATIENT SIGNATURE	PRINT NAME	DATE	TIME

PLACE PATIENT LABEL HERE