Evaluation for Metabolic Surgery to Manage Obesity
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
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

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