

# 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? \_\_\_\_\_

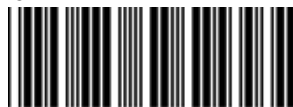
Is your weight stable now?  Yes  No    Increasing?  Yes  No    Decreasing?  Yes  No

PLACE PATIENT LABEL HERE

**UW Medicine**  
Harborview Medical Center – University of Washington Medical Center  
UW Medicine Primary Care – Valley Medical Center – UW Physicians

### WEIGHT LOSS PATIENT QUESTIONNAIRE

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V.2403 | CONTENT LAST APPROVED FEB 24

**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 <b>yes</b> 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 |

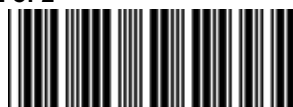
PATIENT SIGNATURE	PRINT NAME	DATE	TIME
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