Stony Brook Medicine

Bariatric and Metabolic Weight Loss Center

Weight Loss Program Questionnaire:

Please complete this questionnaire and bring it with you to your appointment with the practitioner. This information will assist us in your care plan. Thank you.

Full Name: _____ **Date of Birth:** _____

Gender: Female Male

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone:_____

Cell Phone: _____

Email: _____

Date Attended Seminar: _____

Race: (please circle all that apply)

African-American Asian Caucasian Hispanic Pacific Islander/Hawaiian

Native American Other:_____

Operation/Procedure Requested:

□ Roux-en-Y Gastric Bypass
□ Sleeve Gastrectomy
□ Adjustable Gastric Banding
□ Gastric Balloon
□ Duodenal Switch
□ Aspire Assist
□ Other _____
□ Undecided

Surgeon Requested: ☐**Dr. Pryor** ☐**Dr. Spaniolas**

☐**Dr. Docimo** ☐**Dr. Powers** ☐**First Available**

Hospital Requested: ☐**Stony Brook University Hospital** ☐**Long Island Community Hospital**

☐ I'm not interested in surgery; seeking supervised medical weight loss program.

How did you hear about our program? ☐ My physician _____ ☐ A friend _____

☐ Facebook ☐ Internet ☐ Stony Brook's Website ☐ Brochure ☐ Newspaper ☐ Other _____

Primary Care/Family Physician: _____
Practice Name: _____
Address: _____City, State, Zip: _____
Office Phone: _____Office Fax:_____

Referring Physician (if different from above): _____
Practice Name: _____
Address: _____City, State, Zip: _____
Office Phone: _____Office Fax:_____

Please indicate if you **are now experiencing or in the past year experienced** any of the symptoms listed below.

GENERAL

___ Weight Change
___ Fatigue
___ Fever/Chills/Sweats
___ More/less Energy
___ Sleeping Problems

SKIN

____ Rashes/lumps/lesions
____ Color Change
____ Hair/Nail Change
____ Itching
____ Skin irritation/breakdown

CARDIO-VASCULAR

____ Chest Pain
____ Palpitations
____ Light Headedness
____ Leg pain with exercise
____ Leg cramps
____ Varicose Veins
____ Hypertension

HEME

____ Clotting History
____ Anemia
____ Bruising/Bleeding
____ Transfusions/Issues with Blood Product

HEAD, EARS, EYES

NOSE, THROAT

_____ Headache
____ Vision Problems
____ Eye Pain/Rubor/Tears
____ Glaucoma/Cataracts
____ Tinnitus/Ear Pain
____ Stuffy Nose/Sinuses
____ Nasal Discharge/Blood
____ Tooth/Gum Problems
____ Dry Mouth
____ Sore Throat
____ Hoarseness
____ Swollen Nodes
____ Neck lumps
____ Neck Pain
____ Neck Stiffness
____ Hair Loss

RESPIRATORY

_____ Cough
____ Sputum Color/Blood
____ SOB
____ Painful Breathing
____ Wheezing
____ Shortness of breath With activity
____ Sleep Apnea

GASTRO-INTESTINAL

____ Abdominal Pain
____ Difficulty Swallowing
____ Heartburn/Indigestion
____ Nausea/Vomit (blood?)
____ Diarrhea/Constipation
____ Blood in Stool
____ Jaundice (yellow skin)

MUSCULOSKELETAL

____ Muscle/Joint Pain/Stiffness
____ Back Pain
____ Joint Swelling

ENDOCRINE

_____ Heat/Cold Intolerance
____ Excessive Sweating
____ Increased Thirst
____ Shoe/Glove Size Change

PSYCH

____ Anxiety/Nervousness
_____ Depression
____ Memory Problems
____ Disturbing Thoughts
____ Quality of Life Concern

RENAL

_____ Change Urine Frequency/urgency
____ Nocturia
____ Incontinence
____ Painful Urination
_____ Change in Urine Color
_____ Blood/Discharge
____ Kidney Stones
____ Previous/Current UTI

REPRODUCTIVE

____ Previous/Current STI
____ Rash/itch around Genitalia
____ Problems with Sex
____ Menstrual Changes
____ Prev/Current Pregnancy
____ OCP use

NEURO

____ Migraines
____ Seizures
_____ Weakness/Paralysis
_____ Tremor
____ Numbness/tingling

Medical History: Please indicate if you have been diagnosed with any of the following illnesses:

_____ Heart Attack
_____ Cardiac Disease
_____ CAD
_____ Hypertension
_____ Hyperlipidemia/ high Cholesterol
_____ High triglycerides
_____ Obesity

_____ COPD
_____ Asthma
_____ Sleep Apnea
_____ Emphysema
_____ Reflux/GERD
_____ Stomach ulcers
_____ Hiatal Hernia
_____ Abdominal Hernia
_____ Dysphagia

_____ Achalasia
_____ Small Bowel Obstruction
_____ Hypothyroid
_____ Hyperthyroid
_____ Type 1 Diabetes
_____ Type 2 Diabetes
_____ Autoimmune Disease

_____ Epilepsy/Seizures
_____ Neurological Disease
_____ Depression
_____ Anxiety
_____ Arthritis
_____ Cancer Type:_____

Please indicate any other illnesses or medical history:

_____

Surgical History

Please indicate any previous surgeries:

_____

_____

Do you have pain that interferes with your daily activity? No Yes

If yes, where is the pain? _____

Please circle the number that represents your pain level:

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain

Diabetes/Endocrine

Pre-Diabetic	No	Yes
History of Gestational Diabetes	No	Yes
Excessive Thirst or Urination	No	Yes
Hypoglycemia	No	Yes

Does your Diabetes Type I/II require medication? No Yes

Who manages your diabetes? (Primary care, endocrinologist, etc.) _____

Social History

Employment Status: Full Time Part Time Self Employed Retired Unemployed
Homemaker Student Disabled Not Specified

Occupation: _____ Employer:_____

Marital Status (please circle one): Single Married Separated Divorced Widowed Partnered
Do you have children/how many? _____

Do you use?		**If YES, how much/often?**
Tobacco/Nicotine products *(cigarettes, pipes, cigars, chewing tobacco, e cigarettes, vapes, nicotine patches/gums/lozenges, Chantix)*	**YES** **NO**	**_____ packs per day for _____ years** **If you quit, when? _____**
Alcohol	**YES** **NO**	**Type: _____** **Frequency:_____**
Recreational Drugs **(*opioids, marijuana, cocaine, heroin, etc.)***	**YES** **NO**	**Type: _____** **Frequency:_____**

Medications and Supplements:

Medication/Supplement	Dosage & Frequency	Reason

Allergies

Medication/Food	Reaction
Other Allergies	**Reaction**

Weight History

Number of years overweight: _____
Highest Adult Weight and When: _____lbs _____yrs old
Lowest Adult Weight and When:_____lbs _____yrs old
Birth Weight (*if known*) _____
As best you can recall, what was your body weight at each of the following points of your life?

Grade School ____ High School ____ Ages 20-29 ____ 30-39 ____ 40-49 ____ 50-59 ____ 60-69 ____

What is your greatest weight loss and when?_____lbs _____yrs old
How long did you keep this weight off?_____
Have you had previous weight loss surgery? Yes No Type: _____
Previous methods used for weight loss:

Weight Watchers Jenny Craig Diet Pills Nutritionist Prescription Medication Other

Specify: _____

Weight History Comments_____

Activity/Exercise

Do you exercise regularly? □ Yes □ No
Types of exercise? □ Strengthening □ Cardio Other:_____
How often?_____ times/week _____times/month
If no, what prevents you from exercising? Time Work Health Other: _____

Family History

Please specify if you have any family members with:
Obesity _____
Heart Disease _____
Diabetes/Endocrine_____ Disease _____
High Blood Pressure _____
Cancer _____
Type: _____
Arthritis _____
Early Death _____
Asthma _____
Stroke _____
Depression _____
Other Diseases _____

Sleepiness Questionnaires

Do you use a CPAP Machine? ☐ Yes What is the setting?_____ ☐ No, do not use.

Do you experience any of the following: (check all that apply)

□ Excessive sleepiness □ Chronic fatigue □ Daytime sleepiness
□ Sleep walking □ Leg twitching/jerks □ Gasping for air at night

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling tired? Use the following scale to choose the *most appropriate number* for each situation:

0 = would *never* doze
1 = *slight* chance of dozing
2 = *moderate* chance of dozing
3 = *high* chance of dozing

	Chances of Dozing (Scale of 0-3)
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. a theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

(For Staff Epworth Score: _____ ≥10)

Collar size of shirt: S M L XL or _____inches/cm (15.5 inches =40 cm)

1. **Snoring:** Do you snore loudly? **Yes** **No**
(Louder than talking or loud enough to be heard through closed doors)

2. **Tired:** Do you often feel tired, fatigued, or sleepy during daytime? **Yes** **No**

3**. Observed:** Has anyone observed you stop breathing during your sleep? **Yes** **No**

4. **Blood Pressure:** Do you have or are you being treated for high blood pressure? **Yes** **No**

For clinical staff to complete:

5. **BMI:** BMI more than 35 kg/m2 **Yes** **No**
6. **Age:** Age over 50 years old? **Yes** **No**
7. **Neck circumference**: Neck circumference greater than 40 cm? (measured by staff) **Yes** **No**
8. **Gender**: Gender male **Yes** **No**

(STOP BANG Score: _____)
Yes ≥ 3 items = High risk of OSA
Score Yes < 3 items = Low risk of OSA

PERMISSION TO EXCHANGE INFORMATION

I, _____ HEREBY GRANT PERMISSION FOR COMMUNICATION BETWEEN THE PROFESSIONAL STAFF OF **The Stony Brook Medicine Bariatric and Metabolic Weight Loss Center**, REGARDING ANY AND ALL OF MY PSYCHOLOGICAL, MEDICAL, PSYCHIATRIC, EDUCATIONAL AND SOCIAL RECORDS AS RELATED TO MY ENGAGEMENT IN THE WEIGHT LOSS CENTER'S PROGRAMS AND/OR WEIGHT LOSS SURGERY INTERVENTIONS.

_____

(CLIENT'S NAME (Please print)

_____ Date:_____

(Signature of client or signature of guardian to client)

In addition, I also grant permission for exchange of information with:

_____

_____

(Indicate name; include address and phone if possible)

Witness: _____

(Please print name)

_____ Date:_____

(Witness Signature)

Part 1: PHQ-4

Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems? *(Please circle your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

Part 1 Total Score = _____

Part 2: Eating Behaviors

5. Questions about eating *(Please circle your answer)*	No	Yes
a. Do you often feel that you can't control what or how much you eat?	0	1
b. Do you often eat, within any 2-hour period, what most people would regard as an unusually large amount of food? **If you checked "NO" to either #a or #b, go to question #8.**	0	1
c. Has this been as often, on average, as once a week for the last 3 months?	0	1
6. In the last 3 months have you <u>often</u> done any of the following in order to avoid gaining weight? *(Please circle your answer)*	No	Yes
a. Made yourself vomit?	0	1
b. Took more than twice the recommended dose of laxatives?	0	1
c. Fasted — not eaten anything at all for at least 24 hours?	0	1
d. Exercised for more than an hour specifically to avoid gaining weight after binge eating?	0	1
7. If you checked "YES" to any of these ways of avoiding gaining weight, were any as often, on average, as once a week?	No 0	Yes 1

Part 2 Total Score = _____

Part 3: Alcohol Use

8. Do you ever drink alcohol (including beer or wine)? ***If you checked "NO" go to question #10.***	No 0	Yes 1
9. Have any of the following happened to you more than once in the last 6 months?	0	1
a. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health.	0	1
b. You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities.	0	1

c. You missed or were late for work, school, or other activities because you were drinking or hung over.	0	1
d. You had a problem getting along with other people while you were drinking.	0	1
e. You drove a car after having several drinks or after drinking too much.	0	1

Part 3 Total Score = _____

Part 4: Symptom Interference

10. If you checked off any problems on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? *(Please circle your answer)*	Not at all difficult	Somewhat Difficult	Very Difficult	Extremely Difficult
	0	1	2	3

Part 4 Total Score = _____

For Office Use Only:
If Part 1 Total Score is ≤ 5, Part 2 Total Score = 0, Part 3 Total Score = 0, and Part 4 Score = 0 or 1 then patient can be scheduled at MB-CRC