



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 PacificIslander/Hawaiin Native American Other
Caucasian Hispanic

Operation/Procedure Requested:

- Roux-en-Y Gastric Bypass v-Bloc
Sleeve Gastrectomy Aspire Assist
Adjustable Gastric Banding Other Undecided
Gastric Balloon

Surgeon Requested: Dr. Pryor Dr. Spaniolas Dr. Bates Dr. Docimo First Available

Hospital Requested: Stony Brook University Hospital Brookhaven Memorial 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.

<p>GENERAL</p> <p><input type="checkbox"/> Weight Change</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Fever/Chills/Sweats</p> <p><input type="checkbox"/> More/less Energy</p> <p><input type="checkbox"/> Sleeping Problems</p> <p>SKIN</p> <p><input type="checkbox"/> Rashes/lumps/lesions</p> <p><input type="checkbox"/> Color Change</p> <p><input type="checkbox"/> Hair/Nail Change</p> <p><input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Skin irritation/breakdown</p> <p>CARDIO-VASCULAR</p> <p><input type="checkbox"/> Chest Pain</p> <p><input type="checkbox"/> Palpitations</p> <p><input type="checkbox"/> Light Headedness</p> <p><input type="checkbox"/> Leg pain with exercise</p> <p><input type="checkbox"/> Leg cramps</p> <p><input type="checkbox"/> Varicose Veins</p> <p><input type="checkbox"/> Hypertension</p> <p>HEME</p> <p><input type="checkbox"/> Clotting History</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Bruising/Bleeding</p> <p><input type="checkbox"/> Transfusions/Issues with Blood Product</p>	<p>HEAD, EARS, EYES</p> <p>NOSE, THROAT</p> <p><input type="checkbox"/> Headache</p> <p><input type="checkbox"/> Vision Problems</p> <p><input type="checkbox"/> Eye Pain/Rubor/Tears</p> <p><input type="checkbox"/> Glaucoma/Cataracts</p> <p><input type="checkbox"/> Tinnitus/Ear Pain</p> <p><input type="checkbox"/> Stuffy Nose/Sinuses</p> <p><input type="checkbox"/> Nasal Discharge/Blood</p> <p><input type="checkbox"/> Tooth/Gum Problems</p> <p><input type="checkbox"/> Dry Mouth</p> <p><input type="checkbox"/> Sore Throat</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Swollen Nodes</p> <p><input type="checkbox"/> Neck lumps</p> <p><input type="checkbox"/> Neck Pain</p> <p><input type="checkbox"/> Neck Stiffness</p> <p><input type="checkbox"/> Hair Loss</p> <p>RESPIRATORY</p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> Sputum Color/Blood</p> <p><input type="checkbox"/> SOB</p> <p><input type="checkbox"/> Painful Breathing</p> <p><input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> Shortness of breath with activity</p> <p><input type="checkbox"/> Sleep Apnea</p>	<p>GASTRO-INTESTINAL</p> <p><input type="checkbox"/> Abdominal Pain</p> <p><input type="checkbox"/> Difficulty Swallowing</p> <p><input type="checkbox"/> Heartburn/Indigestion</p> <p><input type="checkbox"/> Nausea/Vomit (blood?)</p> <p><input type="checkbox"/> Diarrhea/Constipation</p> <p><input type="checkbox"/> Blood in Stool</p> <p><input type="checkbox"/> Jaundice (yellow skin)</p> <p>MUSCULOSKELETAL</p> <p><input type="checkbox"/> Muscle/Joint Pain/Stiffness</p> <p><input type="checkbox"/> Back Pain</p> <p><input type="checkbox"/> Joint Swelling</p> <p>ENDOCRINE</p> <p><input type="checkbox"/> Heat/Cold Intolerance</p> <p><input type="checkbox"/> Excessive Sweating</p> <p><input type="checkbox"/> Increased Thirst</p> <p><input type="checkbox"/> Shoe/Glove Size Change</p> <p>PSYCH</p> <p><input type="checkbox"/> Anxiety/Nervousness</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Memory Problems</p> <p><input type="checkbox"/> Disturbing Thoughts</p> <p><input type="checkbox"/> Quality of Life Concern</p>	<p>RENAL</p> <p><input type="checkbox"/> Change Urine Freq/urgency</p> <p><input type="checkbox"/> Nocturia</p> <p><input type="checkbox"/> Incontinence</p> <p><input type="checkbox"/> Painful Urination</p> <p><input type="checkbox"/> Change in Urine Color/Blood/Discharge</p> <p><input type="checkbox"/> Kidney Stones</p> <p><input type="checkbox"/> Previous/Current UTI</p> <p>REPRODUCTIVE</p> <p><input type="checkbox"/> Previous/Current STI</p> <p><input type="checkbox"/> Rash/Itch around Genitalia</p> <p><input type="checkbox"/> Problems with Sex</p> <p><input type="checkbox"/> Menstrual Changes</p> <p><input type="checkbox"/> Prev/Current Pregnancy</p> <p><input type="checkbox"/> OCP use</p> <p>NEURO</p> <p><input type="checkbox"/> Migraines</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Weakness/Paralysis</p> <p><input type="checkbox"/> Tremor</p> <p><input type="checkbox"/> Numbness/tingling</p>
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MEDICAL HISTORY Please indicate if you have been diagnosed with any of the following illnesses:

<input type="checkbox"/> Heart Attack	<input type="checkbox"/> COPD	<input type="checkbox"/> Small Bowel	<input type="checkbox"/> Epilepsy/Seizures
<input type="checkbox"/> Cardiac Disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> Obstruction	<input type="checkbox"/> Neurological Disease
<input type="checkbox"/> CAD	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Hypothyroid	<input type="checkbox"/> Depression
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hyperthyroid	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Hyperlipidemia/ high Cholesterol	<input type="checkbox"/> Reflux/GERD	<input type="checkbox"/> Type 1 Diabetes	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> High triglycerides	<input type="checkbox"/> Stomach ulcers	<input type="checkbox"/> Type 2 Diabetes	<input type="checkbox"/> Bipolar Disorder
<input type="checkbox"/> Obesity	<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Schizoaffective Disorder
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Abdominal Hernia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Borderline Personality Disorder
	<input type="checkbox"/> Dysphagia	<input type="checkbox"/> Where/ What type_____	
	<input type="checkbox"/> Achalasia		

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

Medication/Food	Reaction
Other Allergies	Reaction

Weight History Current Weight: _____ lbs; kg Current Height: _____ in; cm BMI: _____
Number of yrs overweight: _____
Highest Adult Weight: _____
When was your highest weight?: _____
Lowest Adult Weight: _____
When was your lowest Weight? _____
Birth Weight _____
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 the most weight you lost? _____
When did you lose this weight? _____
How long did you keep this weight off? _____
Method used for this weight loss _____
Have you had previous bariatric surgery? _____
Weight History Comments _____

Activity/Exercise

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

Family History

Overweight Family Members _____
Family History of Heart Disease _____
Family History of Diabetes/Endocrine Disease _____
Family History of High Blood Pressure _____
Family History of Cancer _____ Type: _____
Family History of Arthritis _____
Family History of Early Death _____
Family History of Asthma _____
Family History of Stroke _____
Family History of Depression _____
Other Family Disease History _____

Sleepiness Questionnaires

Have you been diagnosed with sleep apnea? Yes No

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

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they have affected you. 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	_____

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

1. **Snoring:** Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? **Yes** **No**
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/m ² | 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 |

(10 Epworth; 3 STOP BANG)

Please fill out this part of the form with as much detail as possible

Program(s)	Weight Loss	Weight Regained	Month/Year? How long were you on the program(s)? Why did you stop the program(s)?
Weight Watchers			
Overeaters Anonymous			
Jenny Craig/ NutriSystem,			
OTC Diet Pills			
LA weight loss, The Diet Center			
Counseling with RD, psychologist, etc.			
Prescription Medications: (Fen Phen, Phentremine, Redux, Meredia, Xenical, etc.)			
Weight Loss Shots/Injections			
Hypnosis			
Acupuncture			
Low Carbohydrate Diets			
Diet Books/ Fad diets:			
Liquid diets: (Medifast, Optifast, Slimfast, Isagenix, etc.)			
Other: _____			

Do any of the following environmental issues listed below affect your weight? If so, please explain.

Occupation-related eating issues: Yes No

Travel: Yes No

Household issues (family/obligations/schedule): Yes No

Shopping/cooking/etc: Yes No

Financial Issues: Yes No

Meals eaten away from home (frequency/location): Yes No

Sleep: Yes No

Do any of the following eating behaviors listed below affect your weight? If so, please explain.

<input type="checkbox"/> Binge Eating	Current Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Past Problem <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Anorexia	Past Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Bulimia	Current Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Past Problem <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Emotional Eating	Current Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Past Problem <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Frequent Cravings	Current Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Past Problem <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Lack of Awareness of Hunger	Current Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Past Problem <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Lack of Awareness of Fullness	Current Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Past Problem <input type="checkbox"/> Yes <input type="checkbox"/> No

Please answer the questions below to the best of your ability:

Do you have any food allergies? Yes No If yes, what are they?

Do you have any food intolerances? Yes No If yes, what are they?

How often do you eat fast food/take out? Provide an example of what you would order.

How often do you eat at restaurants? Provide an example of what you would order from a restaurant.

How often do you eat sweets? Provide examples of sweets you consume.

How often do you eat fried foods? Provide examples of fried foods you consume.

Please indicate beverages consumed/amount/frequency:

Water: _____

Regular Soda: _____ Diet Soda: _____ Juice: _____ Juice Drink: _____

Crystal light/sugar free beverages: _____ Coffee/tea : _____

Other sugar sweetened beverages: _____ Other: _____

How often do you consume alcoholic beverages? What type? Amount?

What types of food do you crave? How often do you eat them?

How many days per week do you consume vegetables and fruits?

Fruits: _____ Vegetables: _____

Check off the items consumed:

Cheese Yes No If yes, is it Regular full fat 2% reduced fat 1% low fat 0% skim/fat free

Yogurt Yes No If yes, is it Regular full fat 2% reduced fat 1% low fat 0% skim/fat free

Milk Yes No If yes, is it Regular full fat 2% reduced fat 1% low fat 0% skim/fat free

Check off items consumed:

Meat Poultry Fish Beans Tofu Nuts Eggs

Please provide foods consumed on a typical day. Please provide information regarding portion sizes, type of foods consumed, and time meals/snacks are consumed.

Example: Breakfast: 8:30 am: 2 scrambled eggs, 1 slice whole wheat toast with 1 tablespoon natural peanut butter with 8 ounces of 1% milk.

1st Meal

Time:

2nd Meal

Time:

3rd Meal

Time:

Snack 1/ Time:

Snack 2/ Time:

Snack 3/ Time:

Part 1: PHQ-4

Over the <u>last 2 weeks</u> , how often have you been bothered by the following problems? <i>(Please circle your answer)</i>	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 <i>(Please circle your answer)</i>	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?	0	1
If you checked "NO" to either #a or #b, go to question #8.		
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? <i>(Please circle your answer)</i>	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)? <i>If you checked "NO" go to question #10.</i>	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? <i>(Please circle your answer)</i>	Not at all difficult	Somewhat Difficult	Very Difficult	Extremely Difficult
	0	1	2	3

Part 4 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