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

PATIENT SIGNATURE	PRINT NAME	DATE	TIME

PLACE PATIENT LABEL HERE