Pre-assessment Questionnaire

Section 1: Personal details

Name:_____ Sex: O M O F Date of birth:_____

Address:_____

_____

E-mail address:_____

Height: _____ Weight: _____ BMI: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Mobile: _____

GP Details: Name _____ Phone:_____

Address:_____

_____

Marital Status: O Single O Married O Divorced O Live with partner

Children: O No O Yes How many _____

Occupation: _____

It would be helpful if you could keep a one week diet history sheet detailing all foods eaten in the week before your consultation.

Which Weight Loss procedure are you interested in?

O Laparoscopic Gastric Band
O Laparoscopic Roux-en-Y Gastric Bypass
O Laparoscopic Duodenal Switch
O Laparoscopic Revision Bariatric Surgery
O Not sure

Have you had Weight Loss Surgery before? O Yes O No

Operation: _____ Date:_____

Hospital: _____ Surgeon: _____

Section 2: Weight Loss History

How long have you been overweight? _____

Please provide details of any diets you have tried

Diet	Date	Duration	Maximum weight loss
Weight Watchers			
Jenny Craig			
Nutri/System			
Atkins Diet			
Slimfast			
Optifast			
Herbalife			
Liquid Diets			
Other _____			

Please provide details of any medication you have tried

Medication	Date	Duration	Maximum weight loss
Amphetamines			
Phentermine (Fastin)			
Phen-Fen			
Xenical (Orlistat)			
Dexfenfluramine (Reduxil)			
Meridia (Sibutramine)			
Other _____			

Please provide details of any other therapies you have tried

Therapy	Date	Duration	Maximum weight loss
Exercise			
Hypnosis			
Behaviour Modification			
Other _____			

Section 3: Medical History – Obesity Related

Cardiovascular	Yes	No	Not sure	Date diagnosed
Angina				
Heart Attack				
Heart Bypass Surgery				
Angioplasty				
Palpitations (abnormal heart beat)				
Congestive heart failure				
High Blood Pressure				
High Cholesterol				

Diabetes	Yes	No	Not sure	Date diagnosed
Onset – as a child				
Onset – as an adult				
Onset – due to pregnancy				
Diet controlled				
Oral medications				
Insulin injections				

Respiratory	Yes	No	Not sure	Date diagnosed
Asthma				
Shortness of breath				
Sleep Apnoea				
Do you use a CPAP machine?				
Snoring				
Waking at Night				
Daytime drowsiness				

Joint Pain	Yes	No	Not sure	Date diagnosed
Pain or arthritis in your joints				
Pain or sciatica in your back				
Difficulty walking or exercising				
Do you take prescribed medication?				
Do you take over the counter medication?				

Legs and Veins	Yes	No	Not sure	Date diagnosed
Leg or ankle swelling				
Leg ulceration				
Leg skin colour changes				
Deep Vein Thrombosis				
Pulmonary embolism				
Do you require blood thinning medication?				

Hernia	Yes	No	Not sure	Date of surgery
Incisional Hernia				
Umbilical Hernia				
Inguinal Hernia				
Any hernia present at this time?				

Reflux/heartburn	Yes	No	Not sure	Date diagnosed
Hiatus Hernia				
Relux or Heartburn				
Have you ever needed an endoscopy				
Do you take prescribed medication?				
Do you take over the counter medication?				

Menstruation	Yes	No	Not sure	Date diagnosed
Any irregularities?				
Infertility				
Are you losing weight to become pregnant?				

Section 4: Past Medical History

Please provide details of any medical conditions or illnesses not yet mentioned

_____

_____

_____

_____

Please provide details of any hospital admissions you have had in the past

_____

_____

_____

_____

Please provide details of any operations you have had in the past

_____

_____

_____

_____

Please provide details of any allergies that you have. What reaction do you have?

_____

_____

_____

_____

Please provide details of any medications you currently take

_____

_____

_____

_____

Do you smoke? O Yes O No O Ex-smoker

How many a day? _____

Do you drink alcohol? O Yes O No O Occasional

How much a week? _____

Have you ever received treatment for depression? O Yes O No

Have you ever been hospitalized for mental illness? O Yes O No

Family History – please tick if any of your family members have the following:

	Yes	Relationship
Obesity	O	_____
High Blood Pressure	O	_____
Heart Disease	O	_____
Stroke	O	_____
Lung Disease	O	_____
High Cholesterol	O	_____
Breast Cancer	O	_____
Colon Cancer	O	_____
Other Cancers	O	_____
Kidney Disease	O	_____
Diabetes	O	_____
Blood disorders	O	_____
Tendency to bleed	O	_____

Section 5: Please tick if you have had/are having any of these symptoms:

General
__ fatigue
__ tiredness
__ night sweats

Head and Neck
__ blurred vision
__ loss of vision
__ loss of hearing
__ dizziness
__ vertigo
__ sinus problems
__ loss of smell
__ difficulty swallowing
__ lump in neck

Cardiovascular
__ chest pain
__ pounding heart
__ pain in arms or neck
__ heart attack
__ palpitations
__ heart murmur
__ stroke
__ high blood pressure
__ pain in legs
__ cold feet
__ loss of pulses

Respiratory
__ shortness of breath
__ asthma
__ wheezing
__ bloody sputum
__ emphysema
___ pneumonia
___ bronchitis

Gastrointestinal
___ jaundice
___ hepatitis
___ cirrhosis
___ vomiting
___ nausea
___ heartburn
___ abdominal pain
___ diarrhoea
___ constipation
___ blood in stools
___ haemorrhoids
___ irritable bowel
___ colitis

Genitourinary
___ blood in urine
___ pain with urine
___ bladder infection
___ kidney stones
___ kidney infection
___ discharge from penis
___ loss of erection
___ vaginal discharge
___ abnormal vaginal bleeding
___ irregular periods

Musculoskeletal
___ muscular aches
___ swelling of joints
___ arthritis
___ sciatica
___ pain in knees
___ pain in ankles
___ pain in feet
___ pain in hips
___ pain in lower back
___ slipped disc
___ numbness in feet/legs

Endocrine
___ diabetes
___ hyperthyroid
___ low thyroid
___ goitre
___ swollen glands
___ previous steroid use

Skin/Breast
___ skin cancer
___ abnormal moles
___ breast lump

Neurological
___ convulsion or fit
___ fainting
___ falling
___ muscle weakness
___ loss of consciousness

Psychological
___ depression
___ suicidal thoughts
___ anxiety
___ suicide attempts
___ eating disorder
___ required counselling
___ mental illness