WAVERLY HEALTH
CENTER

312 9th Street SW
Waverly, IA 50677
(319) 352-8033

Bariatric Patient Health Questionnaire

Last name, first name, middle initial	Date of Birth	Sex	Age	Marital Status M S D W
Street Address	Home Phone	Cell Phone		
City State Zip Code	Work Phone	Alternate Phone #		
What do you prefer to be called?				
EMERGENCY CONTACT INFORMATION				
Emergency Contact	Home Phone	Work Phone		
Relationship	Street Address (include City, State, Zip Code)			

Please check your policy for Bariatric surgery benefits.

The Insurance Company may ask you for the CPT Codes.
Gastric Bypass/RNY-43644 Sleeve-43775 Gastric Band-43774

Primary Insurance	Secondary Insurance
Address	Address
Customer Service Phone Number	Customer Service Phone Number
Policy or ID Number	Policy or ID Number
Subscriber Name	Subscriber Name
Subscriber Date of Birth	Subscriber Date of Birth
Relationship to Patient	Relationship to Patient
Subscriber Employer, Address, Telephone Number __________ __________	Subscriber Employer, Address, Telephone Number __________ __________

Date of Seminar: ______________________________ (Leave blank-Office will complete)

Primary Care Physician: ______________________________

I am interested in: *(Circle one)* Gastric Bypass/RNY Gastric Sleeve Gastric Band

Name: ___________________________________
Date of Birth: ______________________________

The information requested in this questionnaire is very important. To give you the best care, and to obtain your insurance approval, we must have complete answers. Please be thorough. Blue or black ink only please.

How much do you weigh?	
How tall are you?	
Office Use Only	
Current BMI	
Ideal Body Weight	
Excess Body Weight	

EXERCISE and ACTIVITY

Do you currently exercise? ☐ Yes ☐ No
If yes, please specify amount/frequency: ____

What kind of exercise do you like to do? ____

To assist in the prior authorization process we request you provide details on your previous diet attempts. This is a major area of concern in meeting the requirements of your insurance company. Most insurance carriers insist you try formal weight loss programs before they will agree to pay for bariatric surgery.

Please include:

1. The name of the program, for example: Weight Watchers, Nutri-Systems, etc./personal diets (informal).
2. The approximate date and length of time you were on the program.
3. What the program included, for example: low carb, calorie counting, prepared meals etc.
4. What exercise you did while on the program.
5. How much weight you lost and subsequently regained when you stopped following the program.
6. Finally, what meetings did you attend and what diet counseling was done.

Please take your time in filling out this form and providing as many details as you can. This will be submitted to the insurance company along with the psychiatric evaluation, education documents, and letters from the primary care doctor and notes from the surgeon visit.

Name: ______________________________________
Date of Birth: ________________________________

DIET HISTORY

Dates	Program	Weight Loss/Regain
EXAMPLE 1-15-04 to 10-30-04	Weight Watchers Went to the meetings and weighed two times a week for 9 months.	Lost 50 lbs but gained back 25 after stopping.

Medical History
Have you had, or do you have, any of the following illnesses?

1. Heart Disease ☐ Yes ☐ No
   If yes, year diagnosed ______________
   Diagnosis: _______________________

   Do you have, or have you had:
   ☐ Chest Pain
   ☐ Heart Attack/M.I. (myocardial infarction)
   ☐ CABG (coronary artery bypass grafting)
   ☐ Palpitations
   ☐ Pacemaker
   ☐ Defibrillator/AICD
   ☐ Cardiac Rehabilitation (with diet counseling documentation)

   Have you had these tests/procedures:
   ☐ Echocardiogram
   ☐ Angiogram
   ☐ Abnormal EKG
   ☐ Stress test to rule out cardiac problems

2. High cholesterol ☐ Yes ☐ No
   If yes, year diagnosed ________________
   Medications ☐ Yes ☐ No

3. High Triglycerides ☐ Yes ☐ No
   If yes, year diagnosed ________________
   Medications ☐ Yes ☐ No

Name: ___________________________________
Date of Birth: ______________________________

4. High Blood Pressure ☐ Yes ☐ No
   If yes, year diagnosed _______________
   Medications ☐ Yes ☐ No

5. Diabetes ☐ Yes ☐ No
   If yes, year diagnosed _______________
   Controlled with ☐ Diet ☐ Medication ☐ Insulin ☐ Non-Insulin
   Last Hemoglobin A1C _______________
   Gestational ☐ Yes ☐ No

6. Asthma ☐ Yes ☐ No
   If yes, year diagnosed _______________
   ER visits/last 2 years ________________
   Steroids last 2 years ________________

7. Shortness of breath ☐ Yes ☐ No
   If yes, Can walk ________ blocks
   Stairs ___________ flights

8. Chronic Obstructive Pulmonary Disease (COPD) or Emphysema ☐ Yes ☐ No
   If yes, year diagnosed ___________________
   Past Hospitalization for treatment of COPD ☐ Yes ☐ No
   Oxygen Dependent ☐ Yes ☐ No

9. Sleep History
   Total Sleep Time: _____________ Snoring: ☐ Yes ☐ No Daytime Sleepiness: ☐ Yes ☐ No
   Use oxygen at night: ☐ Yes ☐ No Morning Headaches: ☐ Yes ☐ No
   Difficulty staying asleep? ☐ Yes ☐ No Insomnia: ☐ Yes ☐ No
   Stop breathing at night? ☐ Yes ☐ No Difficulty tolerating anesthesia: ☐ Yes ☐ No

   Epworth Sleepiness Scale: Please answer each question by using the following numbers.

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

   Sitting and Reading: _____
   Watching television: _____
   Sitting inactive in a public place, like a theater or a meeting: _____
   As a passenger in a car for an hour without a break: _____
   Lying down to rest in the afternoon: _____
   Sitting and talking to someone: _____
   Sitting quietly after lunch when you've had no alcohol: _____
   In a car while stopped in traffic: _____
   Total score: _____

Name: ______________________________________
Date of Birth: _________________________________

10. Sleep Apnea Syndrome ☐ Yes ☐ No
If yes, year diagnosed ______________________
Last sleep study ___________________________ month/year
CPAP/BIPAP/AutoPAP used ☐ Yes ☐ No'
Please request your PCP to order test to rule out obstructive sleep apnea-if not currently using CPAP/BIPAP.

11. Heartburn? ☐ Yes ☐ No

12. Esophagitis/reflux (GERD)? ☐ Yes ☐ No
If yes, year diagnosed ______________________
Medications ☐ Yes ☐ No

13. Hiatal hernia? ☐ Yes ☐ No

14. Stomach ulcers? ☐ Yes ☐ No

15. Coughing or choking at night? ☐ Yes ☐ No

16. Gallbladder disease? ☐ Yes ☐ No
Removed ☐ Yes ☐ No

17. Renal Disease/Insufficiency? ☐ Yes ☐ No
If yes, on dialysis? ☐ Yes ☐ No

18. Joint pain? ☐ Yes ☐ No multiple joints/hips/knees/ankles/feet

19. Functional Status (Select the one that best describes you)
☐ Independent
☐ Partially dependent-requires some assistance from another person for activities of daily living (bathing, dressing, etc.)
☐ Totally dependent-requires total assistance for all activities of daily living (bathing, dressing, etc.)

20. Ambulation (Select the one that best describes you)
☐ Independent
☐ Cane or walker
☐ Use assistive device most of the time (wheelchair or scooter)

21. Lupus or Multiple Sclerosis? ☐ Yes ☐ No Describe __________________________

22. Autoimmune Disorder? ☐ Yes ☐ No Describe __________________________
If yes, taking Corticosteroids or Immunosuppressant Medication? ☐ Yes ☐ No

23. Venous Stasis Disease? ☐ Yes ☐ No
If yes, do you have edema or swelling in your legs? ☐ Yes ☐ No
Scaly or thick skin on your legs? ☐ Yes ☐ No
Leg ulcers or open sores on your legs? ☐ Yes ☐ No
Wear compressive stocking on your legs? ☐ Yes ☐ No

24. Have you ever had a deep venous thrombosis (DVT), a blood clot or a pulmonary embolism?
☐ Yes ☐ No
If yes, explain ____
On a therapeutic dosage of anticoagulation medication? ☐ Yes ☐ No
Do you have a vena cava filter inserted? ☐ Yes ☐ No

25. Any family history of Factor 5? ☐ Yes ☐ No

26. Have you ever had psychiatric treatment? ☐ Yes ☐ No
Have you ever had a psychiatric hospitalization? ☐ Yes ☐ No
When was your treatment: ______________________________ Where: ______________________
Current psychiatric treatment by: ☐ Psychiatrist ☐ Therapist ☐ Psychologist ☐ Primary Care Physician
If presently in treatment/therapy, name of provider: ____

27. Attempted suicide within last year? ☐ Yes ☐ No

28. Have you ever been diagnosed with an eating disorder? ☐ Yes ☐ No
If yes, please specify: ____

29. Female Patients:

Last mammogram: _____________________________________
History of infertility: _____________________________________
History of Polycystic Ovarian Disease: ______________________

Do you presently use:

Birth control pills ☐ Yes ☐ No List type: ____________________________________

30. Have you ever had (check all that apply):
☐ Hepatitis ☐ Blood Transfusion ☐ AIDS/HIV Exposure ☐ Thyroid Problems
☐ Colitis ☐ Kidney Disease ☐ Bleeding Abnormality
☐ Endoscopy ☐ Colonoscopy ☐ Sigmoidoscopy ☐ Eating Disorder
If yes, please explain: ____
____

31. Please list all major surgeries Date
____
____
____
____

32. History of cancer or family history? ☐ Yes ☐ No
What kind? ____

33. Allergies:
Are you allergic to any medications? ☐ Yes ☐ No
If yes, please list medication and reaction:
____
____
Allergic to: Surgical tape ☐ Yes ☐ No Latex: ☐ Yes ☐ No Iodine: ☐ Yes ☐ No
Other Allergies: ____

Name: ____________________________________
Date of Birth: _______________________________

Please list all prescription and over-the-counter medications you are currently taking

Medication	Dose and Frequency	Why do you take this medication?

Do you currently use tobacco? ☐ Yes ☐ No
If yes, Type: ___________________________ Amount and Frequency: __________________________

Are you willing to quit? ☐ Yes ☐ No

Are you a former smoker? ☐ Yes ☐ No Quit Date: ____________ Use E-cigarettes: ☐ Yes ☐ No

Do you use alcohol? ☐ Yes ☐ No Amount and Frequency: _________________________
How many drinks per week? ______________________

History of alcohol or drug abuse? ☐ Yes ☐ No