3291 Loma Vista Road, Bldg.340 – Ste.401
Ventura, California 93003
Office #: (805) 652-6565
Fax # (805) 648-8104

MORBID OBESITY QUESTIONNAIRE

MR #

Date: _____

Title: _____ First Name: _____ Last Name: _____

Social Security #: _____ Marital Status: _____

Age: _____ Height Ft: _____ Inches: _____ Weight: _____ BMI: _____

Address: _____ Home phone #: _____

City: _____ State: _____ Zip Code: _____

Cell phone #: _____ Email: _____

Emergency Contact Information:

Name: _____ Telephone #: _____ Relationship: _____

Employer information:

Company Name: _____ Work phone #: _____

Primary Care Provider Information:

M.D. First Name: _____ M.D. Last Name: _____

Physician's Address: _____ Telephone #: _____

City: _____ State: _____ Zip Code: _____ Fax: _____

Insurance information:

Health Plan Name: _____ Type: _____

Subscriber Name: _____

Member I.D. Number: _____ Group Number: _____

Claim Address: _____ Claims Phone #: _____

City: _____ State: _____ Zip Code: _____ Fax: _____

Social History:

What is your occupation? _____ With whom do you live? _____ Number of children? _____

How many hours/day are you employed outside the home? _____ Hours of TV/day _____

How were you referred to Ventura Bariatrics? _____

What are your weight loss goals? _____

Time frame in which to loss desired weight? _____

Obesity History:

What is your lifetime Maximum weight? _____ lbs When? _____

Age of obesity onset? _____ Family history of obesity? YES / NO

Lowest adult weight? _____ Highest adult weight? _____

Have you attended an obesity surgery support group? YES / NO If so, where? _____

Are you considering weight loss surgery? _____

Activity Level:

☐ Inactive – No regular physical activity, with sit down job

☐ Light activity – no organized physical activity during leisure time

☐ Moderate activity – Occasionally involved in activities such as weekend golf, tennis, jogging, swimming…etc

☐ Heavy activity – Consistent lifting, stair climbing, heavy construction, or regular participation in jogging, swimming or active sports at least three times per week

☐ Vigorous activity – Participation in extensive physical exercise for at least 60 minutes per session 4 times per week

☐ Is there a physical problem that would keep you from participating in some sort of activity? YES / NO

If yes, please _____

Please circle an option below: (Also Please fill out 3-day food Journal included in package)

Diet Quantity	**Diet Quality**	**Frequency**	**Exercise5**
Large meals	Balanced food	Regular meals	Never
Average meals	Junk food	Nibble all day	Seldom
Small helpings			Regular

Eating Habits:

Do you eat when you aren't hungry? ☐ YES ☐ NO

What are your "go-to" foods? _____

Do you hide food in your house/car to eat when you are alone? ☐ YES ☐ NO

Do you ever eat until you feel sick? ☐ YES ☐ NO

If Yes, How often? _____

Do you lie to family and friends about how much you eat? ☐ YES ☐ NO

Have you ever made yourself throw up after eating too much? ☐ YES ☐ NO

Have you ever used laxatives after eating too much? ☐ YES ☐ NO

Previous Supervised Weight Loss Programs:

	Name of Program	Date started	# Months	# Lbs lost
1.)				
2.)				
3.)				
4.)				

Medications for weight loss: _____

Past Medical History:

Please list any hospitalizations you have had for an illness or accident **not** requiring surgery:

1.) _____

2.) _____

3.) _____

4.) _____

Other Obesity-related Medical Problems:

Do you have now or have you ever had any of the following obesity-related medical problems?

Cardiac

☐ Hypertention (High blood pressure) ☐ Heat attack or angina (Chest pain, pressure or tightness)

☐ Irregular heart rhythm or palpitations ☐ Congestive Heart Failure (CHF)

Respiratory

☐ Sleep apnea ☐ Asthma

☐ Shortness of breath ☐ Other lung or breathing problems

Gastrointestinal

☐ Frequent heartburn / acid reflux disease ☐ Gallstones

☐ Hernia (hiatal, umbilical, incisional) ☐ Hemorrhoids

Hormonal/Blood

☐ Diabetes ☐ High cholesterol and/or high triglycerides

☐ Thyroid problems

Urological

☐ Stress incontinence (leak urine with coughing or laughing) ☐ Need to wear pads

Vascular

☐ Leg swelling ☐ Leg ulcers ☐ Leg cellulites

☐ Varicose veins ☐ History of clots in the leg

Skin / Muscle / Skeletal (check all that apply)

☐ Low back pain

☐ Arthritis or degenerative joint disease (circle all that apply)

Hips Knees Ankles Feet

Mental Health

☐ Depression ☐ Anxiety

☐ Other Emotional _____

Any other obesity related problems: _____

General Symptoms:

Do you currently have any of the following symptoms or problems?

General / Central Nervous

☐ Headache ☐ Blackouts / dizziness ☐ Temporary loss or blurring of vision

☐ Fever ☐ Temporary weakness ☐ Seizures or epilepsy

Cardiovascular

☐ Chest pain ☐ Palpitations ☐ Irregular heart beats

☐ Swelling ankles ☐ Stroke ☐ Muscle weakness

Respiratory

☐ Chronic cough or sputum ☐ Blood in your sputum ☐ Tuberculosis

Gastrointestinal

☐ Black or tarry stools ☐ Diarrhea ☐ Frequent or new constipation

☐ Difficulty swallowing ☐ Frequent nausea or vomiting ☐ Liver problems or hepatitis

Urinary

☐ Burning with urination ☐ Frequent urination ☐ Kidney or bladder problems

Gynecologic History

Menstruation age of onset? _____ Duration? _____ LMP? _____
On birth control? _____ Fertility Problems? _____

Blood

☐ Abnormal bleeding or bruising ☐ blood clot or embolus ☐ Anemia

☐ Gout

Emotional / Social

☐ Anxiety ☐ Depression treated with medications and / or counseling

☐ History of physical / sexual abuse ☐ History of alcoholism

☐ Other mental health problems ☐ History of substance abuse

☐ History of cancer ☐Planning of future pregnancy

Past Surgical History

	Operation:	Date:	Complications:
1.)			
2.)			
3.)			
4.)			

Medications

List below all the medications you take and include those which do not require a prescription

	Medication	Dosage / Amount	Number of times taken daily
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Have you taken steroids such as Prednisone or Cortisone in the last 6-months? YES / NO

Allergies

List all medications/medical products to which you have an allergic or bad reaction:

Medication / Medical Product	Type of reaction

Habits

Have you ever smoked? ☐ Yes ☐ No ☐ Never

☐ Yes, but I quit _____ years ago, and smoked _____ packs per day for _____ years.

☐ Yes, I smoke _____ packs per day and have smoked for _____ years.

Do you drink alcoholic beverages?

☐ Yes, I drink _____ Beverages weekly.

☐ I use to drink but I quit.

Family History

Do your blood relatives have the following problems? Explain which relatives and the type of problem.

☐ Heart Disease ☐ Obesity and/or morbid obesity ☐ Diabetes

☐ Serious problems with anesthesia ☐ Bleeding and blood clot problems ☐ Cancer

Any others that you feel we should know about: _____

Are you interested in obesity surgery? If so what type? _____

Comments or issues: _____

_____