Stony Brook Medicine

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
□ Sleeve Gastrectomy
□ Adjustable Gastric Banding
□ Gastric Balloon
□ v-Bloc
□ Aspire Assist
□ Other _____ □ Undecided

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.

GENERAL

___ Weight Change
___ Fatigue
___ Fever/Chills/Sweats
___ More/less Energy
___ Sleeping Problems

SKIN

___ Rashes/lumps/lesions
___ Color Change
___ Hair/Nail Change
___ Itching
___ Skin irritation/breakdown

CARDIO-VASCULAR

___ Chest Pain
___ Palpitations
___ Light Headedness
___ Leg pain with exercise
___ Leg cramps
___ Varicose Veins
___ Hypertension

HEME

___ C!otting History
___ Anemia
___ Bruising/Bleeding
___ Transfusions/Issues with Blood Product

HEAD, EARS, EYES

NOSE, THROAT

___ Headache
___ Vision Problems
___ Eye Pain/Rubor/Tears
___ Glaucoma/Cataracts
___ Tinnitus/Ear Pain
___ Stuffy Nose/Sinuses
___ Nasal Discharge/Blood
___ Tooth/Gum Problems
___ Dry Mouth
___ Sore Throat
___ Hoarseness
___ Swollen Nodes
___ Neck lumps
___ Neck Pain
___ Neck Stiffness
___ Hair Loss

RESPIRATORY

___ Cough
___ Sputum Color/Blood
___ SOB
___ Painful Breathing
___ Wheezing
___ Shortness of breath with activity
___ Sleep Apnea

GASTRO-INTESTINAL

___ Abdominal Pain
___ Difficulty Swallowing
___ Heartburn/Indigestion
___ Nausea/Vomit (blood?)
___ Diarrhea/Constipation
___ Blood in Stool
___ Jaundice (yellow skin)

MUSCULOSKELETAL

___ Muscle/Joint Pain/Stiffness
___ Back Pain
___ Joint Swelling

ENDOCRINE

___ Heat/Cold Intolerance
___ Excessive Sweating
___ Increased Thirst
___ Shoe/Glove Size Change

PSYCH

___ Anxiety/Nervousness
___ Depression
___ Memory Problems
___ Disturbing Thoughts
___ Quality of Life Concern

RENAL

___ Change Urine Freq/urgency
___ Nocturia
___ Incontinence
___ Painful Urination
___ Change in Urine Color
___ Blood/Discharge
___ Kidney Stones
___ Previous/Current UTI

REPRODUCTIVE

___ Previous/Current STI
___ Rash/Itch around Genitalia
___ Problems with Sex
___ Menstrual Changes
___ Prev/Current Pregnancy
___ OCP use

NEURO

___ Migraines
___ Seizures
___ Weakness/Paralysis
___ Tremor
___ Numbness/tingling

MEDICAL HISTORY **Please indicate if you have been diagnosed with any of the following illnesses:**

_____ Heart Attack
_____ Cardiac Disease
_____ CAD
_____ Hypertension
_____ Hyperlipidemia/ high Cholesterol
_____ High triglycerides
_____ Obesity
_____ Arthritis

_____ COPD
_____ Asthma
_____ Sleep Apnea
_____ Emphysema
_____ Reflux/GERD
_____ Stomach ulcers
_____ Hiatal Hernia
_____ Abdominal Hernia
_____ Dysphagia
_____ Achalasia

_____ Small Bowel Obstruction
_____ Hypothyroid
_____ Hyperthyroid
_____ Type 1 Diabetes
_____ Type 2 Diabetes
_____ Autoimmune Disease
_____ Cancer Where/ What type_____

_____ Epilepsy/Seizures
_____ Neurological Disease
_____ Depression
_____ Anxiety
_____ Schizophrenia
_____ Bipolar Disorder
_____Schizoaffective Disorder
_____Borderline Personality Disorder

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

Diabetes/Endocrine Does your Diabetes Type I/II require medication? No Yes
If yes, how frequently do you test your blood sugar? _____

Provide examples of your fasting blood sugar: _____
Who manages your diabetes? (Primary care, endocrinologist, etc.) _____
Pre-Diabetic No Yes
History of Gestational Diabetes No Yes
Excessive Thirst or Urination No Yes
Hypoglycemia No Yes

Social History

Employment Status Full Time Part Time Self Employed Retired Unemployed Not specified
Homemaker Student Disabled
Occupation _____ Employer _____

Marital Status (please circle one): Single Married Separated Divorced Widowed Partnered
Children _____

Do you use?		**If YES, how much/often?**
Tobacco/nicotine products (cigarettes, pipes, cigars, chewing tobacco, e cigarettes, vapes, nicotine patches/gums/lozenges, Chantix)	**YES NO**	**_____ packs per day for _____ years If you quit, when_____**
Alcohol	**YES NO**	**Type_____ Frequency:_____**
Drugs/Medications NOT prescribed for you	**YES NO**	**Type_____ Frequency:_____**

Medications and Supplements

Medication/Supplement	Dosage & Frequency	Reason

Allergies

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/m2 **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.		
□ Binge Eating	Current Problem □ Yes □ No	Past Problem □ Yes □ No
□ Anorexia	Past Problem □ Yes □ No	
□ Bulimia	Current Problem □ Yes □ No	Past Problem □ Yes □ No
□ Emotional Eating	Current Problem □ Yes □ No	Past Problem □ Yes □ No
□ Frequent Cravings	Current Problem □ Yes □ No	Past Problem □ Yes □ No
□ Lack of Awareness of Hunger	Current Problem □ Yes □ No	Past Problem □ Yes □ No
□ Lack of Awareness of Fullness	Current Problem □ Yes □ No	Past Problem □ Yes □ 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 consumes, 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:**

PERMISSION TO EXCHANGE INFORMATION

I, _____ HEREBY GRANT PERMISSION FOR COMMUNICATION BETWEEN THE PROFESSIONAL STAFF OF **The Stony Brook Medicine Bariatric and Metabolic Weight Loss Center**, REGARDING ANY AND ALL OF MY PSYCHOLOGICAL, MEDICAL, PSYCHIATRIC, EDUCATIONAL AND SOCIAL RECORDS AS RELATED TO MY ENGAGEMENT IN THE WEIGHT LOSS CENTER'S PROGRAMS AND/OR WEIGHT LOSS SURGERY INTERVENTIONS.

_____

(CLIENT'S NAME (Please print)

_____ Date:_____

(Signature of client or signature of guardian to client)

In addition, I also grant permission for exchange of information with:

_____

_____

(Indicate name; include address and phone if possible)

Witness: _____

(Please print name)

_____ Date:_____

(Witness Signature)

Part 1: PHQ-4

Over the last 2 weeks, how often have you been bothered by the following problems? *(Please circle your answer)*	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 *(Please circle your answer)*	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? **If you checked "NO" to either #a or #b, go to question #8.**	0	1
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 often done any of the following in order to avoid gaining weight? *(Please circle your answer)*	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)? ***If you checked "NO" go to question #10.***	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? *(Please circle your answer)*	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