SURGICAL ASSOCIATES MANSFIELD

Bariatric New Patient Assessment

Methodist MEDICAL GROUP

NUTRITION

Describe your personal goal for joining a weight loss management program: _____

_____

# of Years Overweight: _____ years Desired Weight: _____ lbs

Would like to be at desired weight by: _____

Maximum Lifetime Weight (non-pregnant): _____lbs Date: _____

Have you ever tried dieting to lose weight?___No ___Yes

If yes, please check which diets:

- ☐ Atkins
- ☐ Jenny Craig
- ☐ Keto
- ☐ Medifast/Optifast
- ☐ Mediterranean
- ☐ Nutri-System
- ☐ Slim 4 Life
- ☐ Weight Watchers
- ☐ Other: _____

Have you ever tried using medication to lose weight? ___No ___Yes

If yes, please check which medications taken:

- ☐ Acutrim
- ☐ Adipex-P
- ☐ Amphetamines
- ☐ Anorex
- ☐ Benzphetamine
- ☐ Dezatrim
- ☐ Dexfenfluramine
- ☐ Didrex
- ☐ Fastin
- ☐ Fen-Phen
- ☐ Phentermine
- ☐ Xenical
- ☐ Other: _____

Have you ever had weightloss surgery? ___No ___Yes

If yes, which surgery? _____ Date:_____

SLEEP HABITS

Do you have difficuly sleeping? ___No ___Yes

If yes, describe:_____

_____

Do you snore? ___No ___Yes Has anyone ever told you that you snore? ___No ___Yes

Have you ever been told you have obstructive sleep apnea? ___No ___Yes

Have you ever had a sleep study done? ___No ___Yes

If yes: Date:_____ Doctor: _____

Do you have a CPAP/BIPAP (circle one) machine? ___No ___Yes

If yes: Setting: _____CWP

Do you use your CPAP/BIPAP machine every night? ___No ___Yes

If no, reason:_____

History of apparent airway obstruction during sleep

Check the following that apply:

- ☐ Snoring (loud enough to be heard through a closed door)
- ☐ Awakens from sleep with choking sensation
- ☐ Observed pauses in breathing during sleep
- ☐ Frequent snoring
- ☐ Frequent arousals from sleep
- ☐ Talking in your sleep

History of somnolence

Check the following that apply:

- ☐ Somnolence or fatigue, despite adequate sleep
- ☐ Falls asleep easily in a nonstimulating envitoment despite adequate sleep
- ☐ Difficult to arouse at usual awakening time

PSYCHO-SOCIAL

Please describe your relationship with each of the following:

	Excellent	Satisfactory	Unsatisfactory	N/A
Spouse/ Significant Other				
Child(ren)				
Other Family				
Finances				

What do you do to handle stress? _____

Do you have a history of physical, sexual, or emotional abuse? ___No ___Yes

If yes, describe: _____

Have you ever attempted suicide? ___No ___Yes

Have you ever received treatment for psychiatric illness (ex. Depression)? ___No ___Yes

If yes, type of illness:_____

ANESTHESIA HISTORY

Has any family member had a problem with anesthesia? ___No ___Yes

If yes, describe: _____

Have you had a problem with anesthesia? ___No ___Yes

If yes, describe: _____

Do you have difficulty moving your head side-to-side? ___No ___Yes

Do you have difficulty opening or closing your jaw? ___No ___Yes