Portneuf BARIATRICS

PMG Metabolic and Bariatric Surgery
New Patient Questionnaire

Welcome to our practice! We are excited to learn more about you and how we can help you achieve your weight loss goals. Please answer the following questions as accurately as possible. Your surgical team will use your answers to help guide your treatment.

Name: _____Birthdate:_____ Age: _____

To be completed by clinic staff:
Height:_____ Weight:_____ BMI:_____ Neck circumference: _____ cm

1. For how many years have you struggled with your weight? _____
2. What was your highest weight in the last 5 years?_____
3. What was your lowest weight in the last 5 years?_____
4. What was your weight in high school?_____
5. Has anyone else in your family had bariatric surgery? If so, which surgery?

6. What do you hope to gain from bariatric surgery?

7. Please indicate which (if any) of the following medical conditions you have been diagnosed with:

- High blood pressure
- High cholesterol
- Diabetes mellitus
- Obstructive sleep apnea
- Fatty liver disease
- Gastroesophageal reflux disease
- Joint or back pain
- Coronary artery disease
- Heart failure
- Abnormal heart rhythm
- Urinary incontinence
- Infertility or Irregular Menses
- Polycystic Ovarian Syndrome
- Pseudotumor cerebri
- Other medical conditions: _____

8. Have you or other immediate family members ever developed a venous blood clot (DVT) or pulmonary embolism? If so, please provide details.

- Yes
- No

9. Do you have nausea or feel full for many hours after eating?

- Yes
- No

10. Do you suffer from arthritis, fibromyalgia, or other chronic pain conditions?

11. Do you have irritable bowel syndrome, constipation, or loose stools?

12. Do you take non-steroidal anti-inflammatory medications (Motrin, Aleve, Naproxen, Voltaren, Mobic), steroids, or prescription pain medications on a routine basis? Please specify which medications and how frequently.

13. Please indicate current or prior use of each of the following substances. If you have never used a particular substance, you may leave the row blank.

	Current use	Prior use	Date last used
Alcohol			
Cigarettes			
Tobacco products			
Vaping			
Marijuana			
Methamphetamines			
Other drugs:			

14. Have you ever been diagnosed with any of the following mental health conditions?

- Depression
- Suicide attempts or hospitalization for mental health illness
- Anxiety
- Bipolar disorder
- Schizophrenia
- Other:_____

Gastroesophageal Reflux Disease Questionnaire (GERD-Q)

Please circle the number in the column that corresponds to the frequency of symptoms you experience in an average **7 day period**. Add the numbers together to calculate your total score.

Symptom	Frequency of symptom per 7 day period			
	None	**1 day**	**2-3 days**	**4-7 days**
Burning feeling behind your breastbone (heartburn)	0	1	2	3
Stomach contents moving back up to your throat or mouth (regurgitation)	0	1	2	3
Pain in the center of the upper stomach	3	2	1	0
Nausea	3	2	1	0
Difficulty getting a good night's rest because of heartburn and regurgitation	0	1	2	3
Took additional medication for reflux symptoms, other than what was already prescribed by a physician	0	1	2	3

***TOTAL SCORE:*_____**

Do you take prescription medication for acid reflux on a daily basis?

- Yes
- No

Assessment:

- LOW LIKELIHOOD (Total score <3)
- MODERATE LIKELIHOOD (Total score 3-7)
- HIGH LIKELIHOOD (Total score >8)

_____

Adapted from Development of the GerdQ, a tool for the diagnosis and management of gastro-esophageal reflux disease in primary care. Jones R, Junghard O, Dent J, et al. Alimentary Pharmacology & Therapeutics 2009;30:1030-8.

STOP BANG Questionnaire

for obstructive sleep apnea

Your BMI and neck circumference will be measured during your clinic visit. Please answer the remaining questions to the best of your knowledge.

If you have already been diagnosed with obstructive sleep apnea and are using a CPAP machine at home, you may skip this portion of the questionnaire.

Do you snore loudly?	● Yes	● No
Do you often feel tired, fatigued, or sleepy during the day?	● Yes	● No
Has anyone witnessed you stop breathing during sleep?	● Yes	● No
Have you been diagnosed with high blood pressure?	● Yes	● No
Is your body mass index (BMI) over 35?	● Yes	● No
Is your age over 50 years old?	● Yes	● No
Is your neck circumference over 40 cm?	● Yes	● No
Are you male?	● Yes	● No
TOTALS:		

Assessment:

- LOW RISK (answering “Yes” to 2 or fewer questions)
- HIGH RISK (answering “Yes” to 3 or more questions)

Adapted from STOP Questionnaire: A Tool to Screen Patients for Obstructive Sleep Apnea. *Anesthesiology* 2008; 108:812-21. Copyright 2008, the American Society of Anesthesiologists, Inc. Lippincott Williams & Wilkins, Inc.