Weight Loss Surgery Screening Questionnaire

PATIENT DETAILS			
Name:		DOB:	
Address:		Age:	
		Ref:	
Phone (home):		Phone (mobile):	
e-mail:		Phone (work):	

NEXT OF KIN DETAILS			
Name:		Relation:	
Phone Number:			

GP DETAILS			
GP Name:		Phone:	
GP Practice Name:		Is you GP aware that you are considering weight loss surgery?	Yes No
Address:			

Please acknowledge the following statement by ticking the box on the right: We would highly recommend you discuss with your GP your plans to consider weight loss surgery. It is important to have the support of your GP and family when adapting to the changes following surgery.	

PATIENT CHARACTERISTICS	
Height (m)	
Current Weight (kg)	
Heaviest Weight (kg)	
BMI (weight (kg) ÷ height (m) × height (m))	

MOTIVATIONS	
Briefly describe what motivates you to pursue weight loss surgery:	

MEDICAL QUESTIONNAIRE				
DIABETES HISTORY				
	Yes	No	Duration	Complications
Type 1 diabetes				
Type 2 diabetes				
Treatment	Yes	No	Medication Dose (e.g. 500 mg, units etc) and Frequency	
Diet alone				
Insulin				
Metformin (Glucophage)				
Gliclazide				
Other Diabetes Medications				
Diabetes Control				
Last Known HbA1c			Date HbA1c last checked:	
Other Endocrine Problems	Yes	No	Comments/details	
Hypothyroidism				
Polycystic ovaries				
Infertility				
Other				
Pregnancy Planned next 2 years?			Please acknowledge the following statement by ticking the box on the right: It is advisable to avoid pregnancy during the 1st year following surgery. It is advisable that if you do become pregnant following surgery you contact your midwife or obstetrician for nutritional advice	

CARDIAC HISTORY							
	Yes	No	Medication				
High Blood Pressure							
High Cholesterol							
Angina (Chest Pains)							
Irregular Heart Beat							
Pacemaker / Defibrillator			Date Last Checked:				
Previous Heart Attack?			**Stents**?	YES	NO	DATE	

RESPIRATORY HISTORY			
	Yes	No	Medication Name, Dose (e.g mg/mcg) and Frequency
Asthma / COPD			
Oral/IV Steroids used?			
Previous Hospital or ITU admission with chest problem?			Details:
Other respiratory conditions?			Details:
Current smoker?			Number smoked per day:

Please acknowledge the following statement by ticking the box on the right:

I understand that smoking increases my risk of suffering surgical and anaesthetic complications.
This includes:

- Increased risk of Blood clots (DVT and PE)
- Breathing difficulties after surgery
- Chest infections
- Stomach ulcers

SLEEP APNOEA		
	Yes	No
Do you have Sleep Apnoea?		
Do you use CPAP?		
Please acknowledge the following statement by ticking the box on the right: I am aware that having sleep apnoea increases my risk of breathing complications and chest infections following surgery. I am aware that a well-functioning CPAP machine that is used every time I go to sleep for a minimum of 6 weeks prior to surgery will reduce my risks of complications. I am aware that I will need to bring my CPAP machine into hospital with me for use if necessary, after my surgery.		

SCREENING TOOL FOR SLEEP APNOEA		
	Yes	No
Do you Snore very loudly? (louder than talking or loud enough to be heard in adjacent room)		
Do you usually feel tired and below par when you wake up and/or do you often fall asleep during daytime when you shouldn't, eg. when you're stopped in traffic for a few minutes or when you're sitting talking to someone		
Have you been observed to temporarily stop breathing during your sleep?		
Do you have or are you being treated for high blood Pressure?		
BMI > 35?		
Are you Aged over 50 years old?		
Neck circumference > 40cm (15.5)?		
Male?		

FITNESS AND MOBILITY QUESTIONS	
Can you climb a flight of stairs without stopping due to shortness of breath	
How far can you walk before needing to stop due to shortness of breath?	

GASTROINTESTINAL HISTORY			
	Yes	No	Details (Including medications)
Reflux?			
Swallowing issues			
Crohns disease?			
Ulcerative colitis			
Coeliac Disease			

SURGICAL HISTORY			
	Yes	No	Details:
Known gallstones?			
Previous Cholecystectomy?			Key hole (Laparoscopic) or Open
Known abdominal wall hernias?			
Previous Gastric Surgery?			
Previous bowel surgery?			

BLOOD CLOT AND BLEEDING RISK			
	Yes	No	Details:
Previous DVT?			
Previous PE?			
Known clotting problem?			
Known bleeding problem?			
Aspirin use?			

<table>
<tr><th colspan="6">DIETARY ASSESSMENT</th></tr>
<tr><th colspan="6">WEIGHT LOSS ACHIEVED THROUGH:</th></tr>
<tr><th></th><th>YES</th><th>NO</th><th colspan="3">COMMENTS / REASONS FOR STOPPING</th></tr>
<tr><td>Slimming clubs</td><td></td><td></td><td colspan="3"></td></tr>
<tr><td>Gym / exercise class</td><td></td><td></td><td colspan="3"></td></tr>
<tr><td>Community Dietician</td><td></td><td></td><td colspan="3"></td></tr>
<tr><td>Community weight management programme</td><td></td><td></td><td colspan="3"></td></tr>
<tr><td>Xenical (Orlistat)</td><td></td><td></td><td colspan="3"></td></tr>
<tr><td colspan="3">Reason stopped</td><td>Ineffective</td><td>Side effects</td><td>Weight regain</td></tr>
<tr><td colspan="6">Support Groups Attended</td></tr>
<tr><td colspan="4">Maximum weight loss achieved in last year and how?</td><td colspan="2"></td></tr>
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ABOUT YOUR DIETARY HABITS **Tick how often you eat the foods below:**					
Food Frequency:	Every Day	2-3 times a week	2-3 times a month	Rarely or Never	Other
Biscuits					
Desserts					
Chocolate					
Sweets					
Crisps					
Nuts					
Takeaways					
Soft drinks					
Ready Meals					
Alcohol					
What is your alcohol intake per week?					
How many pieces of fruit and vegetables do you eat per week?					

Eating Pattern	
Problem / Vulnerable Foods?	
Do you consider your portions to be large?	
Do you have a regular meal pattern?	
Do you skip meals? If yes how often?	
Do you graze on foods throughout the day?	
Are you an emotional eater?	
Triggers/ causes of overeating?	
Are you intolerant to any foods?	
Are you allergic to any foods?	
Do you follow a special diet?	
Are you currently taking any nutritional supplements / vitamins / minerals?	
Who does the food shopping?	
Who prepares the meals?	
Are you: a good cook a basic cook cannot cook	

Once completed please post or email back for review by your Bariatric Surgeon