BARIATRIC SURGERY **HEALTH QUESTIONNAIRE**

Please complete as many of the following questions as you can.

Your name:	Date:
Your Address:	
Weight (Kg):	Tel No:
Height (cm):	
E mail address:	BMI (if known):
Occupation:	
WEIGHT HISTORY:	
How long have you been overweight (years)	
What is your Heaviest weight (Kg)?	
What problems is it causing?	

If you have any of the following problems please tick the box. Please also list for how long you have been aware of the problem in years.

- ☐ Diabetes
- ☐ Hypertension (blood pressure
- ☐ Dyslipidaemia (high cholesterol)
- ☐ Poly cystic ovaries
- ☐ Heart disease (angina and heart attack)
- ☐ Gout
- ☐ Back problems
- ☐ Hip/knee pain
- ☐ Asthma
- ☐ Sleep apnoea requiring CPAP
- ☐ Snoring
- ☐ Daytime drowsyness
- ☐ Reflex disease
- ☐ Depression

How much weight have you been able to lose before?		
Why do you want to have the surgery?		
What research about the surgery have you done? (Please tick box)		
☐ Healthpoint	☐ Personal contacts	
☐ Internet	☐ Other (please specify)	
When did you start thinking about the surgery?		
What weight would you like to get to (Kg)?		
Are you aware of the options/operations for surgical treatment of obesity?		☐ YES
		☐ NO
Which of the following operations are you aware of?		
☐ Laparoscopic Adjustable Gastric Band (Lap Band)		
☐ Gastric Bypass (Open, Laparoscopic and the Fobi operation)		
☐ Sleeve Gastrectomy		
☐ Other		

Have you read the following booklets?			
☐ Bariatric Surgery – a guide for patients			
☐ The Sleeve Gastrectomy – Central Region Metabolic and Bariatric Service			
MAJOR ILLNESS/ MEDICAL PROBLEMS (Please list all conditions that you see your GP or other Doctors for):			
SURGERY: Have you had any surgery in the past? Please list all operations.			
MEDICATIONS (which medicines do you take, how often and what dose):			
ALLERGIES			
SOCIAL HISTORY:			
Do you smoke:	☐ Yes	☐ No	☐ Ex-smoker How long? _____
How much alcohol do you drink per week:	☐ Wine glass per week	☐ Beer glass per week	☐ Spirits glass per week
Do you have children (how many, how old):			
FAMILY HISTORY:			
Is there a family history of any of the following problems (please tick)?			
☐ Obesity		☐ Premature death (i.e. death before age 60)	
☐ Heart disease		☐ Diabetes	
☐ Stroke			
SLEEP QUESTIONS: (Please tick the relevant boxes)			
☐ Do you snore loudly (louder than normal speech or loud enough to hear it in another room)?			
☐ Do you often feel tired, fatigued or sleepy during the daytime?			
☐ Has anyone ever noticed you stop breathing during your sleep?			
☐ Have you been diagnosed with sleep apnoea?			
☐ Do you use a CPAP machine for treatment of sleep apnoea?			

Thank you for taking the time to fill in the questionnaire.