

**Columbia University Center for Metabolic and Weight Loss Surgery
New Patient Questionnaire**

NAME: _____

DATE: _____

Past Medical History (check all that apply & write the date of diagnosis)

_____ Heart Disease	_____ Gallbladder Disease
_____ High Blood Pressure	_____ Kidney Stone Disease
_____ Stroke	_____ Chronic Renal failure
_____ High Cholesterol	_____ Osteoporosis/Osteopenia
_____ High Triglycerides	_____ Hepatitis
_____ Diabetes	_____ Blood Clots
_____ Gout	_____ Tuberculosis
_____ Sleep Apnea	_____ Asthma/Emphysema
_____ Irritable Bowel Syndrome	_____ Recent Respiratory Illness
_____ Diverticulosis/Diverticulitis	_____ Skin Infections/Diseases
_____ Crohn's/Ulcerative Colitis	_____ Arthritis - OA or RA
_____ GERD	_____ Hypothyroidism
_____ Ulcers (Location _____)	_____ Other Thyroid Disorder
_____ Other Gastrointestinal Disorder	_____ Autoimmune Disease
(Type _____)	(Type _____)
_____ Cancer (Type _____)	_____ Malnutrition
_____ Polycystic Ovary Syndrome	_____ Bleeding Tendencies
_____ Depression or Psych. Illness	_____ Other _____
_____ Frequent Headaches/Migraines	

Hospital Admissions & Operations Year Age Type of Anesthesia

Significant Family History

Check if anyone in your family has had any of the following medical problems.

_____ Heart Disease	_____ Diabetes
_____ Stroke	_____ Obesity
_____ Tuberculosis	_____ Thyroid Disorder
_____ Cancer (What type? _____)	

Current Medications, Nutritional Supplements & Over-the-Counter Meds

Most insurance companies are requesting a diet history before approving surgery. For each of the weight loss methods below that you have tried, indicate to the left the number of times that you have tried that method. Then give the starting and ending dates of your trial with that method as well as the amount of weight that you lost. If you need more room for additional trials of the same method, use the reverse side of this page.

	Dates		Amt. WT. Lost
	From	TO	
<u>Weight loss programs:</u>			
_____ Weight Watchers	_____	_____	_____
_____ Weight Loss Camp	_____	_____	_____
_____ Jenny Craig	_____	_____	_____
_____ LA Weight Loss Center	_____	_____	_____
_____ Overeaters Anonymous	_____	_____	_____
<u>Comprehensive Wt. Loss Programs:</u>			
_____ Duke's	_____	_____	_____
_____ St. Luke's	_____	_____	_____
_____ Structure House	_____	_____	_____
_____ Other _____	_____	_____	_____
<u>Diets:</u>			
_____ Atkins	_____	_____	_____
_____ The Zone	_____	_____	_____
_____ Carbohydrate Addict's Diet	_____	_____	_____
_____ Optifast	_____	_____	_____
_____ Medifast	_____	_____	_____
_____ Slimfast	_____	_____	_____
_____ MD Supervised	_____	_____	_____
_____ Nutritionist Supervised	_____	_____	_____
_____ Grapefruit Diet	_____	_____	_____
_____ Beverly Hills Diet	_____	_____	_____
_____ Scarsdale Diet	_____	_____	_____
_____ Cabbage Soup Diet	_____	_____	_____
_____ Rice Diet	_____	_____	_____
_____ South Beach Diet	_____	_____	_____
_____ Other diet _____	_____	_____	_____
<u>Medications:</u>			
_____ Phen/Fen	_____	_____	_____
_____ Meridia	_____	_____	_____
_____ Redux	_____	_____	_____
_____ Ionamin	_____	_____	_____
_____ Xenical	_____	_____	_____
_____ Fastin	_____	_____	_____
_____ Other _____	_____	_____	_____
<u>Weight Loss Aides:</u>			
_____ Dieter's Tea	_____	_____	_____
_____ Dexatrim	_____	_____	_____
_____ Herbalife	_____	_____	_____
_____ Herbalite	_____	_____	_____
_____ Xenadrine	_____	_____	_____
_____ Tonalin	_____	_____	_____
_____ Other _____	_____	_____	_____
<u>Other Weight Loss Methods:</u>			
_____ Increased Exercise	_____	_____	_____
_____ Other _____	_____	_____	_____

Have you ever forced yourself to vomit after eating too much?

_____ Yes _____ No

If Yes: How long did this behavior last? _____

When was the last time that you forced yourself to vomit? _____

Have you ever used laxatives to lose weight? _____ Yes _____ No

If Yes: How long did this behavior last? _____

When was the last time that you used laxatives in this way? _____

Do you eat larger-than-usual amounts of food until you are uncomfortably full two or more times per week? _____ Yes _____ No

If yes: Do these binges start after you become angry, stressed, depressed, etc.? _____ Yes _____ No

Do you eat even though you are really not hungry during these binges?

_____ Yes _____ No

Do you feel out of control and unable to stop eating during these binges? _____ Yes _____ No

Do you eat more quickly than usual during these binges?

_____ Yes _____ No

Do you eat alone out of embarrassment? _____ Yes _____ No

Do you have feelings of disgust, depression or guilt after overeating?

_____ Yes _____ No

Have you been overeating this way for more than 4 months?

_____ Yes _____ No

Would you consider yourself to be an emotional eater? In other words, do you tend to eat more when you are stressed, angry, depressed, bored, celebrating happy events, etc...? _____ Yes _____ No

Were you heavy as a child, i.e. 10 years old or younger?

_____ Yes _____ No

If no: At what age did you start to gain weight? _____ years

At what age did you actively begin to diet to lose weight? _____ years

Are you on a diet for special medical purposes? _____ Yes _____ No

If yes, please indicate below the medical condition and the type of diet recommended:

Please check below any dietary problems that apply to you:

- | | |
|---|---|
| _____ Meal skipping | _____ Crave bread, pasta, rice or other starchy food |
| _____ Large portion sizes | _____ Crave cake, cookies, pies or other sweet bakery items |
| _____ Frequent eating out at/ordering-in from restaurants | _____ Crave chocolate |
| _____ Frequent fast food consumption | _____ Crave candy other than chocolate |
| _____ Frequent snacking/grazing | _____ Crave cheese |
| _____ Eating foods too high in fat | |
| _____ Can not cook | |

If female, when was the date of your last menstrual period? _____

Are your menstrual cycles fairly regular? _____ Date of last mammo _____
Date of your last pap smear _____ How many pregnancies? _____
Do you desire pregnancy at this time? _____
Are you pregnant/nursing? _____
What birth control do you currently use? _____

When was your last physical exam? _____

Result _____
Have you ever had a echocardiogram? _____ If so, when & why? _____
Date of last colonoscopy _____ Date of last EKG _____
Date of last chest x-ray _____

Do you exercise regularly? _____ Yes _____ No

If yes, what type of exercise & how often per week? _____

Have you ever smoked? _____ Yes _____ No

If yes: What year did you start? _____
Do you presently smoke? _____ Yes _____ No
If yes: How many packs per day do you smoke per day? _____
If no: What year did you quit? _____

How many servings of alcoholic beverages do you drink per week and type?

Number of servings per week: _____ (1 serving= 1.5 oz. hard liquor; 12 oz
beer; or 4 oz wine)

Type of alcohol preferred: _____

Are you a recovering alcoholic? _____ Yes _____ NO

If yes: How many years have you been clean and sober? _____

Have you ever used street drugs? _____ Yes _____ No

If yes: What kind did you use? _____
When was the last time that you used drugs? _____
Are you recovering from drug addiction? _____ Yes _____ NO

How many caffeinated beverages do you drink per day (e.g. coffee, dark colored
soda) _____

How many sugar-containing beverages (e.g. regular Soda, juice, sugar in coffee or
tea) do you drink per day? _____

How many meals do you generally eat each day? _____

Do you eat breakfast? _____ Yes _____ No

Do you eat more food in the evening than during the day? _____ Yes _____ No

How many times per day do you generally eat sweets (e.g. candy, cake, ice cream,
cookies)? _____

- _____ 29. Getting into frequent arguments.
- _____ 30. Feeling nervous when you are left alone.
- _____ 31. Feeling so restless you could not sit still.
- _____ 32. Feelings of worthlessness.
- _____ 33. Feeling that familiar things are strange or unreal.
- _____ 34. Shouting or throwing things.
- _____ 35. The idea that you should be punished for your sins.
- _____ 36. The idea that something is wrong with your mind.

If applicable, what are your reasons for desiring surgery? (Check all that apply)

- _____ To decrease medical problems, specifically _____
- _____ To prevent medical problems
- _____ To improve quality of life
- _____ Cosmetic reasons
- _____ Other - specify: _____

How did you learn about our program? (Check all that apply)

- _____ Talked with someone who had surgery. Who? _____
- _____ From relative, friend, religious leader
- _____ Researched it through the Internet
- _____ Read books or articles about it
- _____ Discussed it with a health provider
- _____ From advertising Type (eg. TV, newspaper, magazine)? _____
- _____ Other _____

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