



BROWN SURGICAL ASSOCIATES
BROWN PHYSICIANS, INC.

Brown Surgical Associates Weight Management Program

Patient Questionnaire:

*Please complete this questionnaire and bring it with you to your appointment with the practitioner.
This information will assist us in your care plan. Thank you.*

Full Name: _____ **Date of Birth:** _____

Gender: _____ Female _____ Male _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Email: _____

Race: (please circle all that apply)

African-American Asian Caucasian Hispanic Pacific Islander/Hawaiian

Native American Other: _____

Operation/Procedure/Program Requested:

- | | |
|--|---|
| <input type="checkbox"/> Roux-en-Y Gastric Bypass | <input type="checkbox"/> Duodenal Switch / SADI |
| <input type="checkbox"/> Sleeve Gastrectomy | <input type="checkbox"/> Surgical Revision |
| <input type="checkbox"/> Adjustable Gastric Banding | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Gastric Balloon | <input type="checkbox"/> Lifestyle Management |
| <input type="checkbox"/> Weight Management with Meds | <input type="checkbox"/> Undecided |

Surgeon Requested (if known): _____

Hospital Requested (if known): _____

How did you hear about our program?

My physician _____ A friend _____

Facebook Internet Brown Surgical Associates Website Brochure Newspaper

Other _____



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Primary Care/Family Physician: _____

Practice Name: _____

Address: _____ City, State, Zip: _____

Office Phone: _____ Office Fax: _____

Referring Physician (if different from above): _____

Practice Name: _____

Address: _____ City, State, Zip: _____

Office Phone: _____ Office Fax: _____

Please indicate if you **are now experiencing or in the past year experienced** any of the symptoms listed below.

<p>GENERAL</p> <p>___ Weight Gain ___ Weight Loss ___ Fever ___ Chills ___ Night Sweats ___ Fatigue</p> <p>HEAD, EARS, EYES, NOSE, THROAT</p> <p>___ Eye Pain ___ Red Eyes ___ Dry Eyes ___ Vision Problems ___ Trouble Swallowing ___ Pain with Swallowing ___ Hearing Loss ___ Nose Bleeds ___ Dry Mouth ___ Sore Throat ___ Hoarseness ___ Swollen Nodes</p>	<p>CARDIO-VASCULAR</p> <p>___ Chest Pain ___ Palpitations ___ Light Headedness</p> <p>___ Leg pain with exercise ___ Leg swelling</p> <p>RESPIRATORY</p> <p>___ Shortness of Breath ___ Wheezing ___ Cough ___ Painful Breathing ___ Shortness of breath With activity ___ Sleep Apnea</p> <p>GASTRO-INTESTINAL</p> <p>___ Abdominal Pain ___ Heartburn/Reflux ___ Nausea/Vomiting ___ Hernia ___ Constipation ___ Diarrhea</p>	<p>RENAL/REPRODUCTIVE</p> <p>___ Painful Urination incontinence ___ Vaginal Discharge ___ Abnormal Vaginal Bleeding</p> <p>MUSCULOSKELETAL</p> <p>___ Joint Pain ___ Joint Stiffness</p> <p>___ Back Pain ___ Muscle Pain ___ Muscle Weakness</p> <p>SKIN</p> <p>___ Rashes ___ Skin wound</p>	<p>NEUROLOGIC</p> <p>___ Confusion ___ Dizziness ___ Fainting ___ Difficulty walking</p> <p>PSYCH</p> <p>___ Suicidal ___ Insomnia ___ Anxiety ___ Depression</p> <p>ENDOCRINE</p> <p>___ Bulging eyes ___ Hot Flashes ___ Muscle Weakness ___ Voice Change</p> <p>HEME</p> <p>___ Easy Bleeding ___ Easy Bruising ___ Swollen Glands</p>
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Medical History: Please indicate if you have been diagnosed with any of the following illnesses:

<p>___ Heart Attack ___ Cardiac Failure ___ Coronary Disease ___ High Blood Pressure ___ High Cholesterol ___ High triglycerides ___ Obesity ___ Constipation</p>	<p>___ COPD (lung disease) ___ Asthma ___ Sleep Apnea ___ Emphysema ___ Reflux/GERD ___ Stomach ulcers ___ Hiatal Hernia ___ Abdominal Hernia ___ Swallowing trouble</p>	<p>___ Achalasia ___ Small Bowel Obstruction ___ Hypothyroid ___ Hyperthyroid ___ Type 1 Diabetes ___ Type 2 Diabetes ___ Autoimmune Disease</p>	<p>___ Epilepsy/Seizures ___ Neurological Disease ___ Depression ___ Anxiety ___ Arthritis ___ Cancer Type: _____</p>
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Please indicate any other illnesses or medical history:

Surgical History

Please indicate any previous surgeries:

Do you have pain that interferes with your daily activity? No Yes

If yes, where is the pain? _____

Please circle the number that represents your pain level:

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain

Diabetes/Endocrine

Pre-Diabetic No Yes
 History of Gestational Diabetes No Yes
 Excessive Thirst or Urination No Yes
 Hypoglycemia No Yes

Does your Diabetes Type I/II require medication? No Yes

Who manages your diabetes? (Primary care, endocrinologist, etc.) _____

Social History

Employment Status: Full Time Part Time Self Employed Retired Unemployed
 Homemaker Student Disabled Not Specified

Occupation: _____ Employer: _____

Marital Status (please circle one): Single Married Separated Divorced Widowed Partnered Do you have children/how many? _____

Do you use?		If YES, how much/often?
Tobacco/Nicotine products (<i>cigarettes, pipes, cigars, chewing tobacco, e cigarettes, vapes, nicotine patches/gums/lozenges, Chantix</i>)	YES NO	_____ packs per day for _____ years If you quit, when? _____
Alcohol	YES NO	Type: _____ Frequency: _____
Recreational Drugs (<i>opioids, marijuana, cocaine, heroin, etc.</i>)	YES NO	Type: _____ Frequency: _____



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Medications and Supplements:

Medication/Supplement	Dosage & Frequency	Reason

Allergies

Medication/Food	Reaction
Other Allergies	Reaction



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Weight History

Number of years overweight: _____

Highest Adult Weight and When: _____ lbs _____ yrs old

Lowest Adult Weight and When: _____ lbs _____ yrs old

Birth Weight (*if known*) _____

As best you can recall, what was your body weight at each of the following points of your life?

Grade School ____ High School ____ Ages 20-29 ____ 30-39 ____ 40-49 ____ 50-59 ____ 60-69 ____

What is your greatest weight loss and when? _____ lbs _____ yrs old How long did you keep this weight off? _____

Have you had previous weight loss surgery? Yes No Type: _____ *Previous methods used for weight loss:*

Calorie Counting Exercise Weight Watchers Jenny Craig Diet Pills Nutritionist

Prescription Medication (specify) _____ Other _____

Weight History Comments _____

Have you been seen by a medical office within the last 6 months and have been weighed? (ex: primary care physician, cardiologist, gynecologist, etc.)

Yes No If yes: 1. Date: _____ Weight: _____ lbs

2. Date: _____ Weight: _____ lbs

3. Date: _____ Weight: _____ lbs

4. Date: _____ Weight: _____ lbs

5. Date: _____ Weight: _____ lbs

6. Date: _____ Weight: _____ lbs

Activity/Exercise

Do you exercise regularly? Yes No

Types of exercise? Strengthening Cardio Other: _____

How often? _____ times/week _____ times/month

If no, what prevents you from exercising? Time Work Health Other: _____

COVID Status

Have you had COVID? Yes (Date): _____ No

Have you been vaccinated for COVID? Yes (Date): _____ No



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Family History

Please specify if you have any family members with:

- Obesity _____
- Heart Disease _____
- Diabetes/Endocrine _____
- High Blood Pressure _____
- Cancer _____ Type: _____
- Arthritis _____
- Early Death _____
- Asthma _____
- Stroke _____
- Depression _____ Other _____
- Diseases _____

Sleepiness Questionnaires

Do you use a CPAP Machine? Yes What is the setting? _____ No, do not use.

Do you experience any of the following: (check all that apply)

- Excessive sleepiness Chronic fatigue Daytime sleepiness
- Sleep walking Leg twitching/jerks Gasping for air at night

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling tired?

Use the following scale to choose the *most appropriate number* for each situation:

- 0 = would *never* doze
- 1 = *slight* chance of dozing
- 2 = *moderate* chance of dozing
- 3 = *high* chance of dozing

Chances of Dozing (Scale of 0-3)

- Sitting and reading _____
- Watching TV _____
- Sitting, inactive in a public place (e.g. a theater or meeting) _____
- As a passenger in a car for an hour without a break _____
- Lying down to rest in the afternoon when circumstances permit _____
- Sitting and talking to someone _____
- Sitting quietly after a lunch without alcohol _____
- In a car, while stopped for a few minutes in traffic _____

(For Staff Epworth Score: _____ ≥ 10)



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BMI: BMI more than 35 kg/m² **Yes** **No**
Age: Age over 50 years old? **Yes** **No**
Neck circumference: Neck circumference greater than 40 cm? (measured by staff) **Yes** **No**
Gender: Gender male **Yes** **No**

Collar size of shirt: S M L XL or _____ inches/cm (15.5 inches =40 cm)

1. **Snoring:** Do you snore loudly? **Yes** **No**
(Louder than talking or loud enough to be heard through closed doors)
2. **Tired:** Do you often feel tired, fatigued, or sleepy during daytime? **Yes** **No**
3. **Observed:** Has anyone observed you stop breathing during your sleep? **Yes** **No**
4. **Blood Pressure:** Do you have or are you being treated for high blood pressure? **Yes** **No**

For clinical staff to complete:

(STOP BANG Score: _____)
Yes ≥ 3 items = High risk of OSA
Score Yes < 3 items = Low risk of OSA

Part 1: PHQ-4

Over the <u>last 2 weeks</u> , how often have you been bothered by the following problems? (Please circle your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

Part 1 Total Score = _____



Part 2: Eating Behaviors

5. Questions about eating <i>(Please circle your answer)</i>	No	Yes
a. Do you often feel that you can't control what or how much you eat?	0	1
b. Do you often eat, within any 2-hour period, what most people would regard as an unusually large amount of food?	0	1
If you checked "NO" to either #a or #b, go to question #8.		
c. Has this been as often, on average, as once a week for the last 3 months?	0	1
6. In the last 3 months have you <u>often</u> done any of the following in order to		Yes
No avoid gaining weight? <i>(Please circle your answer)</i>		
a. Made yourself vomit?	0	1
b. Took more than twice the recommended dose of laxatives?	0	1
c. Fasted — not eaten anything at all for at least 24 hours?	0	1
d. Exercised for more than an hour specifically to avoid gaining weight after binge eating?	0	1
7. If you checked "YES" to any of these ways of avoiding gaining weight, were any as often, on average, as once a week?	No 0	Yes 1

Part 2 Total Score = _____

Part 3: Alcohol Use

8. Do you ever drink alcohol (including beer or wine)?	No	Yes
<i>If you checked "NO" go to question #10.</i>	0	1
9. Have any of the following happened to you more than once in the last 6 months?	0	1
a. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health.	0	1
b. You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities.	0	1
c. You missed or were late for work, school, or other activities because you were drinking or hung over.	0	1
d. You had a problem getting along with other people while you were drinking.	0	1
e. You drove a car after having several drinks or after drinking too much.	0	1

Part 3 Total Score = _____



Part 4: Symptom Interference

10. If you checked off any problems on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? <i>(Please circle your answer)</i>	Not at all difficult	Somewhat Difficult	Very Difficult	Extremely Difficult
	0	1	2	3

Part 4 Total Score = _____

For Office Use Only:

If Part 1 Total Score is ≤ 5, Part 2 Total Score = 0, Part 3 Total Score = 0, and Part 4 Score = 0 or 1 then patient can be scheduled at MB-CRC

Drug Abuse Screening Test (DAST-10)

General Instructions

"Drug use" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin).

The questions do not include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to drug use in the past 12 months. Please answer No or Yes.

1. Have you used drugs other than those required for medical reasons?	Yes	No
2. Do you use more than one drug at a time?	Yes	No
3. Are you always able to stop using drugs when you want to?	Yes	No
4. Have you have "blackouts" or "flashbacks" as a result of drug use?	Yes	No
5. Do you ever feel bad or guilty about your drug use?	Yes	No
6. Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7. Have you neglected your family because of your use of drugs?	Yes	No
8. Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No

Skinner HA (1982). The Drug Abuse Screening Test. Addictive Behavior. 7(4):363-371. Yudko E, Lozhkina O, Fouts A (2007). A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. J Subst Abuse Treatment. 32:189-198.