The Bariatric Clinic

NEW PATIENT QUESTIONNAIRE

Date of first appointment:_____

PERSONAL DETAILS

1. Name:_____
2. Patient Number:_____
3. Date of birth:_____
4. Address_____

   _____
5. E-mail _____
6. Phone numbers: Home_____

   Mobile _____
7. Sex *(please circle)*: Male Female
8. Marital status: Single Married Divorced Separated Partner
9. Ethnic group:._____
10. Occupation:_____
11. GP address and telephone:_____

    _____

    _____

Data protection and data sharing see our privacy policy on www.svph.ie

PHYSICAL ASSESSMENT

1. Airway *(please circle)*

1. Has anyone ever mentioned that you snore? Yes / No
2. Has anyone ever mentioned that you stop breathing at night? Yes / No
3. What is your neck circumference (collar size of shirt?)
4. Do you feel sleepy during the day? Yes / No
   Epworth sleepiness score *(for clinician use)*:_____
5. Have you ever been diagnosed with sleep apnoea? Yes / No
6. Do you have asthma? Yes / No
7. Have you ever been admitted to hospital due to your asthma? Yes / No
8. Do you have chronic obstructive airway disease? Yes / No

2. Body mass index

1. How tall are you?
2. How much do you currently weigh?
3. What is the heaviest you have ever been and when was that?
4. What is the most weight you have ever lost and how quickly did you regain it?

3. Cardiovascular disease *(please circle)*

1. Have you smoked: Never Ex-smoker (Quit date_____) Currently (Cigarettes per day_____)
2. Do you drink alcohol: Never Occasionally Regularly
3. Roughly how many units per week do you drink?_____

(Pint of beer=2 unit, small glass wine=1 unit, large glass of wine=2 units, single measure of spirits=1 unit)

4. Have you ever been diagnosed with high blood pressure? Yes / No
5. Do you take medication for blood pressure? Yes / No
6. Have you ever been diagnosed with high blood cholesterol? Yes / No
7. Do you take medication for cholesterol? Yes / No
8. Have you ever had a heart attack? Yes / No
9. Have you ever suffered with angina? Yes / No
10. Have you ever had a stroke or mini stroke (TIA)? Yes / No
11. Have you ever had an irregular heart rhythm? Yes / No
12. Have you ever had heart failure? Yes / No
13. Have you ever had a blood clot in the leg (DVT)? Yes / No
14. Have you ever had a clotting disorder of your blood? Yes / No

4. Diabetes

1. Does anyone in your family have diabetes? Yes / No
2. Have you ever been diagnosed with diabetes? Yes / No
3. Do you take pills for diabetes? Yes / No
4. Do you take insulin or other injections for your diabetes? Yes / No
5. Have you ever had problems with your eyes due to diabetes Yes / No
6. Have you ever had problems with your kidneys due to diabetes Yes / No
7. Have you ever had problems with your nerves due to diabetes Yes / No

5. Economic complications

1. Has your weight financially impacted on you, e.g. travel or clothes? Yes / No
2. Have you ever felt discriminated against at work due to your weight? Yes / No
3. Have you ever lost a job or had to stop working because of your weight? Yes / No
4. Has your weight ever had an economic impact on someone else? Yes / No

6. Functional complications

1. If you have to climb 3 flights of stairs where do you rest for the first time?
2. Do you stop because of *(circle appropriate)*: shortness of breath OR knee/back pain
3. Do you need a walking aid? Yes / No
5. Have you ever been housebound or wheelchair dependent? Yes / No
6. Do you currently need someone to help you with daily tasks? Yes / No

7. Gonadal

1. Do you or did you have irregular periods? Yes / No
2. Do you feel you have too much hair on your face, arms or body Yes / No
3. Have ever been diagnosed with polycystic ovarian syndrome Yes / No
4. Has you weight impaired your sexual function? Yes / No
5. Do you think you do or did suffer with infertility? Yes / No

8. Perceived Health status

1. Do you think you are healthy? Yes / No
2. Have you ever had a low mood or depression? No / Yes (Mild / Moderate / Severe)
3. Have you ever used antidepressant medication? Yes / No
4. Have you ever had another psychiatric diagnosis Yes / No

9. Body image

1. What do you see when you look in the mirror?
2. Do you avoid looking in mirrors? Yes / No
3. How much weight do you want to lose?

10. Junction of stomach and gullet (gastro-oesophagus)

1. Do you have indigestion / heart burn or acid reflux Yes / No
2. Have you ever had a gastroscopy? Yes / No

11. Kidney

1. Have you ever had kidney disease? Yes / No
2. Have you ever had kidney stones? Yes / No

12. Liver

1. Have you ever been diagnosed with abnormal liver tests or fatty liver? Yes / No
2. Have you ever been diagnosed with non-alcoholic steatohepatitis (NASH) Yes / No

13. Medication list

14. Tell me how will we know that the operation has been a success a year from not but you are not allowed to use a number? *E.g. can tie my shoe laces*

_____

_____

15. Allergies

Suspected_____

Medically confirmed_____

16. Other

Have you had any other past medical problems or surgical operations not previously mentioned? If so please specify the date

17. Daytime sleepiness

Using the following scale, please choose the most appropriate number for each situation:

0 = would never doze or sleep
1 = slight chance of dozing or sleeping
2 = moderate chance of dozing or sleeping
3 = high chance of dozing or sleeping

Situation	Probability of dozing or sleeping
You are sitting and reading	
You are watching TV	
You are sitting, inactive in a public place (e.g. cinema or theatre)	
As a passenger in a car in a 1 hour journey without breaks	
Lying down in the afternoon	
You are sitting and talking to someone else	
You are sitting calmly after a meal with no alcohol	
In a car, being stopped for some minutes due to the traffic (e.g. traffic light or traffic jam)	

MENTAL HEALTH HISTORY

1. Have you ever had any problems at any time with depression, anxiety, or other emotions that disrupted your health?

Yes / No

2. Have you ever sought professional help for emotional problems?

Yes / No

3. Have you ever been under the care of a local mental health team?

Yes / No

If yes to above please describe when you had the problem, what the problem was and what help you had

……

……

……

WEIGHT HISTORY

1. What has been your highest weight since the age of 21? _____
2. When did you first consider your weight a problem? _____
3. If you take a step back and think about your eating behaviours what do you think are the main problems _____
4. Could you please tell us something about your childhood, growing up and your family of origin including any changes, moves or separation which you experienced that may have influenced your eating pattern over the years?

……

……

……

5. Please record your major weight loss efforts, (i.e. diet, exercise moderation etc). Take time to think over your previous efforts, starting with the first one, whether in childhood or adult hood. You may have difficulty remembering this information at first, but most people can if they take their time. Start with your first weight loss effort and proceed until you reach your most recent one

Age at start	Weight at start	Weight lost	Method used

6. What is the most weight that you have lost and how did you do it? .....

.....

7. Do you currently, or have you ever used any of the following to control your weight? *(please circle)*

Laxatives: last four weeks past 6 months never

Vomiting: last four weeks past 6 months never

Diuretics: last four weeks past 6 months never

Excessive Exercise: last four weeks past 6 months never

8. Do you ever eat to manage emotions?
9. Do you ever get up in the middle of the night eat even if you are not hungry?
10. Do you ever eat much larger amounts of foods than most people would consider normal under similar circumstances? Yes/No
11. Did you feel out of control while you were eating this way? Did you feel you could stop? Yes/No

FAMILY WEIGHT HISTORY

8. Has anyone in your family ever been overweight? Yes / No

If yes please can you estimate their height and weight:

Who (e.g. mother/brother)	Height	Weight

CURRENT PROBLEMS

1. Please indicate if you are currently experiencing any greater than usual stress in your life or any recent changes related to the following events *(please circle)*

a. Work Yes / No

b. Health Yes / No

c. Relationship with partner/ family or children Yes / No

d. Money Problems Yes / No

e. Legal Problems Yes / No

f. School Yes / No

g. Moving house Yes / No

h. Death/ illness of an important person in your life Yes / No

Please explain in a sentence any items to which you responded yes: .....

.....

.....

.....

TOBACCO, ALCOHOL & DRUG USE

1. Do you currently smoke cigarettes? Yes / No
   If yes, how many? _____

2. Have you ever used cannabis, cocaine or other mind altering drugs? Yes / No

3. Have you ever had a problem with alcohol consumption or the use of other drugs? Yes / No

If yes to any of the above please describe the problems and any help you received for it?

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Please answer the following 10 questions. Circle the box most applicable to you.

1. How often do you have drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
Do not answer the next 9 questions if the answer to 1 above is Never.					
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1-2 drinks	3-4 drinks	5-6 drinks	7or 8 or 9 drinks	10 or more drinks
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected from you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get your self going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking	Never	Less than monthly	Monthly	Weekly	]Daily or almost daily
8. How often during the last year have you not been able to remember what had happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured as a result of your drinking?	No, Never	Yes, but not in the last year		Yes, during the last year	
10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?	No, Never	Yes, but not in the last year		Yes, during the last year	

Food and Nutrition Related History:

Please list all foods and drinks eaten over a typical day and include portions sizes

Meal	Time	Food and Drinks
e.g. Breakfast	*10.00*	*2 slices of toast with butter and jam and 1 cup of tea with milk no sugar*

How often do you eat or drink the following?	Frequency
Takeaways /eating out	Daily Weekly Monthly Never
Fizzy drinks	Daily Weekly Monthly Never
Crisps /chocolate / biscuits /cakes	Daily Weekly Monthly Never

Do you tend to eat set meals or snacks? Yes / No
Do you find that you have times when you will eat continuously during the day or the evening? Yes / No

For office use only

Encouraged for follow up routine labs and compliance with vitamins as advised and leaflet given to patient ☐

Pre-op diet provided ☐ **Post-op diet provided** ☐

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE

Patient Consent to Store and Share Information

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice **before** signing this consent and prior to any service being provided to you by the Clinic. The Clinic reserves the right to change the Notice of Privacy Policies. If we change our notice, you may obtain a revised copy by sending a letter to the Clinic's Data Protection Officer, by asking your Consultant's Secretary or asking at Reception.

By signing this form, you acknowledge that you have been given the opportunity to read the Clinic's Notice of Privacy Practices prior to any service being provided to you by this Clinic, and you consent to the store, use and disclosure of your medical information to those other healthcare providers involved in your care and for treatment, payment and healthcare operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Clinic must comply with the Regulation (EU) 2016/679 of the European Parliament and of the Council ("GDPR") and the Data Protection Act 1988. This 1988 Act was amended by the Data Protection Act 2018. The 2018 Act brought our law into line with the GDPR.

At all stages in this document the "Clinic" refers to Consultants Private Clinic d.a.c.

By signing this form, I understand that:
Protected health information may be disclosed or used for treatment, payment, or healthcare operations. Examples of the information stored are name, address, date of birth, next of kin.

- **The Clinic reserves the right to change the privacy policy as allowed by law.**
- **The Patient has the right to revoke or amend this consent in writing at any time and all future disclosures will then be amended with immediate effect.**
- **The Clinic may need to tailor treatment depending on the details of this consent form.**

(Please tick as appropriate)

To confirm appointments, may we contact you by:		
Phone	**YES**	**NO**
Email	**YES**	**NO**
Text	**YES**	**NO**
May we leave a message on your:		
Home phone	**YES**	**NO**
Mobile phone	**YES**	**NO**
May we discuss your medical condition with a person appointed by you?	**YES**	**NO**

If yes please indicate their name and relationship to you ……..

May we email correspondence relating to your medical condition to you **YES** **NO**

May we make contact with your GP in relation to your condition via phone, email and fax? **YES** **NO**

Signed by Patient/Legal Guardian : ……. **Date: ……..**

Name of Patient in block capitals :…… **Date of birth : …./…./…..**

Signature of Consultants Private Clinic staff :…… **Date : ……..**

March 2019