# Weight Loss Survey

## PATIENT INFORMATION PROFILE



Suite 1/393 A, Crown St, Wollongong, NSW, 2500

Phone: (02) 4229 6355 Email: info@illawarraobesitysurgery.com.au

#### PERSONAL DATAILS

Surname:	
Given Names:	
Address:	
	Postcode:
Telephone No: (Home)	
(Bus)	
Mobile No:	
Date Of Birth:	Age:
Occupation:	
Health Insurance Fund:	
Membership No:	
Veterans Affairs No:	
Pensioner: Yes \Boxedown NO \Boxedown	

#### PERSONAL DATAILS

#### **CONTACT PERSONS:**

This information often vitall to us if we need to contact you urgently and helps with achieving good follow-up. Occasionally people move or have new phone numbers and do not let us know. Please select some contacts who can inform us if you have moved and forgotten to let us know your new address.

1. NEXT OF KIN	
Name:	Relationship:
Address:	
Telephone No: (Home)	(Bus)
2. ADDITIONAL CONTACT	
Name:	Relationship:
Address:	
Telephone No: (Home)	(Bus)
3. ADDITIONAL CONTACT	
Name:	Relationship:
Address:	
Telephone No: (Home)	(Bus)

#### REFERRAL INFORMATION

Referring Doctor:		D	ate of Referral:	<u>H</u> a
Address:				
Telephone Contact:				
Local Doctor:				
Address:				
Telephone Contact:				
Specialist Physician	/Surgeon:			
Other:				
SOCIAL PR	ROFILE			
FAMILY STRUCTUR	E:			
Married:	Single:	Divorced:	Partner/Relationship:	
Children/Ages:				
Support persons/frie	nds:			
Do you have a pet?	lf so, give details:			

#### PERSONAL MEDICAL HISTORY

Have you ever suffered with any of the following health problems:

Diabetes:		Yes	No 🗌	Details:
Diabetes with	pregnant:	Yes	No 🗌	Details:
Asthma:		Yes	No	Details:
Respiratory/B	reathing problems:	Yes	No 🗌	Details:
Sleep apnoea	<b>)</b> :	Yes	No	Details:
Pains in the:	Hips	Yes	No	Details:
	Feet	Yes	No 🗌	Details:
	Knees	Yes	No 🗌	Details:
	Back	Yes	No 🗆	Details:
Kidney or urin	ary disorder:	Yes	No	Details:
Incontinence	of urine:	Yes	No	Details:
Stroke or nerv	ve loss:	Yes	No	Details:
Depression of psychological	r other /nervous disorder:		No	Details:
Gallstones:		Yes	No	Details:
Heartburn or	reflux	Yes	No	Details:
Peptic ulcer:		Yes	No	Details:
Hepatitis or o	ther liver disease:	Yes	No 🗌	Details:
High blood pr	essure:	Yes	No 🗌	Details:
Heart disease		Yes	No	Details:
High choleste	rol or lipids	Yes	No	Details:

### PERSONAL MEDICAL HISTORY

	Infertility:	Yes	No 🗆	Details:	
	Anaemia or bleeding disorder	Yes	No	Details:	
	Thrombosis or clotting disorder	Yes	No	Details:	
	Varicose veins or leg swelling	Yes	No	Details:	
	Skin conditions, especially under skin folds:	Yes	No	Details:	
	Hayfever or Rhinitis	Yes	No	Details:	
Ple	ase give details of any major illne	esses/prol	blems:		
SI	JRGICAL HISTROY				
Ple	ase give details of any past opera	ations:			

### LADIES

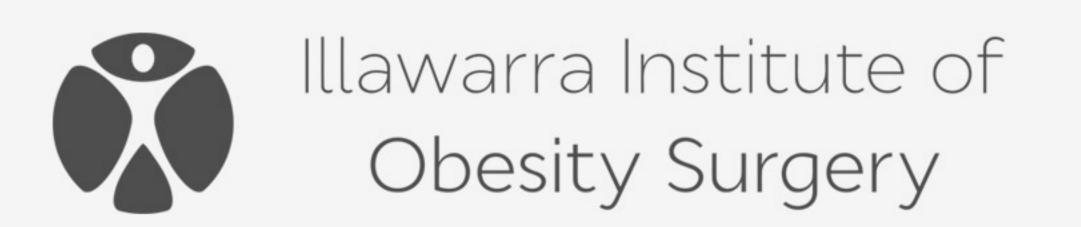
Do you have regular periods (26-33 days)  If not, please describe	Yes	No
Do have problems with excessively heavy periods  If Yes, please described	Yes	No
Have you had difficulty in conceiving in the past?	Yes	No
Do you currently have problems with infertility?	Yes	No
Have you suffered from excess body hair or acne?	Yes	No
Have you every been told by a doctor that you have polycystic ovaries?	Yes	No
Have you had problems with pregnancy and/or childbirth?	Yes	No
If so, in what way		
If so, in what way		
Have you had a caesarean section?	Yes	No
If so, why?		

#### SLEEP HISTROY

	How many hours sleep do you get a night?					
	Is there any thing else that keeps you awake at Details:	night?	Yes		No 🗆	
	Would you consider the quality of your sleep is		Good	d 🗌	Fair	Poor _
	If your sleep is a major problem to you or your would you be prepared to have a sleep study now and after you lose weight?		Yes		No	
SYI	MPTOMS OF SLEEP APNOEA					
	nswer each question, mark the horizontal line answer.	with a   in the p	ositio	n that	best indi	cates
1	Do you snore?					
	NEVER	ALWAYS				
2	Do you wake during the night with a choking	feeling?				
	NEVER	FREQUENTLY				
3	Would you sleep more than 8 hours in total in	n a 24 hour perio	od?			
	NEVER	ALWAYS				
4	Do you wake up more than once during the r	night?				
	NEVER	ALWAYS				
5	Do you have a headache when you wake up	in the morning?				
	NEVER	ALWAYS				

### SLEEP HISTROY

6	Have you noticed a reduction in your libido or sex drive?  NOTOTAL					
7	Do you feel sleepy during the day?  NEVER	ALWAYS				
8	Has anyone noticed that you momentarily sto	p breathing during your sleep? FREQUENTLY				
9	Do you fall asleep while reading?  NEVER	FREQUENTLY				
10	Do you wake up in the morning feeling confu	sed? ALWAYS				
11	Do you have a nap during the day?  NEVER	ALWAYS				
12	Do you feel sleepy in the evenings?  NEVER	ALWAYS				
13	Have you or anyone else noticed a change in	your personality recently?  DEFINITELY				
14	Do you doze off or fall asleep while driving?  NEVER	FREQUENTLY				



#### SLEEP HISTROY

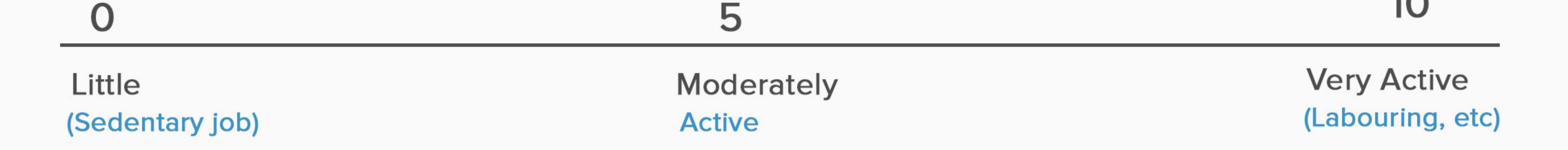
How likely are you to **doze off or fall asleep** in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you.

Use the following table to choose the most appropriate option for each situation by placing a tick in the boxes below:

Situation	[0] Never doze	[1] Slight chance of dozing	[2] Moderate chance of dozing	[3] High chance of dozing
Sitting and reading				
Watching TV				
Sitting, inactive in a public place (e.g. a theater or a 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 the traffic				

#### **EMPLOYMENT**

Current Employment:
Are you currently employed?
Are you full-time, part-time or casual?
What type of the work are you doing?
If you are unemployed, what is the reason?
Are you actively looking for work?
Has your weight made it difficult to find employment?
If employed, please state what level of activity your job involves:





(Place a cross at the appropriate point along the line)

#### SLEEP HISTROY

MEDICATIONS	
Please list all the tablets, drops, creams e	tc. which you are currently taking:-
	sly taken any of the following medications. ation and how long you have been or were taking it.
Medication for psychiatric disorder	Yes No Details:
Migraine medication	Yes No Details:
Medications to assist weight loss	Yes No Details:
Drugs for epilepsy	Yes No Details:
Drugs for asthma or breathing	Yes No Details:
Hormones, e.g. The Pill	Yes No Details:
HRT	Yes No Details:
Cortisone	Yes No Details:

#### WEIGHT HISTORY

Please indicate your weight at the following times. Please indicate whether you consider your weight was below average, above average or very heavy in the relevant boxes.

	Below Average	Average weight	Above Average	Very Heavy
Birth weight				
Weight at starting school (5-6 years)				
Weight at beginning of high school (10-12 years)				
Weight at end of high school (15-18 years)				
Weight at time of commencing work (21 years)				
Weight at time of marriage (if applicable)				



#### WEIGHT LOSS HISTROY

Dieting:-	fad diets, something you have read about, etc	
Exercise:-	walking, swimming, sporting activities, etc	
Surgical Methods:-	Stomach stapling	
	Fixed gastric banding	
	Small bowel bypass	
	Apronectomy	
	Liposuction	
	Other cosmetic procedures —list :-	
Commercial weight	Jenny Craig	
loss groups:-	Weight watchers	
	Gloria Marshall	
	Lite n'easy	
	Lite n'easy Nutrisystem	
	Nutrisystem	
	Nutrisystem Town club	

#### WEIGHT LOSS HISTROY

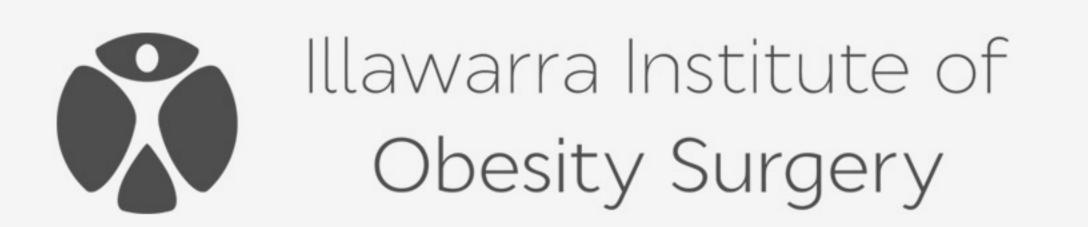
Diet Pills:	Duromine Tenuate Adifax Xenical Reductil Others – please list:-	
Professional Advice:-	Local doctor Dietician Naturopath Hypnotherapist Psychologist Acupuncturist	
Very low calorie diets:-	Modifast Optifast	
Others:-	Injection therapy Herbal remedies Weight loss devices	

Do you have a family history of any of the following and if so, please indicate:

	PARENT	SIBLING/ CHILD	OTHER RELATIVES (Cousins, aunts, grandparents etc.)	NO FAMILY HISTROY	DON'T KNOW
Diabetes					
Heart Disease					
Hypertension					
Gout					
Gallstones					
Obesity					
Snoring/sleep apnoea					
Asthma					
Allergies					
Hayfever					
Dermatitis/Eczema					
High Cholesterol					
Osteoporosis					
Hip fractures					
ALLERGIES (including food  If yes, please give details: _	s, medicatio	ons, dressing	gs):	Ye	s No
ALCOHOL:					
Do you drink alcohol:			Never _	Rarely	Regularly
How many standard glas	sses do you	drink per d	ay		
How many days do you	drink per w	eek			
Do you drink			Beer _	Wine _	Spirits

#### FAMILY MEDICAL HISTROY

Ok	Not too god	od		Revolting
0	5			10
	would you describe your ap opropriate point along the lin			
Do you avoid socia	al activities if possible		Yes	No
Are you embarrass	sed about your appearance?		Yes	No 🗌
SOCIAL EFFECTS:				
gr <del>ee</del>				
List any other partie	cular difficulties:-			
Travel, especially in	n planes, is difficult		Yes	No 🗌
Cannot cut your to	enails			No
Have difficulty with	personal hygiene		Yes	No
What size clothes	do you now buy?			
Have difficulty buyi	ing clothes			No
Cannot take part in	n family outdoor activities			No
Always tired and le			Yes $\square$	
Get short of breath	easily		Yes $\square$	No $\square$
Do you suffer any of t	he following physical limitatio	ns because of your wei	ght?	
PHYSICAL EFFECTS:				
For how many year	s when did	you stop smoking?		
Have you smoked i	n the past? Yes No	if so: how many per day	?	
Do you smoke?	Yes No Never	if yes: how many per da	y?	
SIMORING.				
SMOKING:				



	about the effect that your weight will have a lyour life expectancy?	on your Yes No
•	our future health in causing you to conside appropriate point along the line)	er surgery?
0	5	10
Not much	Quite a lot	The most important factor
	TNIECC OF DDEATH.	
COUGH AND SHOR	TNESS OF BREATH:	
Do you usually ha	ave a cough?	Yes No
Do you usually br	ring up phlegm from your chest when you c	cough? Yes No
Do you get short	of breath on exertion?	Yes No
Do you get short	of breath walking on the flat?	Yes No
Do you get short	of breath walking uphill or doing housewor	rk? Yes No
	on the stack of shortness of each of shortness of each when you were not exercising and cause	f Yes No
WHEEZE (a whistling	noise that cames from the chest and may cause brea	athlessness or difficulty in breathing)
In the last 12 mon	iths, have you had wheezing in your chest?	Yes No
In the last 12 mon on after you stop	ths, have you had an attack of wheezing th ped exercising?	nat Came Yes No
In the last 12 mon walking in the mo	nths,have you had feeling of tightness In you orning?	ur chest on Yes No

ACTIVITY LEVEL " What exercise do you do on a regular basis?

How many sessions of exercise (walking, sports, etc) do you do per week for more than 30 minutes at a time.	
What sort of activities:	
How do you feel when exercising.  Please mark level on scale:	
0	10
Awful Average	Excellent
There is inceasing evidence that alcohol consumption may help some of the ris heart disease and stroke. Indeed it may even decrease the mortality associated w conditions.	
We wish to look at these risk factors in people who are obese. To assist us we would these few simple questions about your alcohol consumption and a few question multivitamins you may take.	
Please circle your answers where appropriate.	
PART A Do you drink any alcohol? Yes No	o (go to part B)
How often do you have a drink containing alcohol?	
Every Day	t months
What is the main type of beverage you drink?  ( Please circle one only. )  Beer	

From the list below please circle the main alcoholic beverage you drink and tick any others you would drink at times.					
Beer Light Beer Red wine White Wine Sparkling Wine					
Fortified Wine Spirirts (specify)					
When do you usually drink? Please circle the main one. Tick any others that are relevent .					
Social occasions Parties With meals Before/after meals weekend seesion/s					
If you indicated above that you drank every day, most days or most weeks, please circle how many standard drinks you would have in a typical week.  (1 standard drink= 1 small glass of wine, 1 glass of full strength beer or a nip of spirits).  1-2 3-10 11-20 21-40 40+					
PART B For non-drinkers only.					
Is there a reason you don't drink any alcohol?					
PART C					
1 Do you take multivitamin tablets or other dietary supplements? Yes ☐ No ☐ (go to 2)					
If yes, how often do you take them?					
Rarely Monthly Weekly Most days Every day					
Please the name of multivitamin or other dietary supplements you usually take.					

2	Do you take f	olate tablets?	Yes	No _		
	If yes, how oft	en do you take	them?			
	Rarely	Monthly	Weekly		Most days	Every day
	What dose do y	ou take?				
	200mcg	400mg				

#### GASTRO OESOPHAGEAL REFLUX / INDIGESTION

Do you have a history of heartburn or indigestion	
Yes No Details:	
If yes, how often do you have reflux during the day?	
Many times a day everyday most days most weeks occasionally	
Do you suffer heart burn / indigestion during the night? If so how often	
Many times a night  everynight most nights most weeks coccasionally	
■ What aggrevates or causes your reflux?	
Details:	
Do you have difficulty swallowing?	
Yes No Details:	
■ Does food ever get stuck?	
Yes No Details:	
Does food or fluid reflux into the mouth?	
Yes No Details:	
Do you vomit with reflux?	
Yes No Details:	

#### GASTRO OESOPHAGEAL REFLUX / INDIGESTION

Do you	suffer fro	m recurrent sore throats?
Yes	No	Details:
Do you	suffer fro	m a hoarse voice?
Yes	No	Details:
	· · · · ·	
Do you	suffer fro	m a regular cough at night?
Yes	No	Details:
Please li	ist any tre	eatments you may use for reflux / heartburn or indigestion.
	Yes  Do you  Yes  Do you  Yes   The state of	Yes No Do you suffer fro Yes No Do you suffer fro Do you suffer fro Yes No Do you suffer fro

#### BREATHING HISTORY

Does being at work ever make your chest tight or wheezy?
Yes No Details:
Have you ever had to change your job because it affected your breathing?
Yes No Details:
Have you ever worked in a job, which exposed you to vapours, gas dust or fumes?
Yes No Details:
ASTHMA
Have you ever had asthma? (tick one of the following)
Never  Current In the past Don't know
Have you ever had to spend a night in hospital because of asthma / breathing problems?
Yes No
$\blacksquare$ If yes, was it in the last 12 months $ \text{Yes} \; \square  \text{No} \; \square$
In the last 12 months, have you visited a hospital casualty dapartment or seen a doctor urgently because you had asthma or breathing problems
Yes No Details:
In the last 12 months, have you taken a course or prednisolone because of asthma or breathing problems
Yes No Details:
In the last 12 months, have you missed work or school because of asthma or breathing problems?
Yes No Details: