# Weight Loss Survey

## PATIENT INFORMATION PROFILE

Illawarra Institute of Obesity Surgery

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

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

www.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 ☐ NO ☐



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# 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) _____



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# REFERRAL INFORMATION

Referring Doctor: _____ Date of Referral: _____

Address: _____

Telephone Contact: _____

Local Doctor: _____

Address: _____

Telephone Contact: _____

Specialist Physician/Surgeon: _____

Other: _____

# SOCIAL PROFILE

**FAMILY STRUCTURE:**

Married: ☐ Single: ☐ Divorced: ☐ Partner/Relationship: ☐

Children/Ages: _____

Support persons/friends: _____

Do you have a pet? If 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/Breathing problems: Yes ☐ No ☐ Details: _____
- Sleep apnoea: Yes ☐ No ☐ Details: _____
- Pains in the:
  - Hips Yes ☐ No ☐ Details: _____
  - Feet Yes ☐ No ☐ Details: _____
  - Knees Yes ☐ No ☐ Details: _____
  - Back Yes ☐ No ☐ Details: _____
- Kidney or urinary disorder: Yes ☐ No ☐ Details: _____
- Incontinence of urine: Yes ☐ No ☐ Details: _____
- Stroke or nerve loss: Yes ☐ No ☐ Details: _____
- Depression or other psychological /nervous disorder: Yes ☐ No ☐ Details: _____
- Gallstones: Yes ☐ No ☐ Details: _____
- Heartburn or reflux Yes ☐ No ☐ Details: _____
- Peptic ulcer: Yes ☐ No ☐ Details: _____
- Hepatitis or other liver disease: Yes ☐ No ☐ Details: _____
- High blood pressure: Yes ☐ No ☐ Details: _____
- Heart disease: Yes ☐ No ☐ Details: _____
- High cholesterol or lipids Yes ☐ No ☐ Details: _____



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# 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: _____

**Please give details of any major illnesses/problems:**

# SURGICAL HISTROY

**Please give details of any past operations:**

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# LADIES

- Do you have regular periods (26-33 days) Yes ☐ No ☐

If not, please describe _____

_____

- Do have problems with excessively heavy periods Yes ☐ No ☐

If Yes, please described _____

_____

- 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 _____

_____

- Have you had a caesarean section? Yes ☐ No ☐

- If so, why? _____

_____



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# SLEEP HISTROY

- How many hours sleep do you get a night? _____
- Is there any thing else that keeps you awake at night? Yes ☐ No ☐

  Details: _____
- Would you consider the quality of your sleep is Good ☐ Fair ☐ Poor ☐
- If your sleep is a major problem to you or your partner, would you be prepared to have a sleep study performed now and after you lose weight? Yes ☐ No ☐

## SYMPTOMS OF SLEEP APNOEA

To answer each question, mark the horizontal line with a | in the position that best indicates your answer.

**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 a 24 hour period?

NEVER _____ ALWAYS

**4** Do you wake up more than once during the night?

NEVER _____ ALWAYS

**5** Do you have a headache when you wake up in the morning?

NEVER _____ ALWAYS



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# SLEEP HISTROY

**6** Have you noticed a reduction in your libido or sex drive?

NO _____ TOTAL

**7** Do you feel sleepy during the day?

NEVER _____ ALWAYS

**8** Has anyone noticed that you momentarily stop breathing during your sleep?

NO _____ FREQUENTLY

**9** Do you fall asleep while reading?

NEVER _____ FREQUENTLY

**10** Do you wake up in the morning feeling confused?

NEVER _____ 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?

NO _____ 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)*

| 0 | 5 | 10 |
|---|---|---|
| Little (Sedentary job) | Moderately Active | Very Active (Labouring, etc) |

# SLEEP HISTROY

## MEDICATIONS

**Please list all the tablets, drops, creams etc. which you are currently taking:-**

_____ _____

_____ _____

_____ _____

Please indicate whether you have previously taken any of the following medications.
If yes, please state the name of the medication 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, 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

For how long have you been seriously trying to lose weight?_____ Yrs.

**Which of the following have you tried at some time?**

**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 loss groups:-**

- Jenny Craig ☐
- Weight watchers ☐
- Gloria Marshall ☐
- Lite n’easy ☐
- Nutrisystem ☐
- Town club ☐
- Herbalife ☐
- Gutbusters ☐

Others – please list:-

_____

_____

# 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 ☐



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# FAMILY MEDICAL HISTROY

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 foods, medications, dressings): Yes ☐ No ☐

If yes, please give details: _____

## ALCOHOL:

- Do you drink alcohol: Never ☐ Rarely ☐ Regularly ☐
- How many standard glasses do you drink per day _____
- How many days do you drink per week _____
- Do you drink Beer ☐ Wine ☐ Spirits ☐

# FAMILY MEDICAL HISTROY

## SMOKING:

- Do you smoke? Yes ☐ No ☐ Never ☐ if yes: how many per day? _____
- Have you smoked in the past? Yes ☐ No ☐ if so: how many per day? _____
- For how many years _____ when did you stop smoking? _____

## PHYSICAL EFFECTS:

Do you suffer any of the following physical limitations because of your weight?

- Get short of breath easily Yes ☐ No ☐
- Always tired and lethagic Yes ☐ No ☐
- Cannot take part in family outdoor activities Yes ☐ No ☐
- Have difficulty buying clothes Yes ☐ No ☐
- What size clothes do you now buy? _____
- Have difficulty with personal hygiene Yes ☐ No ☐
- Cannot cut your toenails Yes ☐ No ☐
- Travel, especially in planes, is difficult Yes ☐ No ☐
- List any other particular difficulties:- _____

## SOCIAL EFFECTS:

- Are you embarrassed about your appearance? Yes ☐ No ☐
- Do you avoid social activities if possible Yes ☐ No ☐

**Looking in the mirror, would you describe your appearance as:-**

*(place a cross at the appropriate point along the line)*

| 0 | 5 | 10 |
|---|---|---|
| Ok | Not too good | Revolting |

# FAMILY MEDICAL HISTROY

- Are you worried about the effect that your weight will have on your future health and your life expectancy? Yes ☐ No ☐

**How imporant is your future health in causing you to consider surgery?**
*place a cross at the appropriate point along the line)*

| 0 | 5 | 10 |
|---|---|---|
| Not much | Quite a lot | The most important factor |

## COUGH AND SHORTNESS OF BREATH:

- Do you usually have a cough? Yes ☐ No ☐
- Do you usually bring up phlegm from your chest when you 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 housework? Yes ☐ No ☐
- In the last 12 months, have you had an attack of shortness of breath that came on when you were not exercising and without obvious cause Yes ☐ No ☐

## WHEEZE (a whistling noise that cames from the chest and may cause breathlessness or difficulty in breathing)

- In the last 12 months, have you had wheezing in your chest? Yes ☐ No ☐
- In the last 12 months, have you had an attack of wheezing that Came on after you stopped exercising? Yes ☐ No ☐
- In the last 12 months,have you had feeling of tightness In your chest on walking in the morning? Yes ☐ No ☐



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# FAMILY MEDICAL HISTROY

## 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 risk factors that lead to heart disease and stroke. Indeed it may even decrease the mortality associated with these serious conditions.

We wish to look at these risk factors in people who are obese. To assist us we would like you to answer these few simple questions about your alcohol consumption and a few questions about any folate or multivitamins you may take.

*Please circle your answers where appropriate.*

**PART A** **Do you drink any alcohol?** Yes ☐ No ☐ ( go to part B )

How often do you have a drink containing alcohol?

Every Day ☐ Most days ☐ Most weeks ☐ Most months ☐

Rarely(once or twice a year) ☐

What is the main type of beverage you drink?

*( Please circle one only. )*

Beer ☐ wine ☐ Spirits ☐



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# FAMILY MEDICAL HISTROY

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.

# FAMILY MEDICAL HISTROY

**2** Do you take folate tablets? Yes ☐ No ☐

If yes, how often do you take them?

Rarely ☐ Monthly ☐ Weekly ☐ Most days ☐ Every day ☐

What dose do you 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 ☐ occasionally ☐

- 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: _____



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# GASTRO OESOPHAGEAL REFLUX / INDIGESTION

- Do you suffer from recurrent sore throats?

  Yes ☐ No ☐ Details: _____

- Do you suffer from a hoarse voice?

  Yes ☐ No ☐ Details: _____

- Do you suffer from a regular cough at night?

  Yes ☐ No ☐ Details: _____

- Please list any treatments you may use for reflux / heartburn or indigestion.

# BREATHING HISTORY

- Does being at work ever make your chest tight or wheezy?

  Yes ☐ [2] No ☐ [1] Details: _____

- Have you ever had to change your job because it affected your breathing?

  Yes ☐ [2] No ☐ [1] Details: _____

- Have you ever worked in a job, which exposed you to vapours, gas dust or fumes?

  Yes ☐ [2] No ☐ [1] 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 ☐

- If yes, was it in the last 12 months Yes ☐ No ☐

- 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: _____



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