Bariatric Surgery Center

Patient Questionnaire

Salem Health® Hospitals & Clinics

DEMOGRAPHIC INFORMATION

Last name:	**First name:**	**MI:**	**Age:**
Home phone:	**Work phone:**	**Cell phone:**	
Mailing address:		**Apt #:**	
City:	**State:**	**Zip:**	
E-mail:	**Date of birth:**	**Gender at birth:** ☐ Male ☐ Female ☐ Intersex ☐ Prefer not to answer	

Race: ☐ White ☐ Black/African American ☐ American Indian ☐ Asian ☐ Hispanic/Latino ☐ Other *(specify)*

Employer *(Name of company)* and occupation if applicable:

Height: ft. in.	**Weight:** lb.	**How long have you been at this weight?**

I attended the Salem Hospital Bariatric Surgery Center information session on *(date)*:

Which surgery are you interested in? ☐ Gastric bypass ☐ Sleeve ☐ Undecided ☐ Band removal

A copy of your insurance card will be made for our records

PRIMARY INSURANCE INFORMATION

Company:	**Member ID#:**	**Phone number:**

SECONDARY INSURANCE INFORMATION

Company:	**Member ID#:**	**Phone number:**

PRIMARY HEALTH CARE PROVIDERS AND SUPPORT PERSONS

Name:	**Phone:**	
Address:	**State:**	**Zip:**

How long has he/she provided medical care for you?

Conditions treated:

Please list other physicians and conditions treated:

Referring PCP:

Name of support person for before and after surgery	**Phone:**

PATIENT LABEL

DSC 436904 (11/21)

Bariatric Surgery Center

Patient Questionnaire

Salem Health® Hospitals & Clinics

LIST ANY MEDICAL PROBLEMS, ILLNESSES OR HOSPITALIZATIONS *(past or present)*

Medical problem/Illness	Date	Treatment	Outcome

LIST ANY SURGERIES

Surgery	Date	Reason

Have you ever had surgery to aid in weight loss? ☐ **Yes** ☐ **No**

If yes, please describe:

Date of surgery:

PATIENT LABEL

Bariatric Surgery Center

Patient Questionnaire

Salem Health® Hospitals & Clinics

CURRENT MEDICATIONS *(please list all prescription, over the counter medications, vitamins and supplements you are taking)*

Name of drug *(including inhalers)*	Strength *(Dose)*	How many and what time?	When did you start taking it?	Who is the prescribing provider?
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

(If the space provided is not adequate, please attach a complete list)

ALLERGIES: *(Please list any medication allergies you have)*

Are you allergic to any medications? ☐ **Yes *(please list below)*** ☐ **No**

Are you allergic to any foods? ☐ **Yes *(please list below)*** ☐ **No**

1.	Reaction	5.	Reaction
2.	Reaction	6.	Reaction
3.	Reaction	7.	Reaction
4.	Reaction	8.	Reaction

I refuse the administration of part or all blood and blood products during surgery. ☐ **Yes**

Comments:

PATIENT LABEL

Bariatric Surgery Center

Patient Questionnaire

Salem Health® Hospitals & Clinics

SOCIAL HISTORY

Do you drink alcohol: ☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently

If yes, what beverages?	How many drinks per day?

Do you currently, or have you in the past, consumed alcohol heavily? ☐ Yes ☐ No

If so, when?

Do you use tobacco products? *(Includes smoking, vaping, chewing, e-cigarettes, cigars, pipes)*
Or do you use recreational or street drugs? *(including Medical/recreational marijuana —smoking, edibles, oils)*
☐ Yes *(This is an EXCLUSION in our program. You must be drug-free at least six weeks before submitting your packet.)*

Have you ever used tobacco products in the past? ☐ Yes ☐ No	Do you use a nicotine patch/gum/medication to remain tobacco free? ☐ Yes ☐ No

If so, what type: ☐ Chew ☐ Smoke ☐ Smokeless ☐ Vaping ☐ E-cigarettes

How much?	For how long? When did you quit?

Have you ever used recreational or street drugs in the past? *(Includes medical/recreational marijuana —smoking, edibles, oils)*
☐ Yes ☐ No If so, what and when did you quit?

Do you use CBD products? ☐ Yes ☐ No	What kind of CBD do you use?

Do you consume caffeine *(coffee, cocoa, colas, Mountain Dew, chocolates, No-Doz, Aqua-Ban)*? ☐ Yes ☐ No

If yes, in what form?	How much per day?

What is your employment status? ☐ FT ☐ PT ☐ Unemployed ☐ Self-employed ☐ Student

If yes, what is your occupation?	How long have you been at your current job?
If not, what was your most recent job and when?	Why are you not employed now? ☐ Retired ☐ Disabled ☐ Other *(explain)*:

FAMILY HISTORY *(Parents and Siblings Only)*

Family member	Brother/ Sister (B)/(S)	Living/ dead? (L)/(D)	Age	Health problems	Cause of death	Normal	Slightly overweight	Moderately overweight	Very overweight
Mother		☐ L or D ☐			☐	☐	☐	☐	☐
Father		☐ L or D ☐			☐	☐	☐	☐	☐
Sibling	☐ B or S ☐	☐ L or D ☐			☐	☐	☐	☐	☐
Sibling	☐ B or S ☐	☐ L or D ☐			☐	☐	☐	☐	☐
Sibling	☐ B or S ☐	☐ L or D ☐			☐	☐	☐	☐	☐
Sibling	☐ B or S ☐	☐ L or D ☐			☐	☐	☐	☐	☐
Sibling	☐ B or S ☐	☐ L or D ☐			☐	☐	☐	☐	☐

Do any of your children suffer from weight problems? ☐ Yes ☐ No

Please describe:

PATIENT LABEL

Bariatric Surgery Center

Patient Questionnaire

Salem Health® Hospitals & Clinics

NUTRITION AND EXERCISE HISTORY

Your weight at birth:	**Your weight at start of high school:**	**Your weight at HS graduation:**
What is the most you have ever weighed?		**How old were you at the time?**
What is the least you have ever weighed as an adult?		**How old were you at the time?**

Have you tried diet pills? ☐ **Yes** ☐ **No**	**Have you taken taken Fen-Phen?** ☐ **Yes** ☐ **No**

Which of the following weight loss program(s) have you tried:

Diet	From *(year)*	To *(year)*	Diet	From *(year)*	To *(year)*
☐ Atkins			☐ Nutri-System		
☐ Diet medications			☐ Optifast		
☐ Herbal Life			☐ Overeaters Anonymous		
☐ High protein			☐ Physician supervised diet		
☐ Jenny Craig			☐ SlimFast		
☐ Liquid protein			☐ South Beach		
☐ Low calorie diet			☐ The Zone		
☐ Magazine/Book diet			☐ Tops		
☐ Mayo Clinic			☐ Weight Watchers		
☐ Medifast			☐ Paleo		
☐ Metabolife			☐ Keto		

Other diets:

What was your most successful weight loss program?

How much weight did you lose and why did this work for you?

How long did you maintain the weight loss?

What are your favorite foods?

What are your favorite snacks?

Who does the cooking and food shopping at home?

Who else is at home that you cook for?

Do you exercise regularly *(three or more times/week)* ?: ☐ **Yes** ☐ **No**

What exercise program(s) have you tried to lose weight?

If no, why?: ☐ **Joint pain** ☐ **Shortness of breath** ☐ **Dislike exercise**
☐ **Other *(please explain)***

If you exercise regularly, what do you do?	**And how often?**

PATIENT LABEL

DSC 436904 (11/21)

Bariatric Surgery Center

Patient Questionnaire

Salem Health® Hospitals & Clinics

REPRODUCTIVE HISTORY

Have you ever had a period? ☐ Yes ☐ No If yes, at what age?	Are *(or were)* your periods: ☐ Regular ☐ Irregular ☐ No period
How many days does your period usually last?	
Have you gone through menopause? ☐ Yes ☐ No	If yes, at what age:
What was the date of the first day of your last menstrual period?	
What birth control method do you use now? *We require 2 methods of birth control for 18 months after surgery.*	
Have you ever been pregnant? ☐ Yes ☐ No	If yes, how many times?

Pregnancy #	Year	Weight at start of pregnancy	Weight at the end of pregancy

Any miscarriages or abortions? ☐ Yes ☐ No	
Date of last Pap smear	Was it normal? ☐ Yes ☐ No *(Please get path report)*
Date of last mammogram	Was it normal? ☐ Yes ☐ No *(Please get X-ray report)*

Have you had any of the following problems: ☐ Hysterectomy (Date: _____) ☐ Cancer (specify: ☐ cervical ☐ ovarian ☐ uterine)
☐ Infertility ☐ Dysfunctional uterine bleeding

POLYCYSTIC OVARIAN SYNDROME: Have you ever had polycystic ovarian syndrome (PCOS)?

☐ NO

☐ YES, *(Please check one of the following which best describes you)*

- ☐ I have been diagnosed with PCOS, but have never been treated.
- ☐ I take birth control pills or spironolactone medication for PCOS.
- ☐ I take metformin, actos, or avandia medication for PCOS.
- ☐ I take a combination of the above-mentioned medications for PCOS.
- ☐ I have been unable to have children because of PCOS.

☐ I'M NOT SURE.

PATIENT LABEL

Bariatric Surgery Center

Patient Questionnaire

Salem Health® Hospitals & Clinics

OTHER GASTROINTESTINAL HISTORY

Any changes in bowel movements? ☐ Yes ☐ No	If yes, describe:
How often do you have a bowel movement now?	
Any bloody stools? ☐ Yes ☐ No	If yes, frequency:
History of hemorrhoids? ☐ Yes ☐ No	If yes, when?
Have you had a upper endoscopy? ☐ Yes ☐ No	
If so, when and where?	Any abnormalities?
Have you had a colonoscopy? ☐ Yes ☐ No	
If so, when and where?	Any abnormalities?

CO-MORBIDITY QUESTIONNAIRE

1) HYPERTENSION: Have you ever had high blood pressure?

☐ NO

☐ YES, *(Please check one of the following which best describes you)*

- ☐ I have been told I have borderline high blood pressure but am not on any medication for it.
- ☐ I have been diagnosed with high blood pressure but do not take any medication.
- ☐ I have been diagnosed with high blood pressure and take one medication.
- ☐ I have been diagnosed with high blood pressure and take two or more medications for it.
- ☐ I have had kidney, eye, or other organ damage caused by my high blood pressure.

☐ I'M NOT SURE.

2) CHF: Have you ever been treated for congestive heart failure?

☐ NO

☐ YES, *(Please check one of the following which best describes you)*

- ☐ Class I: I get short of breath with activity beyond the ordinary activity.
- ☐ Class II: I get short of breath with ordinary activity.
- ☐ Class III: I get short of breath with minimal activity.
- ☐ Class IV: I get short of breath at rest.

☐ I'M NOT SURE.

3) ISCHEMIC HEART DISEASE: Have you ever been treated for heart disease?

☐ NO, (no history of heart disease or cardiac chest pain).

☐ YES, *(Please check one of the following which best describes you)*

- ☐ I've had tests, such as an EKG that was abnormal but no current chest pains.
- ☐ I've had a heart attack or am currently on medications to prevent chest pain.
- ☐ I've had heart surgery or catheterization procedure for blocked arteries in my heart.
- ☐ I have current heart disease or chest pain and take medications for it.

☐ I'M NOT SURE.

4) ANGINA ASSESSMENT: Have you ever had chest pain, which was thought to be related to your heart?

☐ NO

☐ YES, *(Please check one of the following which best describes you)*

- ☐ I get chest pain with extreme exertion *(running, hill or stair climbing)*.
- ☐ I get chest pain with moderate activity or exertion.
- ☐ I get chest pain with minimal exertion *(walking across a room)* or at rest.
- ☐ I have frequent cardiac chest pain not relieved by rest or medications.
- ☐ I've had a heart attack or I'm undergoing tests *(e.g., echocardiogram, heart catheterization, etc.)* for heart disease.

☐ I'M NOT SURE.

PATIENT LABEL

DSC 436904 (11/21)

Bariatric Surgery Center

Patient Questionnaire

Salem Health® Hospitals & Clinics

CO-MORBIDITY QUESTIONNAIRE *(CONTINUED)*

5) PERIPHERAL VASCULAR DISEASE: Do you have narrowing or hardening of the arteries causing poor circulation?

☐ **NO**

☐ **YES,** ***(Please check one of the following which best describes you)***

- ☐ **I don't have any symptoms, but I've been told I have abnormal sounds in my arteries from decreased blood flow.**
- ☐ **I have pain in my calves and thighs when I walk, and/or I take medication for my circulation.**
- ☐ **I've had a transient ischemic attack *(TIA, mini-stroke)* and/or pain in my feet at night in bed.**
- ☐ **I've had a procedure for narrowing and blockage in my arteries, either in my neck, abdomen, or legs.**
- ☐ **I've had a stroke or loss of tissue in my feet *(such as amputations)* due to poor circulation.**

☐ **I'M NOT SURE.**

6) LOWER EXTREMITY EDEMA: Do you have swelling or abnormal fluid in your ankles, feet, or legs?

☐ **NO**

☐ **YES,** ***(Please check one of the following which best describes you)***

- ☐ **I have swelling in my legs on and off but am not using any treatment.**
- ☐ **I have swelling in my legs treated with medications such as water pills, compression stockings, and/or leg elevation.**
- ☐ **I have skin sores on my legs due to venous disease.**
- ☐ **I have severe swelling in my legs decreasing my ability to walk, requiring hospitalization or making me disabled.**

☐ **I'M NOT SURE.**

7) DVT/PE: Have you ever had a blood clot in your lung or leg?

☐ **NO**

☐ **YES,** ***(Please check one of the following which best describes you)***

- ☐ **I had a blood clot in my leg cured with blood thinners.**
- ☐ **I've had more than one blood clot in my leg and I currently take blood thinners.**
- ☐ **I developed a blood clot that went to my lung.**
- ☐ **I've had a blood clot in my lung more than once that required a hospital stay and decreased my usual activities.**
- ☐ **I've had a procedure to place a special device in the vein near my heart to filter blood clots.**

☐ **I'M NOT SURE.**

8) Has anyone in your family ever had a deep vein thrombosis (DVT)?

☐ **NO**

☐ **YES**

☐ **I'M NOT SURE.**

9) GLUCOSE METABOLISM: Do you have diabetes at this time?

☐ **NO**

☐ **YES,** ***(Please check one of the following which best describes you)***

- ☐ **I've had high fasting blood sugars.**
- ☐ **I have diabetes treated with pills.**
- ☐ **I have diabetes treated with insulin.**
- ☐ **I have diabetes treated with both insulin and pills.**
- ☐ **My diabetes has resulted in serious problems, such as:**
- ☐ **Blindness**
- ☐ **Kidney disease**
- ☐ **Leg or foot pain associated with neuropathy**

☐ **I'M NOT SURE.**

PATIENT LABEL

CO-MORBIDITY QUESTIONNAIRE *(CONTINUED)*

10) LIPIDS: Have you ever had high cholesterol, or high lipid levels?

☐ **NO**

☐ **YES,** ***(Please check one of the following which best describes you)***

- ☐ **I have high lipid** ***(cholesterol or triglyceride)*** **levels but do not take medication or treatment for it.**
- ☐ **I have high lipid** ***(cholesterol or triglyceride)*** **levels treated with low fat diet and exercise.**
- ☐ **I have high lipid** ***(cholesterol or triglyceride)*** **levels treated with one medication.**
- ☐ **I have high lipid** ***(cholesterol or triglyceride)*** **levels treated with two or more medications.**
- ☐ **I have high lipid** ***(cholesterol or triglyceride)*** **levels that are not controlled with any treatments.**

☐ **I'M NOT SURE.**

11) GOUT OR HYPERURICEMIA: Have you ever had gout?

☐ **NO**

☐ **YES,** ***(Please check one of the following which best describes you)***

- ☐ **I have high uric acid levels but no symptoms.**
- ☐ **I have high uric acid levels and take medication for this.**
- ☐ **I have gout causing pain, redness, or swelling in my joints.**
- ☐ **I have gout that has damaged my joints.**
- ☐ **I have gout that left me disabled and/or unable to walk.**

☐ **I'M NOT SURE.**

12) OBSTRUCTIVE SLEEP APNEA: Do you have disruptions of your sleep, loud snoring, gasping for breath, choking, also known as sleep apnea?

☐ **NO**

☐ **YES,** ***(Please check one of the following which best describes you)***

- ☐ **I have symptoms of sleep apnea** ***(such as snoring, waking up unable to breathe, daytime sleepiness, etc.)*** **but did not have a sleep study or had a negative sleep study.**
- ☐ **I've been diagnosed with sleep apnea based on an overnight sleep study, but it is not being treated.**
- ☐ **I've been diagnosed with sleep apnea and currently use a CPAP or BiPAP machine to help me sleep.**
- ☐ **I've been diagnosed with sleep apnea resulting in low blood oxygenation, or requiring oxygen treatment.**
- ☐ **I've been diagnosed with severe sleep apnea that resulted in heart and other complications** ***(such as pulmonary hypertension, etc.).***

☐ **I'M NOT SURE.**

13) OBESITY HYPOVENTILATION SYNDROME: Do you have difficulty getting enough air and oxygen into your lungs?

☐ **NO**

☐ **YES,** ***(Please check one of the following which best describes you)***

- ☐ **I have mild levels of low blood oxygen and/or high blood carbon dioxide levels when breathing ordinary air.**
- ☐ **I have difficulty breathing causing such low oxygen levels that it requires treatment with oxygen or other assistance device.**
- ☐ **I have difficulty breathing which has resulted in a lung problem called pulmonary hypertension.**
- ☐ **I have breathing problems causing symptoms suggestive of right heart failure** ***(e.g., leg swelling, liver congestion, etc.).***
- ☐ **I've had breathing problems for a long time causing failure of the right side of my heart, and decreased pumping action of my heart muscle.**

☐ **I'M NOT SURE.**

CO-MORBIDITY QUESTIONNAIRE *(CONTINUED)*

14) PULMONARY HYPERTENSION: Have you been told that you have high blood pressure in the arteries of your lungs?

- ☐ **NO**
- ☐ **YES,** ***(Please check one of the following which best describes you)***
  - ☐ **I have symptoms associated with pulmonary hypertension** ***(such as fatigue, shortness of breath, dizziness, and fainting).***
  - ☐ **I've been tested and diagnosed with pulmonary hypertension** ***(i.e., based on echocardiogram, heart catheterization, etc.).***
  - ☐ **I've been diagnosed with pulmonary hypertension, which is treated with blood thinners and/or calcium channel blocker medication.**
  - ☐ **I've been diagnosed with pulmonary hypertension and need stronger medications and/or oxygen for treatment.**
  - ☐ **I've been diagnosed with pulmonary hypertension and have had or am waiting for a lung transplant.**
- ☐ **I'M NOT SURE.**

15) ASTHMA: Do you have asthma?

- ☐ **NO**
- ☐ **YES,** ***(Please check one of the following which best describes you)***
  - ☐ **I have asthma symptoms occasionally but do not need any medications for it.**
  - ☐ **I have asthma treated occasionally with an oral inhaler** ***(such as albuterol).***
  - ☐ **I have asthma treated with daily medication or inhaler.**
  - ☐ **I have asthma, which is hard to control even with medications such as prednisone or ipratropium.**
  - ☐ **I have asthma, which has resulted in a hospitalization in the past two years, or required a breathing tube into the trachea and ventilator in the past.**
- ☐ **I'M NOT SURE.**

16) GERD: Do you have gastroesophageal reflux, heartburn or acid reflux?

- ☐ **NO**
- ☐ **YES,** ***(Please check one of the following which best describes you)***
  - ☐ **I have heartburn and acid backwash symptoms at times, but it does not require medication.**
  - ☐ **I have GERD and take medication only when I have symptoms.**
  - ☐ **I have GERD, which is treated with daily acid reducer medications such as Pepcid, Zantac, or over the counter Prilosec.**
  - ☐ **I have GERD, which is being treated with higher doses of medications such as Protonix, Prilosec, or Nexium.**
  - ☐ **I've had surgery for my GERD or will require an operation in the future.**
- ☐ **I'M NOT SURE.**

17) CHOLELITHIASIS: Have you ever had gallstones?

- ☐ **NO**
- ☐ **YES,** ***(Please check one of the following which best describes you)***
  - ☐ **I've been told I have gallstones, but have never had any symptoms.**
  - ☐ **I have gallstones and have some mild symptoms from time to time.**
  - ☐ **I have gallstones, which cause severe symptoms and/or had surgery to remove my gallbladder.**
  - ☐ **I have gallstones requiring immediate surgery before gastric bypass.**
  - ☐ **I've had gallbladder surgery previously but my gallbladder-related symptoms still persist.**
- ☐ **I'M NOT SURE.**

PATIENT LABEL

Bariatric Surgery Center

Patient Questionnaire

Salem Health® Hospitals & Clinics

CO-MORBIDITY QUESTIONNAIRE *(CONTINUED)*

18) LIVER DISEASE: Have you ever had liver disease?

☐ **NO**

☐ **YES,** ***(Please check one of the following which best describes you)***

- ☐ **I've been told I have a slightly enlarged or "fatty" liver but normal liver blood tests.**
- ☐ **I 've been told I have an enlarged or "fatty" liver and have had abnormal liver function tests.**
- ☐ **I have abnormal liver function tests, an enlarged or "fatty" liver or changes in the appearance of my liver based on a liver biopsy, which are being followed by my physician.**
- ☐ **I have abnormal liver function tests; my liver does not function normally or has cirrhosis and is being treated by a physician.**
- ☐ **I've been told I need a liver transplant due to liver failure or have had a liver transplant in the past.**

☐ **I'M NOT SURE.**

19) BACK PAIN: Have you had back pain?

☐ **NO**

☐ **YES,** ***(Please check one of the following which best describes you)***

- ☐ **I have back pain from time to time, but no treatment is needed.**
- ☐ **I have back pain that gets better with over-the-counter medications, such as Tylenol, Aleve, or ibuprofen.**
- ☐ **I have back pain, or have structural changes of my spine on x-rays, and use prescription narcotic medications, such as Vicodin, Percocet, morphine, or methadone.**
- ☐ **I have back pain for which I've had back surgery, or the surgery is delayed pending my weight loss.**
- ☐ **I've had previous back surgery, but it failed, and my symptoms still persist**

☐ **I'M NOT SURE.**

20) MUSCULOSKELETAL DISEASE: Do you have muscle, bone or joint pain?

☐ **NO**

☐ **YES, What joints or where?** _____ ***(Please check one of the following which best describes you)***

- ☐ **I have pain when I walk around in my community.**
- ☐ **I have pain requiring pain medication such as Tylenol, Aleve, or ibuprofen, but not narcotics.**
- ☐ **I have pain walking around my house.**
- ☐ **I've had or will require surgery** ***(such as arthroscopy)*** **for my joint pain.**
- ☐ **I've had joint replacement surgery** ***(knee, hip, shoulder)*** **or will need joint replacement in the near future.**

☐ **I'M NOT SURE.**

21) FIBROMYALGIA: Do you have fibromyalgia?

☐ **NO**

☐ **YES,** ***(Please check one of the following which best describes you)***

- ☐ **I've been diagnosed with fibromyalgia, and have been placed on an exercise regimen.**
- ☐ **I take over-the-counter medication such as Tylenol, Aleve, or ibuprofen for my fibromyalgia.**
- ☐ **I've been prescribed narcotics** ***(such as Vicodin or Percocet)*** **for my fibromyalgia.**
- ☐ **I've been prescribed narcotics** ***(such as Vicodin or Percocet)*** **for my fibromyalgia, and have undergone** ***(or am scheduled to undergo)*** **surgical procedures to treat it.**
- ☐ **The symptoms from my fibromyalgia are disabling and previous treatments have not been effective.**

☐ **I'M NOT SURE.**

22) CONFIRMED MENTAL HEALTH DIAGNOSIS: Have you ever been treated for any psychiatric illnesses ***(other than depression)*****?**

☐ **NO**

☐ **YES,** ***(Please check one of the following which best describes you)***

- ☐ **Bipolar disorder** ***(manic-depressive disorder)*****.**
- ☐ **Anxiety or panic disorder.**
- ☐ **Personality disorder.**
- ☐ **Psychosis**

☐ **I'M NOT SURE.**

PATIENT LABEL

DSC 436904 (11/21)

CO-MORBIDITY QUESTIONNAIRE *(CONTINUED)*

23) DEPRESSION: Do you have or have you ever had depression?

☐ **NO**

☐ **YES,** ***(Please check one of the following which best describes you)***

- ☐ **I currently have or have had intermittent bouts of mild depression which have gone away on their own or required no medical treatment.**
- ☐ **I currently have or have had moderate depression symptoms affecting some life activities with or without treatment.**
- ☐ **I currently have or have had moderate depression symptoms affecting daily life requiring medical treatment such as antidepressants.**
- ☐ **I currently have or have had severe depression symptoms requiring ongoing and frequent medical treatment by a mental health professional.**
- ☐ **I've been hospitalized for severe depression in the past.**

☐ **I'M NOT SURE.**

24) Have you ever had any thoughts of attempting suicide?

☐ **NO**

☐ **YES,** ***(if yes, explain)*****:**

25) Have you ever been hospitalized or gone to the emergency room for attempting suicide?

☐ **NO**

☐ **YES,** ***(if yes, explain)*****:**

26) PSYCHOSOCIAL CONDITIONS: Have you ever been treated for a social disorder ***(e.g., panic disorder, phobias, autism, bi-polar disorder, ADHD, etc.)***

☐ **NO**

☐ **YES,** ***(Please check one of the following which best describes you)***

- ☐ **I have a mild condition but am able to perform all of my daily tasks in society.**
- ☐ **I have a moderate condition but am able to perform most of my daily tasks in society.**
- ☐ **I have a moderate condition and am unable to perform some of my daily tasks in society.**
- ☐ **I have a severe condition and am unable to perform most of my daily tasks in society.**
- ☐ **I have a severe condition and am unable to function.**

☐ **I'M NOT SURE.**

27) STRESS URINARY INCONTINENCE: Do you have involuntary loss of urine when you cough, sneeze, or exert yourself?

☐ **NO**

☐ **YES,** ***(Please check one of the following which best describes you)***

- ☐ **I have leakage of urine on occasion but less than once a week.**
- ☐ **I have leakage of urine more than once a week but not significant.**
- ☐ **I have leakage of urine daily requiring use of sanitary pad.**
- ☐ **I have severe leakage of urine that affects my life daily and causes disability.**
- ☐ **I've had bladder surgery for severe urinary leakage done in the past, but urine still leaks.**

☐ **I'M NOT SURE.**

28) PSEUDOTUMOR CEREBRI: Have you been diagnosed with pseudotumor cerebri?

☐ **NO**

☐ **YES,** ***(Please check one of the following which best describes you)***

- ☐ **I have headaches with dizziness, nausea, and/or pain behind the eyes, but no vision changes.**
- ☐ **My headaches cause vision changes, but symptoms are controlled with diuretics** ***(water pills)*****.**
- ☐ **I was diagnosed with pseudotumor cerebri and verified with an MRI, and am well controlled with diuretics** ***(water pills)*****.**
- ☐ **My pseudotumor cerebri is controlled with stronger medications.**
- ☐ **I require narcotic medication for pain, have undergone or may need surgery for my pseudotumor cerebri.**

☐ **I'M NOT SURE.**

PATIENT LABEL

Bariatric Surgery Center

Patient Questionnaire

Salem Health® Hospitals & Clinics

CO-MORBIDITY QUESTIONNAIRE *(CONTINUED)*

29) ABDOMINAL HERNIA: Have you ever been diagnosed with an abdominal bulging or hernia?

☐ **NO**

☐ **YES,** ***(Please check one of the following which best describes you)***

- ☐ **I've been diagnosed with a smaller hernia *(less than 6 inches)*, but I have no pain or symptoms and have not undergone surgery.**
- ☐ **I have pain and symptoms related to my hernia.**
- ☐ **I've had a successful surgical repair of my hernia.**
- ☐ **I have a hernia which came back after surgery or is a large hernia *(greater than 6 inches in size)*.**
- ☐ **I have a large hernia, which has been operated upon and failed several times.**

☐ **I'M NOT SURE.**

30) FUNCTIONAL STATUS: Do you have difficulty walking?

☐ **NO**

☐ **YES,** ***(Please check one of the following which best describes you)***

- ☐ **I have some trouble walking, but I can walk 200 ft. with a cane or some other assistance device.**
- ☐ **I cannot walk 200 ft. even using a cane, walker or assistance device.**
- ☐ **I use a wheelchair for mobility.**
- ☐ **I am bedridden.**

☐ **I'M NOT SURE.**

31) ABDOMINAL PANNUS: Have you had problems with a large hanging flap of skin on your stomach?

☐ **NO**

☐ **YES,** ***(Please check one of the following which best describes you)***

- ☐ **I've had skin irritation or rash under the fold of my abdomen.**
- ☐ **I have a large hanging flap of skin on my abdomen that interferes with walking.**
- ☐ **I have a large hanging flap of skin on my abdomen which has resulted in recurring skin infections or lingering sores.**
- ☐ **I've had surgery to remove the excels flap of skin on my abdomen because of infections.**

☐ **I'M NOT SURE.**

OTHER MEDICAL HISTORY	COMMENTS
Skin condition: ☐ **NO** ☐ **YES *(if yes, explain)*:**	
Bleeding or blood disorder: ☐ **NO** ☐ **YES *(if yes, explain)*:**	
Arthritis such as rheumatoid/osteoarthritis: ☐ **NO** ☐ **YES *(if yes, explain)*:**	
History of kidney disease: ☐ **NO** ☐ **YES *(if yes, explain)*:**	
Thyroid condition: ☐ **NO** ☐ **YES *(if yes, explain)*:**	
Epilepsy or seizure disorder: ☐ **NO** ☐ **YES *(if yes, explain)*:**	
Cancer: ☐ **NO** ☐ **YES *(if yes, explain)*:** **What type?** _____	
Any other medical conditions not listed:	

PATIENT LABEL

Bariatric Surgery Center

Patient Questionnaire

Salem Health® Hospitals & Clinics

REVIEW OF SYMPTOMS

Unless otherwise specified, answer the following referring to your current status:

Condition	No	Yes	Details or comments
AIDS/HIV	☐	☐	
Anemia	☐	☐	
Anxiety	☐	☐	
Asthma	☐	☐	
Birth control *(Please state method)*	☐	☐	
Bleeding tendency	☐	☐	
Breast lump, pain or discharge	☐	☐	
Chest pain with exercise or activity	☐	☐	
Chronic sinus congestion	☐	☐	
Chronic skin rash or hives	☐	☐	
Convulsions, seizures	☐	☐	
Coughing	☐	☐	
Deep vein thrombosis or blood clots in legs	☐	☐	
Dental problems	☐	☐	
Dentures	☐	☐	
Depression	☐	☐	
Diabetes	☐	☐	
Drug or alcohol abuse	☐	☐	
Ear pain	☐	☐	
Eyeglasses or contact lenses	☐	☐	
Fever, chills or night sweats	☐	☐	
Frequent bloody nose	☐	☐	
Frequent or severe headaches	☐	☐	
Frequent or severe weakness	☐	☐	
Frequent or severe fatigue	☐	☐	
Hay fever	☐	☐	
Hearing problems	☐	☐	
Heart murmur	☐	☐	
Hepatitis	☐	☐	
High blood pressure readings	☐	☐	
History of head injury with loss of consciousness	☐	☐	
Infertility or irregular menses	☐	☐	
Memory loss	☐	☐	
Mood swings	☐	☐	
Nasal congestion	☐	☐	
Numbness or Tingling	☐	☐	
Paralysis	☐	☐	
Sexually transmitted disease *(left untreated)*	☐	☐	
Sleeping problems	☐	☐	
Sleep apnea *(diagnosed)*	☐	☐	
Sores in mouth	☐	☐	
Thyroid problems	☐	☐	
Vision problems that aren't correctable	☐	☐	
Wheezing	☐	☐	

Patient signature

Today's date

PATIENT LABEL