Northwell Comprehensive 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:

□ Roux-en-Y Gastric Bypass
□ Sleeve Gastrectomy
□ Adjustable Gastric Banding
□ Gastric Balloon
□ Weight Management with Meds
□ Duodenal Switch / SADI
□ Surgical Revision
□ Other _____
□ Lifestyle Management
□ Undecided

Surgeon Requested (if known): _____

Hospital Requested (if known): _____

How did you hear about our program? ☐ My physician _____ ☐ A friend _____

☐ Facebook ☐ Internet ☐ Northwell's Website ☐ Brochure ☐ Newspaper ☐ Other _____

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.

GENERAL

___ Weight Gain
___ Weight Loss
___ Fever
___ Chills
___ Night Sweats
___ Fatigue

HEAD, EARS, EYES, NOSE, THROAT

_____ Eye Pain
_____ Red Eyes
_____ Dry Eyes
_____ Vision Problems
_____ Trouble Swallowing
_____ Pain with Swallowing
_____ Hearing Loss
_____ Nose Bleeds
_____ Dry Mouth
_____ Sore Throat
_____ Hoarseness
____ Swollen Nodes

CARDIO-VASCULAR

_____ Chest Pain
_____ Palpitations
_____ Light Headedness
_____ Leg pain with exercise
_____ Leg swelling

RESPIRATORY

_____ Shortness of Breath
____ Wheezing
____ Cough
____ Painful Breathing
____ Shortness of breath With activity
____ Sleep Apnea

GASTRO-INTESTINAL

____ Abdominal Pain
____ Heartburn/Reflux
____ Nausea/Vomiting
____ Hernia
____ Constipation
____ Diarrhea

RENAL/REPRODUCTIVE

____ Painful Urination
____ incontinence
____ Vaginal Discharge
____ Abnormal Vaginal Bleeding

MUSCULOSKELETAL

____ Joint Pain
____ Joint Stiffness
____ Back Pain
____ Muscle Pain
____ Muscle Weakness

SKIN

____ Rashes
____ Skin wound

NEUROLOGIC

____ Confusion
____ Dizziness
____ Fainting
____ Difficulty walking

PSYCH

____ Suicidal
____ Insomnia
____ Anxiety
____ Depression

ENDOCRINE

_____ Bulging eyes
____ Hot Flashes
____ Muscle Weakness
____ Voice Change

HEME

____ Easy Bleeding
____ Easy Bruising
____ Swollen Glands

Medical History: Please indicate if you have been diagnosed with any of the following illnesses:

_____ Heart Attack
_____ Cardiac Failure
_____ Coronary Disease
_____ High Blood Pressure
_____ High Cholesterol
_____ High triglycerides
_____ Obesity
_____ Constipation

_____ COPD (lung disease)
_____ Asthma
_____ Sleep Apnea
_____ Emphysema
_____ Reflux/GERD
_____ Stomach ulcers
_____ Hiatal Hernia
_____ Abdominal Hernia
_____ Swallowing trouble

_____ Achalasia
_____ Small Bowel Obstruction
_____ Hypothyroid
_____ Hyperthyroid
_____ Type 1 Diabetes
_____ Type 2 Diabetes
_____ Autoimmune Disease

_____ Epilepsy/Seizures
_____ Neurological Disease
_____ Depression
_____ Anxiety
_____ Arthritis
_____ Cancer Type:_____

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 *(cigarettes, pipes, cigars, chewing tobacco, e cigarettes, vapes, nicotine patches/gums/lozenges, Chantix)*	**YES** **NO**	**_____ packs per day for _____ years** **If you quit, when? _____**
Alcohol	**YES** **NO**	**Type: _____** **Frequency:_____**
Recreational Drugs **(*opioids, marijuana, cocaine, heroin, etc.)***	**YES** **NO**	**Type: _____** **Frequency:_____**

Medications and Supplements:

Medication/Supplement	Dosage & Frequency	Reason

Allergies

Medication/Food	Reaction
Other Allergies	**Reaction**

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

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)

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:

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

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

Part 1: PHQ-4

Over the last 2 weeks, 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 *(Please circle your answer)*	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? **If you checked "NO" to either #a or #b, go to question #8.**	0	1
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 often done any of the following in order to avoid gaining weight? *(Please circle your answer)*	No	Yes
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)? *If you checked "NO" go to question #10.*	No 0	Yes 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? *(Please circle your answer)*	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.

6/2021