Bariatric Questionnaires (1 & 2)

To have a complete understanding of your health while preparing you for weight loss surgery, we asked that you complete this questionnaire as soon as possible. This will allow our team to build a case showing your insurance that surgery is a medical necessity for you. There are no commitments!

To successfully submit this questionnaire, complete in the following order:

1) **Click the download arrow**  **on the top right of the screen to save in your files**
2) **Open questionnaire from your files and complete form**
3) **Submit this form one of the three ways:**
   - **E-mail: bariatrics@thedacare.org**
   - **Fax Number: 920.729.2321**
   - **Mailing Address:**
     Attn: ThedaCare Bariatrics
     200 Medical Plaza, Suite 420
     Neenah, WI 54956-5217

Contact us at 920.720.7211 with any questions filling out this form. We are happy to assist!

Check how and when you completed the Informational Session

☐ I attended a live webinar informational Session on ____/____/____ (date)

☐ I watched the recorded video Informational Session on ____/____/____ (date)

List any barriers to communication or special accommodations that you require:

Demographics

Name: _____ Date of Birth:_____/_____/_____ Age:_____

Gender: ◯Male ◯Female Occupation:_____

Address: _____

E-mail address: _____

Home Number: _____-_____-_____ Cell Number:_____-_____-_____ Work Number:_____-_____-_____

May we leave a message: Home Phone? ◯**Yes** ◯**No** Cell Phone? ◯**Yes** ◯**No** Work Phone? ◯**Yes** ◯**No**

Best way to reach you? _____ Time?_____

Preferred Procedure

Which surgery do you wish to have?

☐ Roux-en-Y Gastric Bypass
☐ Revision of Prior Bariatric Surgery
☐ Sleeve Gastrectomy
☐ Gastric Balloon Placement (ORBERA™, etc)

Why are you seeking weight loss surgery?

_____

If you use eating as an emotional outlet, what will you substitute when your eating is restricted?

_____

What is your greatest fear regarding surgery?

The below information is use to determine your insurance coverage and requirements for weight loss surgery. If at any time your insurances changes, notify us at 920.720.7211.

Primary Insurance

Insurance Plan Name: _____

Member ID Number: _____

Group Number: _____

Subscriber Name: _____

Relationship to Subscriber: _____

Customer Service Phone: _____

Insurance Address:

Secondary Insurance

Insurance Plan Name: _____

Member ID Number: _____

Group Number: _____

Subscriber Name: _____

Relationship to Subscriber: _____

Customer Service Phone: _____

Insurance Address:

Current Weight & Height

Weight: _____ pounds

Height: _____ Feet _____Inches

Medical Conditions: Check the box if you had or have any of the following conditions?

Heart Disease: ☐ **NONE**

☐ Angina Year diagnosed_____

☐ Heart Attack Year diagnosed_____

☐ High Blood Pressure Year diagnosed_____

☐ High Cholesterol Year diagnosed_____

☐ Atrial Fibrillation Year diagnosed_____

☐ Stress Test Year diagnosed_____

☐ Abnormal EKG Year diagnosed_____

☐ Other Heart Diagnosis _____

Circulation: ☐ **NONE**

☐ Edema (swelling) Location:_____

☐ Healed leg ulcers

☐ Unhealed leg ulcers Treatment_____

☐ Varicose vein

Blood clots: ☐ **NONE**

Where_____ **When**_____ **Treatment**_____

Did your clot move to your lung? (Pulmonary Emboli) ◯ **No** ◯ **Yes**

Respiratory: ☐ **NONE**

☐ Use of CPAP/BIPAP ☐ Use of Oxygen

☐ Asthma On prescribed steroids in the last 2 years due to asthma? ◯ **No** ◯ **Yes**

☐ Other breathing problems:_____

☐ Sleep apnea Year diagnosed_____ Last sleep study: ___/____(month/year) by Dr._____

Note: We will need a copy of your last sleep study if you wish to pursue surgery. If you are in the ThedaCare system, we can retrieve these documents.

Joint Pain: ☐ **NONE**

☐ Hips ☐ Feet/ankles

☐ Knees ☐ Back

List any weight related injuries or trauma: _____

Diabetes: ☐ **NONE**

☐ Type 1 Diabetes Year diagnosed _____ ☐ Type 2 Diabetes Year diagnosed _____

☐ Nephropathy (Kidney problems) as a result of your diabetes

Other Medical Conditions:

☐ Hepatitis ☐ Fibromyalgia

☐ AIDS/HIV ☐ Stroke or TIA

☐ Colitis ☐ Leakage of Urine

☐ Irritable Bowel ☐ Gallbladder disease

☐ *History* of c-diff ☐ Heartburn or reflux

☐ Thyroid disorder ☐ Bleeding disorder

☐ Kidney Disease ☐ Blood Clot

☐ Rheumatoid Arthritis ☐ *Family history* of bleeding disorders

☐ Multiple Sclerosis ☐ *Family history* of blood clots

☐ Sickle Cell Disease

List below all serious illnesses and hospitalization you have experienced as an *adult*:

Major illness	Date	Treatment

Physicians: List any physicians that you are currently seeing.

Specialty	Provider Name
Primary Care Physician	
Gastroenterologist	
Cardiologist	
Pulmonologist	
Psychologist/Psychiatrist/Therapist	
Orthopedic	
Other	

Surgical Procedures ☐ **NONE**

☐ Coronary artery bypass graft	Year _____	☐ Hiatal Hernia Repair	Year _____
☐ Gallbladder removed	Year _____	☐ Other Hernia Repairs	Year _____
☐ Appendix removed	Year _____	☐ Hysterectomy	Year _____
☐ Stomach surgery	Year _____	☐ Organ Transplant	Year _____
☐ Nissen fundoplication for reflux	Year _____	☐ Endoscopy	Year _____
☐ Colon Surgery	Year _____		

☐ Previous weight loss surgery Year _____ Type: _____ Surgeon:_____

Other Major Surgeries:

Social History

Do you use tobacco now? ◯ **No** ◯ **Yes** If Yes, how many packs per day? __

Are you willing to quit using tobacco? ◯ **No** ◯ **Yes**

Did you used to use tobacco?? ◯ **No** ◯ **Yes** If Yes, quit date: _____

Do you consume alcohol? ◯ **No** ◯ **Yes**

If Yes, how often? ____ times per ◯ week ◯ month ◯ year # of drinks each time___

Do you use street drugs now? ◯ **No** ◯ **Yes**

If Yes, type of drug used: _____ Frequency: _____

Allergies: List allergies to medications below.

Medication	Reaction

Check box if allergic to the following:

☐ Dairy Products ☐ Latex

☐ Surgical Tape ☐ Iodine

Medications: List *ALL* medications that you are currently taking including *vitamins, herbal supplements, and over the counter medications.*

Medication Name	Dosage	Frequency

*If more room is needed, please attach a separate sheet of paper with additional medications

Do you take…

…Medication for blood thinning (Coumadin/Warfarin/Plavix)? ◯ **No** ◯ **Yes**

…Medications with Aspirin in it? ◯ **No** ◯ **Yes**

…NSAIDS (Ibuprofen/Aleve/Advil/Celebrex/ Motrin/ Toradol)? ◯ **No** ◯ **Yes**

Please completely fill out the following questionnaire. This will determine whether or not you may need to be tested for sleep apnea prior to surgery.

Have you been diagnosed with Sleep Apnea by a physician? ◯ **Yes** ◯ **No**

If Yes, are you being treated for your sleep apnea with C-PAP/BiPAP? ◯ **Yes** ◯ **No**

If you have not been diagnosed with Sleep Apnea, please complete the following:

1. Do you snore?
   - ◯ Yes
   - ◯ No
   - ◯ Do not know

If you snore:

2. Is your snoring?
   - ◯ Sightly louder than breathing
   - ◯ As loud as talking
   - ◯ Louder than talking
   - ◯ Very loud. Can be heard in adjacent rooms

3. How often do you snore?
   - ◯ Nearly every day
   - ◯ 3-4 times a week
   - ◯ 1-2 times a week
   - ◯ 1-2 times a month
   - ◯ Never or nearly never

4. Has your snoring ever bothered other people?
   - ◯ Yes
   - ◯ No

5. Has anyone noticed that you quit breathing during your sleep?
   - ◯ Nearly every day
   - ◯ 3-4 times a week
   - ◯ 1-2 times a week
   - ◯ 1-2 times a month
   - ◯ Never or nearly never

6. How often do you feel tired or fatigued after your sleep?
   - ◯ Nearly every day
   - ◯ 3-4 times a week
   - ◯ 1-2 times a week
   - ◯ 1-2 times a month
   - ◯ Never or nearly never

7. During your wake time, do you feel tired, fatigued or not up to par?
   - ◯ Nearly every day
   - ◯ 3-4 times a week
   - ◯ 1-2 times a week
   - ◯ 1-2 times a month
   - ◯ Never or nearly never

8. Have you ever nodded off or fallen asleep while driving?
   - ◯ Yes
   - ◯ No

9. Do you have high blood pressure?
   - ◯ Yes
   - ◯ No
   - ◯ Do not know

If you watched our info session online, please complete the following questions:

1) **Obesity is a disease, which increases the risk of death.**
   A. ☐ True
   B. ☐ False

2) **What is considered a qualifying BMI (body mass index) for bariatric surgery?**
   A. ☐ BMI of 30 or above
   B. ☐ BMI of 35-39 with a medical condition related to obesity (hypertension, high cholesterol, diabetes)
   C. ☐ BMI of 40 or above
   D. ☐ B and C

3) **The following bariatric surgery procedures are performed at ThedaCare:**
   A. ☐ Roux-en-Y gastric bypass
   B. ☐ Sleeve gastrectomy
   C. ☐ Duodenal switch
   D. ☐ A and B

4) **Risks to bariatric surgery may include infection, pneumonia, blood clots in the legs or lungs, staple line leak, or hemorrhaging.**
   A. ☐ True
   B. ☐ False

5) **How long will it take to complete the action items on the pathway letter for insurance approval?**
   A. ☐ 2 months
   B. ☐ 3 months
   C. ☐ 6 months
   D. ☐ Any of the above, it will depend on how many dietary visits my insurance will require of me.

6) **Insurance companies recognize the following as a supervised weight loss attempt:**
   A. ☐ A physician monitoring your weight loss progress on a prescribed medication
   B. ☐ Monthly counseling with a dietitian
   C. ☐ Participating in Jenny Craig or Weight Watchers <u>without</u> monthly follow up by physician on weight loss progress
   D. ☐ A and B

7) **The purpose of the psychology evaluation is:**
   A. ☐ To ensure long-term success following surgery
   B. ☐ To stop all counseling
   C. ☐ To stop all anti-depressants
   D. ☐ All of the above

8) **Including physical activity in daily routine before surgery is associated with greater weight loss and fewer complications after surgery.**
   A. ☐ True
   B. ☐ False

9) **Once the surgery is performed, you do not have to do anything else. The weight loss will just happen, without regular medical care.**
   A. ☐ True
   B. ☐ False

By typing your name, you verify that all the information you have provided is accurate and to the best of your knowledge.

Name: _____Date___/___/___

Please read and sign the following authorization:
By typing my name, I am authorizing ThedaCare to request medical information from the physicians I listed as part of this health history questionnaire on page 4. The purpose for their request of this information is so that they may coordinate my care as I pursue and investigate bariatric surgery and/or care alternatives. The types of information that they may request includes, but is not limited to: history and physical exams, discharge summaries, consultation reports, laboratory and imaging studies, clinic visits, and nutrition records.

Name: _____Date___/___/___