# Whole Health Weight Loss Institute

Scott Perryman, MD, FACS, FASMBS

## New Patient Bariatric Questionnaire

Name: _____ Date: _____

1. How long have you considered bariatric surgery?

2. How did you first learn about bariatric surgery?

3. Do you know other patients who have had the surgery? ☐ Yes ☐ No Were they successful in losing weight? ☐ Yes ☐ No

4. Do your friends and family support your decision to have bariatric surgery? ☐ Yes ☐ No

5. Have you tried dieting in the past? ☐ Yes ☐ No a. How much weight have you lost while dieting? _____

6. How many diets have you tried in the past? ☐ 0 ☐ 1–3 ☐ 3–5 ☐ >5

7. Have you ever tried any of the following? (check all that apply)

☐ Binging and purging
☐ Binging followed by food restriction
☐ Use of laxatives
☐ Use of diuretics
☐ Use of diet pills

If diet pills: a. What type? _____ b. How much did you lose? _____ c. How long did you use them? _____

8. What is the highest weight you have ever reached? _____ lbs

9. What is the lowest weight you have reached in the last ten years? _____ lbs

10. What is the main reason you are overweight? (check one)

☐ I eat many high-calorie sweets
☐ I eat too much normal food
☐ I have an abnormal metabolism
☐ I have a disability that limits my movement

What is your personal goal weight with surgery? _____ lbs

What is your main reason for wanting to lose weight?

_____

_____

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## Medical History

### Do you have any of the following medical problems?

Diabetes ☐ Yes ☐ No

High blood pressure ☐ Yes ☐ No

High cholesterol ☐ Yes ☐ No

High triglycerides ☐ Yes ☐ No

Prediabetes ☐ Yes ☐ No

Arthritis ☐ Yes ☐ No

Obstructive sleep apnea ☐ Yes ☐ No

GERD / acid reflux / heartburn ☐ Yes ☐ No

Polycystic ovary syndrome (PCOS) ☐ Yes ☐ No

Pain? (Back, Feet, Ankle, Knee, Hip)

*(Please circle all that apply for pain.)*

Have you ever had surgery? ☐ Yes ☐ No — If yes, list the operations below:

_____

_____

Family history (medical conditions that run in your family):

_____

_____

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## Lifestyle, Medications & Allergies

Do you smoke? ☐ Yes ☐ No — If yes, how many packs per day? _____

How many alcoholic drinks do you have? ☐ 0 ☐ 1–3 ☐ 3–5 ☐ >5 per: ☐ day ☐ week ☐ month

### Medication list:

_____

_____

_____

_____

_____

_____

### Medication allergies:

_____

_____

_____


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