THE University of Vermont MEDICAL CENTER

University of Vermont Medical Center

BARIATRIC & GENERAL SURGERY

Williston - Blair Park
353 Blair Park Rd.
Williston, VT 05495

PHONE 802-847-3330
FAX 802-847-0733

Dr. Wasef Abujaish
Dr. Patrick Forgione
Bruce Chutter-Cressy PA

Hello,

As part of your appointment we have included a questionnaire to be filled out. These are your options for returning this document:

1. Print attachment and fill out form by hand. Mail to:

   Bariatric Surgery
   353 Blair Park Road
   Williston, VT 05495

2. Print attachment and fill out form by hand. Fax to: (802) 847-0733.

3. Print attachment and fill out form by hand. Drop off form at the front desk at the Bariatric & General Surgery Clinic at:

   Bariatric Surgery Program
   353 Blair Park Road
   Williston, VT 05495

4. If you have a computer, you can fill the form out on your screen using Adobe Reader. Save and print the file and return it by mail, fax, or by dropping it off at the clinic.

If you have any questions about this process, please call 802-847- 3330.

Thank you,
The Bariatric Surgery Team

Today's Date:

Health Questionnaire
Bariatric Surgery Program
University of Vermont Medical Center

Your responses to this questionnaire are strictly confidential and will become part of your medical record.

Personal Information

Name: _____
Date of Birth: _____
Sex at birth: ☐ Female ☐ Male
Gender Identity: ☐ Choose not to disclose ☐ Female ☐ Male ☐ Genderqueer/Neutral
☐ Transgender Female/Male to Female ☐ Transgender Male/Female to Male

Street Address: _____
City: _____ State: _____
Zip Code: _____

Email Address: _____
Home Phone: _____
Work Phone: _____
Mobile Phone: _____

Are you **currently** pregnant? ☐ No ☐ Yes
Are you **currently** breastfeeding? ☐ No ☐ Yes

Can you read? ☐ No ☐ Yes
Can you write? ☐ No ☐ Yes
Do you need an interpreter? ☐ No ☐ Yes Preferred Language: _____

Marital Status: _____
Work Status: ☐ unemployed ☐ full-time ☐ part-time ☐ retired
Occupation: _____
Receiving Social Security Disability Insurance: ☐ No ☐ Yes Start Date: _____
Primary Insurance: _____
Secondary Insurance: _____
Who lives with you? _____
Do you have children? ☐ No ☐ Yes Ages: _____

Are you **currently** being treated for cancer? ☐ No ☐ Yes Type: _____
Are you **currently** using an assistive device? ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other _____
Are you **currently** using:

Nicotine	☐ No	☐ Yes	Type _____	Amount _____
Alcohol	☐ No	☐ Yes	Type _____	Amount _____
Marijuana	☐ No	☐ Yes	Type _____	Amount _____
Other Recreational Drugs	☐ No	☐ Yes	Type _____	Amount _____

Weight History

Current Weight: _____ Current Height: _____
Highest Adult Weight:_____ Lowest Adult Weight:_____
How many years have you been overweight? _____
Greatest number of pounds you have lost in the past: _____
How much weight would you like to lose? _____

Prior Weight Loss Attempts (Please list at least 2 attempts for insurance purposes)

	Weight Loss Method	Dates	Amount Lost
1.			
2.			
3.			
4.			
5.			

Current Prescribed and Over-the-Counter Medications (Attach a separate list if needed):

	Name	Dosage	Frequency	Reason for Taking
1.				
2.				
3.				
4.				
5.				
6.				

Mental Health History

Have you ever been treated for depression? ☐ No ☐ Yes Year: _____ Type of treatment: _____
Have you ever been treated for anxiety? ☐ No ☐ Yes Year: _____ Type of Treatment: _____

Have you ever been treated for an eating disorder? ☐ No ☐ Yes Year _____
Type (e.g., bulimia, anorexia, binge eating disorder) _____
Have you ever attempted suicide? ☐ No ☐ Yes Year ____
Have you ever thought about hurting yourself? ☐ No ☐ Yes Year ____
Have you ever been hospitalized for a mental illness? ☐ No ☐ Yes Year ____
Are you currently in treatment for your mental health? ☐ No ☐ Yes

Provider Name:_____
Address:_____
Phone: _____

Health Habits

Exercise:	☐ Sedentary (No exercise) ☐ Mild Exercise (e.g.climb stairs, walk 3 blocks) ☐ Occasional Vigorous Exercise (e.g.work/recreation, less than 4x/week for 30 min) ☐ Regular Vigorous Exercise (e.g. work/recreation 4x/week for 30 minutes)
Functional Capacity: (check all appropriate boxes)	What can you do without assistance? Take care of yourself: ☐ preparing meal/eating ☐ bathing ☐ dressing ☐ toileting Walking: ☐ inside ☐ outside on flat surface ☐ up and down steps or hills Housework: ☐ light tasks (dishwashing, sweeping) ☐ heavy tasks (scrubbing floors) Recreational: ☐ light ☐ moderate ☐ strenuous
Alcohol:	Do you drink alcohol? ☐ No ☐ Yes Type_____ Drinks per week _____ Have you considered stopping? ☐ No ☐ Yes Do you have a history of problems with alcohol use? ☐ No ☐ Yes Have you ever received treatment for alcohol abuse? ☐ No ☐ Yes Do you "binge" drink? ☐ No ☐ Yes
Nicotine:	Do you use Nicotine? ☐ No ☐ Yes If yes, what form of nicotine do you use? ☐ Cigarettes - Pks/day_____ ☐ Chew - #/day _____ ☐ Vape ☐ Patches ☐ Pills/Lozenges ☐ Other nicotine replacement products How long have you been using nicotine? Number of Years: _____ Past Nicotine Use: ☐ No ☐ Yes Number of Years _____ Year Quit_____
Substance Use:	Medical marijuana: ☐ No ☐ Yes Type:_____ Amt:_____ Year:_____ Recreational marijuana ☐ No ☐ Yes Type:_____ Amt:_____ Year:_____ Other recreational drugs: ☐ No ☐ Yes Type:_____ Amt:_____ Year:_____ Intravenous Drugs: ☐ No ☐ Yes Type:_____ Amt:_____ Year:_____
	Are you sexually active? ☐ No ☐ Yes If yes, are you trying to become pregnant? ☐ No ☐ Yes

Medical History

Do you now have, or have you ever had, any of the following illnesses or symptoms?

Hypertension	☐ No	☐ Yes Year: ____	Arthritis/Rheumatoid Arthritis	☐ No	☐ Yes Year: ____
Stroke/Mini Stroke	☐ No	☐ Yes Year: ____		☐ No	☐ Yes Year: ____
Elevated cholesterol	☐ No	☐ Yes Year: ____		☐ No	☐ Yes Year: ____
Elevated triglycerides	☐ No	☐ Yes Year: ____		☐ No	☐ Yes Year: ____
Liver Disease	☐ No	☐ Yes Year: ____		☐ No	☐ Yes Year: ____
Cirrhosis	☐ No	☐ Yes Year: ____		☐ No	☐ Yes Year: ____
Hepatitis	☐ No	☐ Yes Year: ____		☐ No	☐ Yes Year: ____
Thyroid disease	☐ No	☐ Yes Year: ____		☐ No	☐ Yes Year: ____
Diabetes mellitus	☐ No	☐ Yes Year: ____		☐ No	☐ Yes Year: ____
Asthma	☐ No	☐ Yes Year: ____		☐ No	☐ Yes Year: ____
Shortness of breath.	☐ No	☐ Yes Year: ____		☐ No	☐ Yes Year: ____
COPD	☐ No	☐ Yes Year: ____		☐ No	☐ Yes Year: ____
Sleep apnea	☐ No	☐ Yes Year: ____		☐ No	☐ Yes Year: ____
CPAP/Bipap Machine	☐ No	☐ Yes Year: ____		☐ No	☐ Yes Year: ____
CPAP/BiPAP Settings:	_____				
Coronary artery disease	☐ No	☐ Yes Year: ____			
Congestive heart failure	☐ No	☐ Yes Year: ____			
Crohn's Disease	☐ No	☐ Yes Year: ____		☐ No	☐ Yes Year: ____
Kidney Stones	☐ No	☐ Yes Year: ____		☐ No	☐ Yes Year: ____
Ulcerative Colitis	☐ No	☐ Yes Year: ____		☐ No	☐ Yes Year: ____

Other Past Medical History

Please list any other current or past medical conditions for which you have seen a medical provider, taken medication, or been hospitalized:

_____

_____

_____

_____

_____

The Epworth Sleepiness Scale

Chance of Dozing Ratings: 0 = never, 1 = slight chance, 2 = moderate chance, 3 = high chance

Situation	Chance of Dozing Rating
• Sitting and reading	_____
• Watching Television	_____
• Sitting, inactive, in a public place (e.g. a movie theater or a meeting)	_____
• Passenger in a car for an hour without breaks	_____
• Lying down to rest in the afternoon when circumstances permit	_____
• Sitting and talking to someone	_____
• Sitting quietly after lunch without alcohol	_____
• In a car, while stopped for a few minutes in traffic	_____

Past Surgical History

Abdominal exploration	☐ No	☐ Yes Year ____	Ventral/incisional hernia repair	☐ No	☐ Yes Year ____
Appendectomy	☐ No	☐ Yes Year ____	Groin hernia repair	☐ No	☐ Yes Year ____
Bowel resection	☐ No	☐ Yes Year ____	Hiatal hernia repair	☐ No	☐ Yes Year ____
Hernia repair	☐ No	☐ Yes Year ____	Paraesophageal repair	☐ No	☐ Yes Year ____
Cholecystectomy Gallbladder removal	☐ No	☐ Yes Year ____	Mesh used?	☐ No	☐ Yes Year ____
Operation for reflux	☐ No	☐ Yes Year ____	Back surgery	☐ No	☐ Yes Year ____
Cesarean section	☐ No	☐ Yes Year ____	Heart angioplasty/stents	☐ No	☐ Yes Year ____
Tubal ligation	☐ No	☐ Yes Year ____	Heart catherterization	☐ No	☐ Yes Year ____
Hysterectomy	☐ No	☐ Yes Year ____	Other heart procedure Type:_____	☐ No	☐ Yes Year ____
Oophorectomy	☐ No	☐ Yes Year ____			
Umbilical hernia repair	☐ No	☐ Yes Year ____	Cancer surgery Type:_____	☐ No	☐ Yes Year ____

Other Past Surgical History

Other: _____ Yes Year _____

Other: _____ Yes Year _____

Three Day Food Diary

Instructions: For each time interval, please record everything you eat and/or drink. Include all condiments, sauces, gravies and/or spreads. Give details such as 2% milk, low-fat mayo, tuna in oil or water, cream in coffee.

Day One	Everything Entering Your Mouth Except Medication (Food, Drink, Snacks, Candy)	Amount (Number of Items and/or Volume)
6am-9am		
9am-12pm		
12pm-3pm		
3pm-6pm		
6pm-9pm		
9pm-12am		
12am-6am		

Day Two	Everything Entering Your Mouth Except Medication (Food, Drink, Snacks, Candy)	Amount (Number of Items and/or Volume)
6am-9am		
9am-12pm		
12pm-3pm		
3pm-6pm		
6pm-9pm		
9pm-12am		
12am-6am		

Day Three	Everything Entering Your Mouth Except Medication (Food, Drink, Snacks, Candy)	Amount (Number of Items and/or Volume)
6am-9am		
9am-12pm		
12pm-3pm		
3pm-6pm		
6pm-9pm		
9pm-12am		
12am-6am		

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Directions to Bariatric Surgery Clinic

Southbound on I-89 (From the North)

Take 89 South to Williston Exit 12

At exit ramp light, take a left onto Route 2A North.

Stay straight through 4 sets of lights.

At the 5th light, take a left onto Blair Park Road.

At the "T", take a right.

The University of Vermont Bariatric Surgery Clinic is the second driveway on the right.

Northbound on I-89 (From the South)

Take 89 North to Williston Exit 12

At exit ramp light, take a right onto Route 2A North.

Stay straight through 3 sets of lights.

At the 4th light, take a left onto Blair Park Road.

At the "T", take a right.

The University of Vermont Bariatric Surgery Clinic is the second driveway on the right.

From Route 7

Take I-189 to I-89 Southbound (towards Montpelier) and follow the directions above for I-89 Southbound.