Metabolic and Bariatric Surgery Questionnaire

- Success with previous weight loss attempts? (Exercise, diet, medications, etc.)
- How much?
- Highest weight?
- At what age?
- Primary motivation for bariatric surgery?
- Who is on your support team after surgery? (spouse, children, friends, parents, etc.)
- What is your goal weight?
- How long have you considered bariatric surgery?
- History of difficulty swallowing?
- History of abdominal pain?

Past Medical History

- Gastroesophageal reflux disease (GERD)?
- Deep venous thrombosis/pulmonary embolism?
- Heart disease?
- Congestive heart failure?

Past Medical History, cont.

- Pulmonary disease?
- Kidney disease?
- Gastrointestinal disease?
- Inflammatory Bowel disease?
- Rheumatic disease?
- Diabetes: Type 1 or 2?
- Psychiatric disease?
- List all other past medical history

Past Surgical History

- Previous metabolic and bariatric surgery?
- Gallbladder removal?
- Hiatal hernia repair?
- Abdominal wall hernia repair?
- Other previous surgeries?

Allergies

List all known allergies:

Social History

- Smoking history? (How many packs per day, how many years?)
- E-cigarette use?
- Alcohol use history? Select which best describes you:
  - Don't drink
  - Drink once a month
  - Drink once a week
  - Drink one drink per day
  - Drink more than two drinks per day
  - Drink only socially, usually about one drink.
- Recreational drug use: If yes, which drug(s) and how often?
- Marital Status (circle one): Single | Married | Divorced | Separated | Widowed

Medications

Name	Dosage	Frequency

- GLP-1 Agonist use?
- Anti-coagulation use?
- Insulin use?
- NSAID use?
- Aspirin use?

Screening Questionnaires

STOP/BANG

Do you snore loudly (louder than talking or loud enough to be heard through closed doors?)	Yes	No
Do you often feel tired, fatigued, or sleepy during the daytime?	Yes	No
Has anyone observed you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood pressure?	Yes	No

BMI more than 35kg/m2?	Yes	No
Age over 50 years old?	Yes	No
Neck circumference > 16 inches (40 cm)?	Yes	No
Gender: Male?	Yes	No

TOTAL SCORE		

Screening Questionnaires

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently, try to determine how they would have affected you. For each situation, decide whether or not you would have:

No chance of dozing = 0
Slight chance of dozing = 1
Moderate chance of dozing = 2
High chance of dozing = 3

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation	**Chance of Dozing (From 0-3)**
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g., a theater or a 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	
TOTAL SCORE	

Screening Questionnaires

GERD Health-related Quality of Life (GERD-HRQL)

Are you currently taking any medications for GERD symptoms? YES | NO

Please circle the number that best reflects your symptoms using the scoring scale provided below:

Scoring Scale
0 = No symptoms
1 = Symptoms noticeable but not bothersome
2 = Symptoms noticeable and bothersome but not every day
3 = Symptoms bothersome every day
4 = Symptoms affect daily activities
5 = Symptoms are incapacitating - unable to do daily activities

1. How bad is the heartburn?	0	1	2	3	4	5
2. Heartburn when lying down?	0	1	2	3	4	5
3. Heartburn when standing up?	0	1	2	3	4	5
4. Heartburn after meals?	0	1	2	3	4	5
5. Does heartburn change your diet?	0	1	2	3	4	5
6. Does heartburn wake you from sleep?	0	1	2	3	4	5
7. Do you have difficulty swallowing?	0	1	2	3	4	5
8. Do you have pain with swallowing?	0	1	2	3	4	5
9. If you take medication, does this affect your daily life?	0	1	2	3	4	5
10. How bad is the regurgitation?	0	1	2	3	4	5
11. Regurgitation when lying down?	0	1	2	3	4	5
12. Regurgitation when standing up?	0	1	2	3	4	5
13. Regurgitation after meals?	0	1	2	3	4	5
14. Does regurgitation change your diet?	0	1	2	3	4	5
15. Does regurgitation wake you from sleep?	0	1	2	3	4	5

16. How satisfied are you with your present condition?

☐ Satisfied ☐ Neutral ☐ Dissatisfied

Screening Questionnaires

SAMANTA

For Female Patients Only

Do you experience menstrual bleeding during more than 7 days per month?	Yes	No
Do you experience 3 or more days of heavier menstrual bleeding during your menstrual period?	Yes	No
In general, does menstruation bother you due to its abundance?	Yes	No
During any of these heavier menstrual bleeding days do you spot your clothes at night, or would you spot them if you did not use double protection/did not change your clothes during the night?	Yes	No
During these heavier menstrual bleeding days, are you worried about staining the chair, sofa, etc.?	Yes	No
In general, during these heavier menstrual bleeding days, do you avoid, as far as possible, some activities, trips, or leisure-time plans because you frequently need to change your tampon or sanitary pad?	Yes	No

Scores to be Completed by Office Staff

GERD Questionnaire Score:

STOP-BANG Score:

Epworth Sleepiness Score:

SAMANTA Questionnaire Score (for female patients only):