UCSF Medical Center
Surgery Faculty Practice
400 Parnassus Avenue, 2nd Floor
San Francisco, CA 94143-0338
(415) 353-2161

Please print your full name and date of birth

Duke Activity Survey Index

For each question, circle Yes or No		
Can you take care of yourself (eating dressing bathing or using the toilet)?	Yes ☐ 2.75	No ☐
Can you walk indoors such as around your house?	Yes ☐ 1.75	No ☐
Can you walk a block or two on level ground?	Yes ☐ 2.75	No ☐
Can you climb a flight of stairs or walk up a hill?	Yes ☐ 5.50	No ☐
Can you run a short distance?	Yes ☐ 8.00	No ☐
Can you do light work around the house like dusting or washing dishes?	Yes ☐ 2.70	No ☐
Can you do moderate work around the house like vacuuming, sweeping floors, or carrying in groceries?	Yes ☐ 3.50	No ☐
Can you do heavy work around the house like scrubbing floors or lifting and moving heavy furniture?	Yes ☐ 8.00	No ☐
Can you do yard work like raking leaves, weeding, or pushing a power mower?	Yes ☐ 4.50	No ☐
Can you have sexual relations?	Yes ☐ 5.25	No ☐
Can you participate in moderate recreational activities like golf, bowling, dancing, doubles tennis, or throwing a baseball or football?	Yes ☐ 6.00	No ☐
Can you participate in strenuous sports like swimming, singles tennis, football, basketball, or skiing?	Yes ☐ 7.50	No ☐
Total Score (DASI) =		
Estimate peak 02 =[0 .43 * (DASI)] + 9.6 =		
METS = (peak O2 / 3.5) =		

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Dear Patient,

Welcome to the UCSF Bariatric Surgery Program! During your visit, we will review your medical history. Our health care team consists of medical students, nurse practitioners, physician's assistants, and surgical residents under the supervision of your surgeon. Depending on the complexity of your problem, anticipate your visit may last several hours.

We strive to be detail-oriented and thorough. Your answers here will become part of the UCSF medical record and will be confidential.

Sometimes we will need to reach out to your primary care doctor and/or specialist for information. Providing this information to us will allow us to reach out to your physician as needed, and eliminate the need for you seeking doctor's notes or lab tests and/or the delay in your pre-surgical evaluation.

Can you tell us the names of the doctor who referred you here, your primary care doctor, and any specialist from whom you are receiving care?

Doctor who sent you to see us: _____ City: _____

Primary Care Doctor: _____ City: _____

Cardiologist: _____ City: _____

Renal Specialist: _____ City: _____

Pulmonologist: _____ City: _____

Neurologist: _____ City: _____

Endocrinologist: _____ City: _____

Other: _____ City: _____

At times, your pre-surgical interview can be done by a phone call which would be done about 2 weeks prior to your scheduled surgery date. To help us provide excellent customer service, and align with your needs as much as possible, can you please tell us the day of week and time of day that would be best to reach you, and the best contact number.

Contact number:_____

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Day of Week	Time of Day		Contact Number (if different than above)
Monday	AM	PM	
Tuesday	AM	PM	
Wednesday	AM	PM	
Thursday	AM	PM	
Friday	AM	PM	

What language are you most comfortable speaking? ____________________

Do you also speak English? ____________________

ALLERGIC REACTIONS TO MEDICATIONS

Have you ever had a reaction to any of the following:

YES ☐ NO ☐ Latex

YES ☐ NO ☐ Iodine

YES ☐ NO ☐ Intravenous contrast agent (used in CT scans)

Are you allergic to any medications? If so, list the medication and the reaction that you had:

MEDICATION	REACTION (circle all that apply)
Example: Aspirin	anaphylaxis/shock ☐ rash ☐ (circled) itching ☐ nausea/vomiting ☐ short-of-breath ☐ other: ☐
	anaphylaxis/shock ☐ rash ☐ itching ☐ nausea/vomiting ☐ short-of-breath ☐ other: ☐
	anaphylaxis/shock ☐ rash ☐ itching ☐ nausea/vomiting ☐ short-of-breath ☐ other: ☐
	anaphylaxis/shock ☐ rash ☐ itching ☐ nausea/vomiting ☐ short-of-breath ☐ other: ☐
	anaphylaxis/shock ☐ rash ☐ itching ☐ nausea/vomiting ☐ short-of-breath ☐ other: ☐
	anaphylaxis/shock ☐ rash ☐ itching ☐ nausea/vomiting ☐ short-of-breath ☐ other: ☐
	anaphylaxis/shock ☐ rash ☐ itching ☐ nausea/vomiting ☐ short-of-breath ☐ other: ☐
	anaphylaxis/shock ☐ rash ☐ itching ☐ nausea/vomiting ☐ short-of-breath ☐ other: ☐

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PAST MEDICAL HISTORY

Please check if you have had any of these conditions now or in the past.

Type of Condition	Yes	No	If yes, please describe (where, when and who treated you)	For UCSF Staff Only	
				Documentation	Date Requested
Cardiac					
Hypertension	☐	☐			
Hyperlipidemia	☐	☐			
Arrhythmia (Irregular Heart Beat)	☐	☐			
❖ ***Atrial Fibrillation***	☐	☐		• EKG: past 2 years • Progress notes from cardiologist: past 5 years • Echocardiogram: past 5 years • Stress test: any • Catheterization reports: any • Hospitalization discharge summaries	
❖ ***Chest Pain (Angina)***	☐	☐			
❖ ***If yes, symptoms within past 1 year***	☐	☐			
❖ ***Coronary stents***	☐	☐			
❖ ***Myocardial Infarction (Heart Attack)***	☐	☐			
❖ ***Heart Valve Disease***	☐	☐			
❖ ***Congestive Heart Failure***	☐	☐			
Murmur	☐	☐			
Have you ever had a Stress Test, Echocardiogram or Cardiac Catheter?	☐	☐			
❖ **Pacemaker or Defibrillator (ICD)**	☐	☐		• Interrogation reports: past 1 year • Implantation reports: if available	
Exercise					
❖ **Breathlessness with exercise**	☐	☐			
❖ **Fatigue or difficulty walking 1-2 blocks**	☐	☐			
❖ **Fatigue or difficulty climbing 1 flight of stairs**	☐	☐			
Respiratory					
Sleep apnea	☐	☐			
Do you use CPAP/Bipap?	☐	☐			
Asthma, COPD or Chronic Bronchitis	☐	☐			
❖ **If yes, symptoms within 6 months**	☐	☐			

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Type of Condition	Yes	No	If yes, please describe (where, when and who treated you)	For UCSF Staff Only	
				Documentation	Date Requested
❖ **Other lung disease diagnosed or treated by a lung specialist**	☐	☐			
❖ **Previous hospitalization for lung condition**	☐	☐			
❖ **Do you use oxygen at home?**	☐	☐			
❖ **Have you used steroids in prior 6 months for lung disease?**	☐	☐			
Hematologic					
Do you take aspirin daily?	☐	☐			
❖ **Do you take any other medications to thin the blood (examples- Plavix, Brilinta, Coumadin, Pradaxa, Eliquis, Xarelto)?**	☐	☐			
❖ **Clotting or Bleeding Disorder**	☐	☐			
❖ **DVT (Deep Vein Thrombosis)**	☐	☐			
❖ **Onset within past 6 months**	☐	☐			
❖ **Pulmonary Embolism (Blood Clot in Lungs)**	☐	☐			
❖ **Sickle Cell Anemia**	☐	☐			
❖ **If yes, hospitalization within past 1 year**	☐	☐			
❖ **Blood transfusion within the past 90 days**	☐	☐			
Renal					
Renal insufficiency	☐	☐			
❖ **Kidney failure requiring dialysis**	☐	☐	Dialysis Schedule:	• Note from PMD or nephrologist: past 3 months if available • Any labs: past 3 months, if available	
Neurological					
Brain Tumor	☐	☐			
Seizures	☐	☐			
Other Neurological Disorders	☐	☐			

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Type of Condition	Yes	No	If yes, please describe (where, when and who treated you)	For UCSF Staff Only	
				Documentation	Date Requested
Stroke or TIA (transient ischemic attack)	☐	☐		• H&P or progress note from: 1) Cardiologist 2) PCP • Echocardiogram: if available • Carotid ultrasound: if available • Holter/event monitor: if available	
Seizures within past 6 months	☐	☐		• H&P or progress note from: 1) Neurologist 2) PCP • Hospital discharge summary: if available	
Any of the following: • Myasthenia Gravis • Muscular dystrophy • Polio Myelitis • Multiple sclerosis • Spinal cord injury with weakness	☐	☐			
Other					
Any of these autoimmune diseases: • Lupus • Rheumatoid arthritis • Scleroderma	☐	☐			
Cancer (other than skin cancer)	☐	☐			
❖ **Cirrhosis or chronic hepatitis**	☐	☐		• Any labs: past 1 year, if available • H&P or progress note: past 1 year 1) Liver specialist, if available 2) PCP	
Diabetes	☐	☐			
❖ **If yes, insulin dependent**	☐	☐			
In yes, non-insulin dependent	☐	☐			
Chemotherapy for cancer	☐	☐			
❖ **If yes, within past 6 months?**	☐	☐			
Radiation Therapy	☐	☐			
❖ **If yes, within past 6 months?**	☐	☐			

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Type of Condition	Yes	No	If yes, please describe (where, when and who treated you)	For UCSF Staff Only	
				Documentation	Date Requested
Symptoms of overactive or underactive thyroid function in past 6 months	☐	☐		• H&P or progress note: past 6 months 1) Endocrinologist 2) PCP	
Have you seen a pain management specialist within the past 1 year?	☐	☐			
❖ **Do you take any of the following:** ❖ **Suboxone** ❖ **Subutex** ❖ **Butrans patch**	☐	☐			
❖ **Prior complications after surgery:** ❖ **Unexpected hospitalization** ❖ **Unexpected ICU admission**	☐	☐			
❖ **Hospitalization in prior 6 months**	☐	☐			
❖ **Do you live > 2 hours away from SF, and return to SF for more care a hardship?**	☐	☐			
❖ **Difficulty accessing medical care in your local area**	☐	☐			
Do you have any of the following: ❖ **Current respiratory infection** ❖ **Recent onset shortness of breath** ❖ **Recent onset chest pain or pressure** ❖ **New or worsening swelling in your leg/s**	☐	☐			

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PAST SURGICAL HISTORY

Please check any operations you have had:

Type of Surgery	Yes	No	If yes, please describe (where, when and who treated you)	For UCSF Staff Only	
				Documentation	Date Requested
Appendectomy	☐	☐			
Brain surgery	☐	☐			
Breast surgery	☐	☐			
❖ **Coronary artery bypass surgery**	☐	☐			
Cholecystectomy (gallbladder removal)	☐	☐			
Colon surgery	☐	☐			
Cosmetic surgery	☐	☐			
Cesarian section	☐	☐			
Eye surgery	☐	☐			
Fracture surgery	☐	☐			
Hernia repair	☐	☐			
Hysterectomy (uterus removal)	☐	☐			
Joint replacement	☐	☐			
Prostate surgery	☐	☐			
Small intestine surgery	☐	☐			
Spine surgery	☐	☐			
Tubal ligation	☐	☐			
❖ **Valve replacement**	☐	☐			
Vasectomy	☐	☐			
OTHER	☐	☐			

Information below to be completed by UCSF staff only

Parameter	Yes	No
❖ **Systolic BP < 85**	☐	☐
❖ **Systolic BP > 180 mm Hg**	☐	☐
❖ **Diastolic BP > 100 mm Hg**	☐	☐
❖ **Heart rate < 50 bpm**	☐	☐
❖ **Heart rate > 100 bpm**	☐	☐
❖ **SpO2 < 95% in room air**	☐	☐
❖ **Difficulty ambulating in clinic**	☐	☐

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UCSF BARIATRIC SURGERY CENTER
NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

Please be sure to bring a copy of this completed questionnaire with you on the day of your appointment.

What is your current height?_____

What is your goal weight? _____

How did you find UCSF Bariatric Surgery?

[ ] referred by a friend / relative
[ ] referred by a physician or other provider
[ ] referred by my insurance
[ ] referred by a UCSF bariatric patient
[ ] website: _____
[ ] found you on TV, radio, or magazine

When did your obesity begin? (circle one): childhood adolescence early adulthood adulthood

What diet / weight loss programs have you tried in the past? (circle all that apply)

- Weight Watchers
- Jenny Craig
- Curves
- South Beach Diet
- The Zone
- Rosemary Conley
- Other:
- Slim-Fast
- Nutrisystem
- Glycemic Impact Diet
- Denise Austin Diet
- diettogo
- Life Diet

What was the most weight you ever lost on a diet? _____

Have you ever used diet pills? If so, which ones? _____

Circle YES or NO for each question

YES NO Do you live alone?
YES NO Do you have difficulty shopping or carrying home a 10 pound bag?
YES NO Do you have difficulty dressing yourself?
YES NO Are you receiving any special help at home?
YES NO Have you had 3 or more falls in the past year?

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PAST MEDICAL HISTORY

Please circle any illnesses you have now or in the past.

GENERAL MEDICAL PROBLEMS	OBESITY-RELATED PROBLEMS
Seasonal allergies (hay fever)	Hypertension (high blood pressure)
Anemia	Congestive heart failure
Anxiety	Coronary artery disease (heart attacks)
Arthritis	Varicose veins / venous stasis disease
Bleeding disorders	Diabetes (high blood sugar)
Blood disorder	Dyslipidemia (high cholesterol)
Blood transfusion in the past	Polycystic Ovarian Syndrome
Cancer (list types)	Gout
Clotting disorder	Osteoarthritis (painful joints)
Chronic bronchitis or emphysema	Intertrigo (yeast infections in skin folds)
Glaucoma	Obstructive Sleep Apnea (stop breathing at night)
Heart disease	Pickwickian Syndrome (low blood oxygen)
HIV/AIDS	Asthma
Intestinal disease	Gastroesophageal reflux (Heartburn)
Kidney disease	Fatty liver disease
Liver disease	Urinary Stress Incontinence (leak urine with cough)
Myocardial infarction	Intracranial hypertension
Nerve / muscle disease	Migraines
Osteoporosis	Depression
Seizures	Blood clots in legs or lungs
Sinus disorder	Gallstones or gallbladder disease
Skin disease	
Stroke	
Substance abuse	
Thyroid disease	
Ulcers	

OTHER:

Have you ever been hospitalized? If yes, list the date(s) and reasons.

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FAMILY HISTORY

Mark an "X" in the box if any of relative of yours had one of these diseases:

	Alcoholism	Alzeihmeris	Arthiritis	Asthma	Bleeding disorder	Breast cancer	Cancer	Colon Cancer	Depression	Diabetes	Drug abuse	Early death	Heart disease	Hyperlipidemia	Hypertension	Kidney disease	Liver disease	Mental illness	Osteoporosis	Stroke	Thyroid disease	Tuberculosis	Vision loss
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Daughter	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Son	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mat Aunt	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mat Uncle	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pat Aunt	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pat Uncle	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mat GM	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mat GF	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pat GM	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pat GF	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY

Do you drink alcohol? YES ☐ NOT CURRENTLY ☐ NEVER ☐
If yes, what is your average number of:

	glasses of wine per week
	cans of beer per week
	shots of liquor per week

Do you use drugs recreationally now? YES ☐ NOT CURRENTLY ☐ NEVER ☐
If yes, circle the drugs you use:

amphetamines ☐	amyl nitrate ☐	anabolic steroid ☐	barbituates ☐	benzodiazepines ☐
"crack" cocaine ☐	cocaine ☐	codeine ☐	fentanyl ☐	GHB ☐
heroin ☐	hydrocodone ☐	hydromorphone ☐	ketamine ☐	LSD ☐
marijuana ☐	MDMA ☐	methamphetamine ☐	methaqualone ☐	methylphenidate ☐
morphine ☐	nitrous oxide ☐	opium ☐	oxycontin ☐	PCP ☐
psilocybin ☐	solvent inhalants ☐	IV drugs ☐	other: ☐	other: ☐

Are you a (circle one): current smoker ☐ former smoker ☐ never smoker ☐ passive smoker ☐
How many packs of day do you smoke, on average? _____
How many years have you smoked? _____

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REVIEW OF SYSTEMS

Have you experienced any of the following symptoms in the past 3 months?

			Symptom	Comments
GENERAL	YES	NO	fevers	
	YES	NO	chills	
	YES	NO	weight loss	
	YES	NO	malaise or fatigue	
	YES	NO	sweating	
	YES	NO	weakness	
SKIN	YES	NO	rash	
	YES	NO	itching	
HEAD	YES	NO	headaches	
	YES	NO	hearing loss	
	YES	NO	tinnitus	
	YES	NO	ear pain	
	YES	NO	ear discharge	
	YES	NO	nosebleeds	
	YES	NO	congestion	
	YES	NO	stridor (groan when you breathe)	
	YES	NO	sore throat	
EYES	YES	NO	blurred vision	
	YES	NO	double vision	
	YES	NO	irritation with lights (photophobia)	
	YES	NO	eye pain	
	YES	NO	eye discharge	
	YES	NO	eye redness	
CARDIOVASC	YES	NO	chest pain	
	YES	NO	palpitations (fluttering in the chest)	
	YES	NO	orthopnea (difficulty breathing while flat in bed)	
	YES	NO	claudication (pain in legs with exercise)	
	YES	NO	leg / ankle swelling	
	YES	NO	difficulty breathing during sleep	
LUNGS	YES	NO	cough	
	YES	NO	hemoptysis (coughing up blood)	
	YES	NO	sputum production (coughing up phlegm)	
	YES	NO	shortness of breath	
	YES	NO	wheezing	
ABDOMEN	YES	NO	heartburn	
	YES	NO	nausea	
	YES	NO	vomiting	
	YES	NO	abdominal pain	
	YES	NO	diarrhea	
	YES	NO	constipation	
	YES	NO	bright red blood in stool	
	YES	NO	melena (dark, tar like stools from old blood)	
URINARY	YES	NO	dysuria (burning when you pee)	
	YES	NO	urgency (need to pee quickly, can't barely hold it)	
	YES	NO	frequency (need to pee often)	
	YES	NO	hematuria (blood in the urine)	
	YES	NO	flank pain	

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MUSCLES	YES	NO	myalgias (crampy muscle pain)
	YES	NO	neck pain
	YES	NO	back pain
	YES	NO	joint pain
	YES	NO	falls
BLOOD	YES	NO	easy bruising or easy bleeding
	YES	NO	seasonal allergies
	YES	NO	polydipsia (always thirsty)
NEURO	YES	NO	dizziness
	YES	NO	tingling
	YES	NO	tremor
	YES	NO	sensory change
	YES	NO	speech change
	YES	NO	focal weakness
	YES	NO	seizures
	YES	NO	loss of consciousness
PSYCHIATRIC	YES	NO	depression
	YES	NO	suicidal ideas
	YES	NO	substance abuse
	YES	NO	hallucinations
	YES	NO	nervous / anxious
	YES	NO	insomnia
	YES	NO	memory loss