|  |  |  |
| --- | --- | --- |
| **The Questionnaire on the Surgical Treatment of Obesity** | | |
| 1. First name, last name: |  | |
| 1. Age: |  | |
| 1. Your weight now: |  | |
| 1. BMI: |  | |
| 1. Your weight a year ago: |  | |
| 1. Height: |  | |
| 1. Waist circumference: |  | |
| 1. Hips circumference: |  | |
| 1. Since when are you obese? |  | |
| 1. Does the obesity problem affect other members of your family? |  | |
| 1. Do you like sweets? |  | |
| 1. Have you ever followed a specialist-supervised diet to lose weight? |  | |
| 1. Physical activity at present |  | |
| 1. Have you participated in support group meetings for weight loss? |  | |
| 1. Have you ever had psychotherapy for obesity? |  | |
| 1. Have you used medications to help you lose weight? |  | |
| 1. Do you suffer from depression? |  | |
| 1. Does obesity interfere with your daily activities? |  | |
| 1. Do you have diabetes? (Diabetes medications, if any) |  | |
| 1. Do you suffer from sleep apnea? |  | |
| 1. Do you suffer from thyroid disease? (Describe them and their treatment) |  | |
| 1. Do you suffer from blood pressure? |  | |
| 1. Do you suffer from heart disease? (List these diseases) |  | |
| 1. Do you have elevated cholesterol and triglycerides? |  | |
| 1. Do you suffer from: |  | |
| - cancer |  | |
| - gallstones |  | |
| - osteoarthritis of the spine and joints |  | |
| - peptic ulcer disease |  | |
| - reflux |  | |
| - hiatal hernia |  | |
| - diarrhea |  | |
| - constipation |  | |
| - nausea |  | |
| - stomach ache |  | |
| - urinary incontinence |  | |
| 1. Do you suffer from gynecological diseases? |  | |
| 1. Do you suffer from kidney and bladder diseases? |  | |
| 1. Have you ever had surgery? (If so, what were the operations and when) |  | |
| 1. Present the exact list of medications you are taking and give their doses | |  |
| 1. Are you allergic to any medications? (Specify) | |  |
| 1. Are you allergic to other allergens? (Specify) | |  |
| 1. Do you consume alcoholic beverages? (How much?) | |  |
| 1. Do you smoke? (How much?) | |  |
| 1. Are you ready for a lasting change in your current lifestyle? | |  |
| 1. Are you ready to undergo postoperative Follow up for the next years? | |  |

………………………………………………………………………

Date Signature