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