Weight Loss Surgery Patient Referral Questionnaire

Patient Details

Name:
Address:

Telephone:
Email:

Date of birth:
Marital Status:
Occupation:

Hospital Number:

Referring GP

Name:
Practice Name:
Address:

Telephone:
Fax:

Current Statistics

Height in cm	
Weight in kg	
BMI	
Blood Pressure	
Lipid screen (HDL, LDL)	
Diabetes screen	
Endocrine screen (TFTs, cortisol)	

Medical History

Does the patient suffer from any of the following? If so, please give details of investigation results and current treatments.

Angina	
Asthma	
Arthritis	
Diabetes	
Epilepsy/seizures	
Gallbladder disease	
Gynaecological disease or menstrual irregularities	
Heartburn/reflux	
Heart disease	
Hiatus hernia	
High cholesterol	
Hypertension	
Joint pains	
Psychiatric illness	
Renal disease	
Serious injury	
Sleep apnoea/snoring	
Stroke	
Thyroid disorders	
Other	

Current Medications

Name of medication	Dosage

Previous Surgery

Date	Surgery

Previous Major Illnesses not requiring surgery

Date	Illness

Smoking and alcohol intake

☐ Non smoker ☐ Ex- smoker. Stopped ____ yrs/mths ago

☐ Smoker. ____ per day

☐ Alcohol units per week

Eating Patterns

Please describe any abnormal eating patterns including binging, bulimia, compulsive overeating, excessive sweet tooth etc.

Weight Loss History

Duration of weight loss activity	Method (e.g. diet followed, medication, exercise plan)	Results

	Date (yr)	**Weight**
Highest adult weight		
Lowest adult weight		

Family History

Are other family members obese or suffering from eating disorders? Do immediate family members suffer from obesity co-morbidities such as diabetes, heart disease, hypertension?

Motivation

What is the patient's motivation for this surgery?

Does the patient understand need for long-term follow up? Are they willing to adhere to the recommended diet and other commitments required following surgery (re alcohol and tobacco intake, exercise, keeping scheduled appointments etc)?

Additional information may be provided here or in a supporting letter.