Fairfield County Bariatrics & Surgical Specialists, P.C.
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Reflux Surgery Program Questionnaire

Name: _____ Date of Birth:_____ Race:_____

Address: _____

Phone Number: (Home)_____(Cell/Work)_____

Please provide your Primary Care Physician's information:

Physician's Name: _____

Physician's Address: _____

Phone Number: _____

Please provide your Gastroenterologist's information:

Physician's Name: _____

Physician's Address: _____

Phone Number: _____

Please circle the following if you are currently or have experienced any of these symptoms:

Please Rate Severity 1-3

1= monthly or less	**2= weekly**	**3= everyday**
Heartburn ___	Dysphagia ___	Reflux ___
Regurgitation ___	Odontophagia ___	Nausea ___
Vomiting ___	Abdominal Pain ___	Bloating ___
Belching ___	Bile in Mouth ___	Diarrhea ___
Loss of Appetite ___	Gas/Flatulence ___	Afraid to Eat ___
Get Full Quick ___	Difficulty Sleeping ___	

How long have you suffered from reflux? _____

What was your first symptom(s)? _____

What was your worst symptom(s)? _____

Do these symptoms occur while on medication? Yes No

What medications have you taken in the past? Have they controlled your symptoms?

_____

_____

Are you currently or have you been under the care of another physician for this? Yes No
If yes, please provide that information:

_____

Have you had any diagnostic testing done for these conditions? **Yes** **No**

Please indicate below if you had the testing and if so where it was done:

Upper Endoscopy _____

Manometry _____

Motility _____

24 Hour pH test _____

Gastric Emptying Study _____

Other than the symptoms described in the previous page, have you experienced any of these secondary symptoms? Please indicate below

Please Rate Severity 1-3

1= monthly or less	**2= weekly**	**3= everyday**
Chest Pain/Angina ___	Sore Throat ___	Choking ___
Asthma ___	Difficulty Breathing ___	Wheezing ___
Wheezing ___	Coughing ___	Forced Vomiting ___
Hoarseness ___	Dental Erosion ___	

Do these problems effect your sleep? If yes, how so?

_____

Are these symptoms associated with eating? Do specific foods trigger reflux?

_____

_____

How long after a meal do you experience these symptoms?

_____

What do you take to make it feel better?

Have you tried prescription or over the counter medication? If so, please indicate which medication and what dosage.

<u>Medical History</u>

Do you have or have you had any of the following in the past:

Heart Disease: Yes No

- Chest Pain/Angina
- Heart Attack, how many events _____
- Coronary Artery Disease
- Coronary Heart Failure
- Arrhythmia
- Atrial Fibrillation
- Pacemaker
- Pulmonary Embolism (blood clot in lung)
- High Blood Pressure
- CVA (stroke)

Venous Insufficiency (varicose veins): Yes No

Thrombophlebitis: Yes No

Breathing Problems: Yes No

- Asthma
- Shortness of Breath
- COPD
- Emphysema
- Other: _____

Sleep Problems: Yes No

- Sleep Apnea
- Snoring
- Other: _____

Diabetes: Yes No If yes, how long: _____

- Diet Controlled
- Medication Controlled
- Insulin Dependent
- Gestational Diabetes (pregnancy related)

Thyroid Issues: Yes No
If yes, please specify:

Arthritis: Yes No

- **Osteoarthritis**
- **Rheumatoid Arthritis**

Gastrointestinal Issues: Yes No

- **Hiatal Hernia**
- **Ulcers**
- **Gallstones**
- **Pancreatitis**
- **Infected Gallbladder**
- **Fatty Liver**
- **Hepatitis**

Cancer: Yes No
If yes, please specify:

Are you currently receiving treatment or in remission?

Current Medications (Please indicate dose and frequency of each medication):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies and Intolerances (Please indicate allergen and reaction):

_____ _____

_____ _____

Surgical History

Please check all that apply:

- **C-Section ____**
- **Tonsillectomy ____**
- **Appendectomy ____**
- **Gallbladder Surgery ____**
- **Ventral Hernia Repair ____**
- **Umbilical Hernia Repair ____**
- **Carpal Tunnel Repair ____**
- **Orthopedic Surgery Repair ____**
- **Cosmetic Surgery ____**
- **Other: _____ ____**
- **Other: _____ ____**
- **Other: _____ ____**

Social History

Marital Status: Single Married Divorced Widowed

Do you drink alcohol? Yes No
If yes, how many drinks per day/week? _____

Do you smoke cigarettes? Yes No
If yes, how many packs per day? _____ How many years have you smoked? _____
If you have quit, how long ago did you stop? _____
If you have quit, how many years did you smoke? _____

This Section to be Completed by Physician:

Review of Systems:

Head:
Neck:
Heart:
Lungs:
GU:
GI:
Ortho:
Skin:

Diagnostic Testing:

EGD
UGI
Manometry/Motility
24 pH
Gastric Emptying Study

Treatment Plan/Next Steps: