

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.

Medical History

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: