

Metabolic & Bariatric Program

INITIAL EVALUATION FORM

The following information is very important to your health. It will help us to give you the best possible medical/surgical care. Please take the time to complete this questionnaire.

PLEASE PRINT AND USE BLACK INK.

Date: _____ Phone Number: _____

Name: (First) _____ (Middle) _____ (Last) _____

Age: _____ Date of Birth: _____ / _____ / _____ Occupation: _____

Primary Care Physician: _____ Phone: (_____) _____ Fax (_____) _____

Other Physician(s): _____ Phone: (_____) _____ Fax (_____) _____

Other Physician(s): _____ Phone: (_____) _____ Fax (_____) _____

Have you been referred to us? No Yes If yes, by whom? _____

How did you hear about us?

Primary Care Physician Friends/Family Internet: Specify Website: _____

Other: _____

Are you seeking evaluation for weight loss surgery? No Yes

At what age did you develop a significant weight problem? Child Teen Adult

Your highest weight? _____ At age _____

Are you on a restricted or special diet for any medical reasons? No Yes

If Yes, Explain: _____

In your opinion, what contributes to your excess weight?

Large portions

Three meals a day

Frequent snacking

Skipping meals

Daily sweets

High-calorie drinks

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WEIGHT LOSS METHODS YOU HAVE TRIED

DIET	LENGTH OF TIME	YEAR	WEIGHT LOSS
<input type="checkbox"/> 20/20			
<input type="checkbox"/> 30/10			
<input type="checkbox"/> Appetite Suppressant Gum			
<input type="checkbox"/> Atkins Diet			
<input type="checkbox"/> Beverly Hills Diet			
<input type="checkbox"/> BioSlim			
<input type="checkbox"/> Dexatrim			
<input type="checkbox"/> Diabetic Diet			
<input type="checkbox"/> Diuretics			
<input type="checkbox"/> Gluten-Free Diet			
<input type="checkbox"/> Herbal Remedies			
<input type="checkbox"/> Jenny Craig			
<input type="checkbox"/> Keto Diet			
<input type="checkbox"/> Laxatives			
<input type="checkbox"/> Low Carbohydrate Diet			
<input type="checkbox"/> Low Fat Diet			
<input type="checkbox"/> Medifast			
<input type="checkbox"/> Meridia			
<input type="checkbox"/> MetaboLife			
<input type="checkbox"/> Metabolite			
<input type="checkbox"/> NutriSystem			
<input type="checkbox"/> Optifast			
<input type="checkbox"/> Overeaters Anonymous			
<input type="checkbox"/> Paleo Diet			
<input type="checkbox"/> Phen-Fen			
<input type="checkbox"/> Phentermine			
<input type="checkbox"/> Physician Supervised Diet			
<input type="checkbox"/> Redux			
<input type="checkbox"/> Richard Simmons Deal-A-Meal			
<input type="checkbox"/> Slim-Fast			
<input type="checkbox"/> South Beach Diet			
<input type="checkbox"/> Starvation Diet			
<input type="checkbox"/> The Grapefruit Diet			
<input type="checkbox"/> The Zone			
<input type="checkbox"/> TOPS			
<input type="checkbox"/> TrimSpa			
<input type="checkbox"/> Vegan Diet			
<input type="checkbox"/> Weight Watchers			
<input type="checkbox"/> Weight Loss Camp			
<input type="checkbox"/> Xenical			
<input type="checkbox"/> Other _____			
<input type="checkbox"/> Other _____			

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Have you or any of your family members ever had bariatric surgery? Yes No

If yes, Self Mother Father Spouse Brother Sister

If yes, what type of surgery was performed?

Gastric Banding Gastric Bypass Sleeve Gastrectomy Don't know

Other: _____ Name of surgeon? _____

Do you exercise regularly? No Yes

If so, what type of exercise do you perform? _____

How many times per week? _____

How long do you exercise each time? _____

Do you have or have you ever been treated for an eating disorder? No Yes

MEDICAL HEALTH HISTORY INFORMATION

Please indicate if you have ever suffered from any of the following conditions.
Please include the name of the physician who is currently managing the condition.

MEDICAL HISTORY	YEAR	PHYSICIAN
HEART		
<input type="checkbox"/> Coronary Artery Disease		
<input type="checkbox"/> MI (Heart Attack)		
<input type="checkbox"/> Elevated Cholesterol/Triglycerides		
<input type="checkbox"/> Chest Pain		
<input type="checkbox"/> Congestive Heart Failure		
<input type="checkbox"/> Valvular Disease		
<input type="checkbox"/> Rheumatic Fever		
<input type="checkbox"/> Heart Murmur		
<input type="checkbox"/> Heart Arrhythmia (Irregular Heart Beat)		
<input type="checkbox"/> High Blood Pressure		
LUNGS		
<input type="checkbox"/> Asthma		
<input type="checkbox"/> Pneumonia		
<input type="checkbox"/> Bronchitis		
<input type="checkbox"/> COPD (Emphysema)		
<input type="checkbox"/> Tuberculosis		
<input type="checkbox"/> Obesity Hypoventilation Syndrome		
<input type="checkbox"/> Pulmonary Hypertension		
<input type="checkbox"/> Sleep Apnea		
<input type="checkbox"/> Using CPAP/BiPAP Machine		

MEDICAL HISTORY	YEAR	PHYSICIAN
ENDOCRINE		
<input type="checkbox"/> Diabetes		
<input type="checkbox"/> Hyperthyroid		
<input type="checkbox"/> Hypothyroid		
<input type="checkbox"/> Adrenal (Cushing's)		
GASTROINTESTINAL		
<input type="checkbox"/> Reflux Disease (Heartburn)		
<input type="checkbox"/> Peptic Ulcer Disease		
<input type="checkbox"/> Gallbladder Disease		
<input type="checkbox"/> Liver Disease		
<input type="checkbox"/> Inflammatory Bowel Disease		
<input type="checkbox"/> Hiatal Hernia		
<input type="checkbox"/> Abdominal Hernia		
KIDNEY		
<input type="checkbox"/> Kidney Disease		
<input type="checkbox"/> Urinary Stress Incontinence		
<input type="checkbox"/> Kidney Stones		
VASCULAR DISEASE		
<input type="checkbox"/> Arterial Vascular Disease		
<input type="checkbox"/> Pulmonary Embolism		
<input type="checkbox"/> DVT (Phlebitis)		
<input type="checkbox"/> Superficial Phlebitis		
<input type="checkbox"/> Leg Ulcers		
<input type="checkbox"/> Varicose Veins		
CENTRAL NERVOUS SYSTEM		
<input type="checkbox"/> Stroke		
<input type="checkbox"/> Seizure		
<input type="checkbox"/> Cerebral Aneurysm		
<input type="checkbox"/> Arteriovenous Malformation		
<input type="checkbox"/> Pseudotumor Cerebri		
<input type="checkbox"/> Arterial Vascular Disease		
MUSCULOSKELETAL		
<input type="checkbox"/> Low back pain		
<input type="checkbox"/> Diagnosed Osteoarthritis/ DJD		
<input type="checkbox"/> Joint Pain		
<input type="checkbox"/> Autoimmune Disease		
<input type="checkbox"/> Gout		
<input type="checkbox"/> Fibromyalgia		
<input type="checkbox"/> Abdominal Skin/Pannus		

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MEDICAL HISTORY	YEAR	PHYSICIAN
BLOOD DISORDERS		
<input type="checkbox"/> Anemia		
<input type="checkbox"/> Abnormalities with bleeding or clotting		
PSYCHIATRIC DISORDERS		
<input type="checkbox"/> Depression		
<input type="checkbox"/> Bipolar Depression		
<input type="checkbox"/> Anxiety		
<input type="checkbox"/> Schizophrenia		
<input type="checkbox"/> Anorexia		
<input type="checkbox"/> Bulimia		
CANCER		
Type: _____ Treatment: _____		
Type: _____ Treatment: _____		
IMPLANTS/FOREIGN SURGICAL DEVICES		
<input type="checkbox"/> Pacemaker		
<input type="checkbox"/> Shunt		
<input type="checkbox"/> Artificial Joint		
<input type="checkbox"/> Pump/Stimulator		
<input type="checkbox"/> Other _____		

OBSTETRICAL/GYNECOLOGICAL HISTORY

- Have you ever had a hysterectomy? No Yes
- Have you ever had a C-Section? No Yes
- Have you ever had a Tubal Ligation?
- Are you using birth control? No Yes Postmenopausal

If yes, type of birth control: _____

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SURGICAL HISTORY

Please list all surgical procedures and year performed.

If relevant specify if the surgery was done laparoscopic or open.

SURGERY	YEAR
GALL BLADDER SURGERY	
<input type="checkbox"/> Laparoscopic	
<input type="checkbox"/> Open	
ABDOMINAL HERNIA	
<input type="checkbox"/> Laparoscopic	
<input type="checkbox"/> Open	
<input type="checkbox"/> Mesh	
NISSEN REFLUX SURGERY	
COLON REMOVAL	
<input type="checkbox"/> Laparoscopic	
<input type="checkbox"/> Open	
HYSTERECTOMY	
HEART SURGERY	
OTHER ABDOMINAL SURGERY:	
OTHER SURGERIES:	

ALLERGY INFORMATION

Please list any known allergies and reactions.

ALLERGY	REACTION

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SMOKING/DRUG/ALCOHOL HISTORY

Do you smoke cigarettes? No Yes, packs per day _____ How many years? _____

If you have smoked in the past, quit date: _____ / _____ / _____

Do you vape? No Yes

Do you chew tobacco? No Yes

Do you use nicotine gum or patch? No Yes

Do you drink alcohol? No Yes, drinks per week _____

If yes, what type of alcohol? Wine Beer Liquor Mixed Drinks

Have you ever had a problem with alcohol in the past? No Yes, when and for how long? _____

Have you ever used any illicit drugs? No Yes, indicate drug used and how long ago? _____

FAMILY HISTORY	ALIVE	DECEASED	MAJOR MEDICAL CONDITIONS
MOTHER			
FATHER			
SIBLINGS			
CHILDREN			
<input type="checkbox"/> ADOPTED, NO HISTORY OF BIOLOGICAL PARENTS			

Please list any specific questions or concerns that you may have so that your provider can address them at the time of your consultation:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____

