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INITIAL EVALUATION FORM FOR WEIGHT LOSS SURGERY

DATE: _____

Name _____ Date of Birth _____ Age _____
Insurance Co. _____ Race _____
Home Phone _____ Work Phone _____
Cell Phone _____ Employed: F/T - P/T – Self – Retired - Not Employed
Social Security No. _____ Height _____ Present Wt. _____
Address _____
E-Mail Address _____ Marital Status: S M D W
Race _____
Have you been referred to us? YES NO
If yes, by whom? _____

PATIENT'S PHYSICIAN INFORMATION

Name of Primary Care Physician _____
Address _____
Phone (_____) _____ Fax (_____) _____

Please list any other physicians/ Specialists you see:

Name of Physician _____ Specialty _____
Address _____
Phone (_____) _____ Fax (_____) _____
Name of Physician _____ Specialty _____
Address _____
Phone (_____) _____ Fax (_____) _____

Medical History (check all that apply)

- High Blood Pressure Diabetes High Cholesterol Arthritis Heart Disease Snoring
- Acid Reflux/ Stomach Disorders (GERD) Thyroid Problem Ankle/leg Swelling Depression Urinary Incontinence High Triglycerides Asthma Shortness of Breath Hiatal Hernia Other _____

Record below major diets that resulted in a weight loss of 10 pounds or more. (use additional pages as needed)

Year	Length of Diet	Starting Wt.	# of lbs lost	Length of time weight stayed off	Type of diet program

At what age did you develop a significant weight problem? _____

Patient's Name _____

Are there events that are related to your weight gain? If so, what are they? _____

Are you receiving any medical or psychological services at this time? Yes No
(i.e. repeated doctor visits for the same problems)

Are you currently being treated or have you ever been treated for depression? Yes No

Do you have or have you been treated for an eating disorder? Yes No
(anorexia, bulimia, binge-eating disorder, compulsive overeating)

Counseling services (type of program) _____

Name of Psychiatrist or mental health provider _____

Do you snore? Yes No

Do you ever wake at night gasping for breath? Yes No

Has anyone ever told you that you stop breathing while asleep? Yes No

Do you exercise regularly? Yes No

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

How many times a week do you exercise? _____

How long do you exercise each time? _____

In your opinion, what contributes to your excess weight?

- Portion sizes
- Eating too much fat/sugar
- Nervous eating
- Lack of exercise
- Emotional eating
- Compulsive eating
- Stress
- Lack of knowledge about healthful eating and exercise

Have you or one of your relatives/spouse ever had bariatric surgery? Yes No
(weight reduction surgery)

1. a. If yes, what relationship are they to you?

- Self
- Mother
- Father
- Spouse
- Brother
- Sister
- Other _____

b. If yes, what type of procedure was performed?

- Gastric Banding
- Roux-en-Y Gastric Bypass
- Distal Bypass
- Don't know
- Other _____

Allergy Information (please add additional allergies on reverse)

Do you have any allergies to medication? Yes No

If so please list below

1. _____ What allergic reaction did you have? _____

2. _____ What allergic reaction did you have? _____

3. _____ What allergic reaction did you have? _____

Patient's Name _____

Medical Information

Please list all prescribed and over-the-counter medications that you are currently using:

	Medication	Dose	Times per day	Year started	Purpose
1					
2					
3					
4					
5					
6					
7					

(please add additional medications on reverse)

Pharmacy Information

Name of Pharmacy _____
 Address _____
 Phone Number _____

Surgical Information

Part I. Please list any surgical procedure, reason and year. If relevant, please specify if the surgery was performed laparoscopic or open (i.e. hysterectomy, tubal ligation, hernia repair, gallbladder or appendix removal)

Type of Surgery _____ Reason _____ Year _____
 Type of Surgery _____ Reason _____ Year _____
 Type of Surgery _____ Reason _____ Year _____
 Type of Surgery _____ Reason _____ Year _____
 Type of Surgery _____ Reason _____ Year _____
 Type of Surgery _____ Reason _____ Year _____
 Type of Surgery _____ Reason _____ Year _____
 Type of Surgery _____ Reason _____ Year _____
 Type of Surgery _____ Reason _____ Year _____

Have you or a family member ever have any trouble with anesthesia? Yes No

If yes, please explain what occurred _____

Patient's Name _____

Medical Health Information

Please indicate if any of the following conditions have ever been significant problems for you. Please specify the year diagnosed and the physician who currently manages the problem.

CARDIAC:

Coronary Artery Disease Yes No Year diagnosed _____ Physician _____

MI (heart attack) Yes No Year diagnosed _____ Physician _____

If yes, treatment _____

High Cholesterol/Triglyceride Yes No Year diagnosed _____ Physician _____

Chest Pain Yes No Year diagnosed _____ Physician _____

Congestive Heart Failure Yes No Year diagnosed _____ Physician _____

Valvular Heart Disease (mitral valve prolapse, mitral valve regurgitation, etc) Yes No

Year diagnosed _____ Physician _____

Rheumatic Fever Yes No Year diagnosed _____ Physician _____

Heart Murmur Yes No Year diagnosed _____ Physician _____

Irregular heart beat) Yes No Year diagnosed _____ Physician _____

High blood Pressure Yes No Year diagnosed _____ Physician _____

PULMONARY:

Asthma Yes No Year diagnosed _____ Physician _____

Pneumonia Yes No Year diagnosed _____ Physician _____

Bronchitis Yes No Year diagnosed _____ Physician _____

COPD (Emphysema) Yes No Year diagnosed _____ Physician _____

Tuberculosis Yes No Year diagnosed _____ Physician _____

Diagnosed Sleep Apnea Yes No Year diagnosed _____ Physician _____

If yes, treatment _____

Stop breathing while sleeping Yes No

Loud Snoring Yes No Gasping for Breath at Night Yes No

Family History of Sleep Apnea Yes No Family Member _____

ENDOCRINE:

Diabetes Mellitus Yes No Year diagnosed _____ Physician _____

Are you currently on Insulin Yes No

Hyperthyroid Yes No Year diagnosed _____ Physician _____

Hypothyroid Yes No Year diagnosed _____ Physician _____

Adrenal (Cushings) Yes No Year diagnosed _____ Physician _____

Other _____ Yes No Year diagnosed _____ Physician _____

GASTROINTESTINAL:

Reflux Disease (Heartburn) Yes No Year diagnosed _____ Physician _____

Peptic Ulcer disease Yes No Year diagnosed _____ Physician _____

Gallbladder disease Yes No Year diagnosed _____ Physician _____

Liver Disease Yes No Year diagnosed _____ Physician _____

If yes, describe condition _____

Inflammatory Bowel Disease Yes No Year diagnosed _____ Physician _____

(ex. Crohn's, ulcer colitis, etc.)

Hiatal Hernia Yes No Year diagnosed _____ Physician _____

If yes, describe condition _____

Other _____ Yes No Year diagnosed _____ Physician _____

Patient's Name _____

CANCER:

Type/Organ(s) Effected: _____ Treatment _____

Do you have a history of breast cancer? Yes No Year diagnosed _____**PERIPHERAL VASCULAR DISEASE**Arterial Vascular Disease Yes No Year diagnosed _____ Physician _____Pulmonary Embolism Yes No Year diagnosed _____ Physician _____DVT (Phlebitis) Yes No Year diagnosed _____ Physician _____Superficial Phlebitis Yes No Year diagnosed _____ Physician _____Swelling legs, ankles Yes No Year diagnosed _____ Physician _____Leg Ulcers Yes No Year diagnosed _____ Physician _____Do you have ulcers currently Yes NoVaricose Veins Yes No Year diagnosed _____ Physician _____**RENAL:**Kidney Disease Yes No Year diagnosed _____ Physician _____Urinary Stress Incontinence Yes No Year diagnosed _____ Physician _____Kidney Stones Yes No Year diagnosed _____ Physician _____**OBESTETRICAL/GYNECOLOGICAL:**1. Have you ever been pregnant? Yes No

a. Please indicate the number of pregnancies to term _____

b. Please indicate the number of deliveries _____

c. Please indicate whether you are Pre Menopausal Post Menopausal2. Menstrual Cycles None Irregular3. Polycystic Ovarian Syndrome or History Yes No**MUSCULOSKELETAL:**Lower back pain Yes No Year diagnosed _____ Physician _____Osteoarthritis/DJD Yes No Year diagnosed _____ Physician _____If yes, joints involved: Neck Shoulders Back Hips Hands/Wrist Knees Ankles Feet HeelsPainful Joints(without osteoarthritis/DJD) Neck Shoulders Back Hips Hands/Wrist Knees Ankles Feet Heels**CENTRAL NERVOUS SYSTEM** Seizures Migraines Frequent Headaches Visual disturbances Hearing Impairments Numbness of extremitiesAutoimmune disease Yes No Year diagnosed _____ Physician _____

(ex. Lupus, Rheumatoid Arthritis, Connective Tissue, etc)

Gout Yes No Year diagnosed _____ Physician _____

If yes, list joints involved _____

Have you ever had any broken bones of the face? _____

Have you ever had broken bones of the back/neck? _____

BLOOD DISORDERSAnemia Yes No Year diagnosed _____ Physician _____

If yes, type if known _____

Do you have or have you had any abnormalities with bleeding or clotting? Yes No

If yes, explain _____

Patient's Name _____

PSYCHIATRIC DISORDERS

Depression Yes No Bipolar Disorder Yes No Anxiety Yes No

Schizophrenia Yes No Eating Disorder Yes No Other _____

If yes, to any of the above, please explain _____

Are you currently receiving therapy or medications? Yes No

Have you ever been hospitalized for the above conditions? Yes No

OTHER MEDICAL DISORDERS:

Patient's Name _____

SOCIAL HISTORY:

Occupation _____ Full-Time Part Time Temporary Retired

Disability – indicate cause _____

Marital status Married Single Separated Divorced Widowed

Ethnic origin

Black/ African American White/Caucasian Asian/Pacific Islander Hispanic Other

Highest grade or level of education

9 to 11 years High School Graduate Vocational/Technical Training Attending College

College Graduate Graduate Degree

Religious affiliation (OPITIONAL)

Atheist Catholic Jehovah Witness Jewish Methodist Presbyterian Other

Do you have any children? Yes No If yes, how many? _____ What are their age's _____

SMOKING/DRUG/ALCOHOL HISTORY:

Do you currently use tobacco? Yes No Have you ever used tobacco? Yes No

If you answered yes to the above questions.....

a. What type of tobacco did you use? Cigarettes Cigars Pipe Chew/Snuff

b. What age did you start tobacco use? _____

c. How many years have you used tobacco? _____

d. How much do/did you usually smoke per day ½ pack or less between 1 to 1 ½ packs between 1 1/2 to 2 packs 2 ½ packs or more

e. If applicable, what age did you quite smoking? _____

Do you currently drink alcohol? Yes No

If you answered yes to the above question.....

a. What type(s) of alcohol are you drinking Wine Beer Mixed Drinks Other

b. Please indicate how many drinks you currently drink. 1-2 a month
3-4 a month 5-6 a month 7-9 a month 10 a month Other _____

Have been treated for alcohol problem? Yes No

Have you ever used any illicit drugs? (ex. Marijuana, cocaine, heroin, amphetamine, etc) Yes No

a. If yes, please indicate _____

How long ago? 6 months or less 6 mo-1 yr more than 1 yr

FAMILY HISTORY

In this section, please complete this chart to the best of your knowledge. If adopted and have no history of your biological family please place an X in the box Adopted

FAMILY HISTORY	
Check (✓) if any blood relatives have had:	Medical information about your biological family (i.e., ages, medical conditions, types of cancer, etc.):
<input type="checkbox"/> Colon cancer/polyps	Father:
<input type="checkbox"/> Crohns disease, ulcerative colitis	Mother:
<input type="checkbox"/> Liver disease or hepatitis	Siblings:
<input type="checkbox"/> Pancreatic cancer	
<input type="checkbox"/> Gall bladder disease	Children:
<input type="checkbox"/> Stomach or esophagus cancer	Paternal grandparents:
<input type="checkbox"/> Diabetes	Maternal grandparents:
<input type="checkbox"/> Coronary artery disease	

Patient's Name _____

PREVIOUS DIAGNOSTIC PROCEDURES:

Please list any laboratory diagnostic procedures within the last year. Please indicate what month they were performed.

- EKG _____
- Heart Catheterization _____
- Upper Endoscopy _____
- Sleep Study _____
- CT Scan (body area) _____
- Echocardiogram _____
- Upper GI _____
- Abdominal Sonogram _____
- Pulmonary Function test _____
- Stress Test _____
- Lower GI _____
- Colonoscopy _____
- Chest X-ray _____
- Other _____

It is important for us to know how you heard about us. Please tell us how you heard about us in as much detail as possible:

- Seminar (which location/Date) _____
- Website/internet (which site) _____
- Radio (which station) _____
- Word of mouth Referral (name) _____
- Insurance (name) _____
- Hospital (Which hospital) _____
- Doctor Referral (Dr Name) _____
- Print Ad (name) _____
- Other (please explain) _____

Please list any specific question(s) that you may have about your surgical procedures in order that our doctors may become aware of your concerns prior to your appointment with him.

This information is very important. It helps us to give you the best possible medical/surgical care. Thank you for taking the time and energy to complete this worksheet for your bariatric surgery.

Patient's Name _____