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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  
 Primary Care Physician or Internist \_\_\_\_\_  
 Physician's address and phone \_\_\_\_\_  
 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

Patient's Name \_\_\_\_\_

At what age did you develop a significant weight problem? \_\_\_\_\_

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?  
(i.e. repeated doctor visits for the same problems)  Yes  No

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?  
(anorexia, bulimia, binge-eating disorder, compulsive overeating)  Yes  No

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?  
(weight reduction surgery)  Yes  No

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 \_\_\_\_\_

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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  No

Varicose 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 \_\_\_\_\_

**OBSTETRICAL/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 Menopausal
2. Menstrual Cycles  None  Irregular
3. 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  Heels

Painful 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 extremities

Autoimmune 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 DISORDERS**

Anemia  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  $\frac{1}{2}$  pack or less between 1 to 1  $\frac{1}{2}$  packs  
between 1  $\frac{1}{2}$  to 2 packs 2  $\frac{1}{2}$  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

<b>FAMILY HISTORY</b>	
Check (✓) if any blood relatives have had:	Medical information about your biological family (i.e., ages, medical conditions, types of cancer, etc.):
Colon cancer/polyps	Father:
	Mother:
Crohns disease, ulcerative colitis	Siblings:
Liver disease or hepatitis	
Pancreatic cancer	
Gall bladder disease	Children:
Stomach or esophagus cancer	Paternal grandparents:
Diabetes	Maternal grandparents:
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) \_\_\_\_\_ Hospital (Which hospital) \_\_\_\_\_
- Website/internet (which site) \_\_\_\_\_ Doctor Referral (Dr Name) \_\_\_\_\_
- Radio (which station) \_\_\_\_\_ Print Ad (name) \_\_\_\_\_
- Word of mouth Referral (name) \_\_\_\_\_ Other (please explain) \_\_\_\_\_
- Insurance (name) \_\_\_\_\_

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.

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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 \_\_\_\_\_