

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.

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? Yes No If yes, by whom? _____

How did you hear about us?

Primary Care Physician Friends/Family Internet: Specify Website _____

Other: _____

What is your primary reason for making an appointment? _____

Are you seeking evaluation for weight loss surgery? Yes No

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?

- | | | |
|---|---|---|
| <input type="radio"/> Compulsive Eating | <input type="radio"/> Eating too much fat/sugar | <input type="radio"/> Nervous Eating |
| <input type="radio"/> Stress | <input type="radio"/> Lack of Exercise | <input type="radio"/> Lack of Knowledge |
| <input type="radio"/> Emotional Eating | <input type="radio"/> Portion Size | <input type="radio"/> Sweet Cravings |
| <input type="radio"/> High Calorie Drinks | | |

WEIGHT LOSS METHODS YOU HAVE TRIED:

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

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? Yes No

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

How many times per week? _____

How long do you exercise each time? _____

Do you snore? Yes No

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

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

Is it hard for you to fall asleep? Yes No

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

Has your appetite changed over the last six months? Yes No

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	PHYSICIAN
CARDIAC	
<input type="radio"/> Coronary Artery Disease	
<input type="radio"/> MI (Heart Attack)	
<input type="radio"/> Elevated Cholesterol/Triglycerides	
<input type="radio"/> Chest Pain	
<input type="radio"/> Congestive Heart Failure	
<input type="radio"/> Valvular Disease	
<input type="radio"/> Rheumatic Fever	
<input type="radio"/> Heart Murmur	
<input type="radio"/> Heart Arrhythmia (Irregular Heart Beat)	
<input type="radio"/> High Blood Pressure	
PULMONARY	
<input type="radio"/> Asthma	
<input type="radio"/> Pneumonia	
<input type="radio"/> Bronchitis	
<input type="radio"/> COPD (Emphysema)	
<input type="radio"/> Tuberculosis	
<input type="radio"/> Obesity Hypoventilation Syndrome	
<input type="radio"/> Pulmonary Hypertension	

MEDICAL HISTORY	PHYSICIAN
PULMONARY (continued)	
<input type="radio"/> Sleep Apnea	
<input type="radio"/> Using CPAP/BiPAP Machine	
ENDOCRINE	
<input type="radio"/> Diabetes	
<input type="radio"/> Hyperthyroid	
<input type="radio"/> Hypothyroid	
<input type="radio"/> Adrenal (Cushing's)	
GASTROINTESTINAL	
<input type="radio"/> Reflux Disease (Heartburn)	
<input type="radio"/> Peptic Ulcer Disease	
<input type="radio"/> Gallbladder Disease	
<input type="radio"/> Liver Disease	
<input type="radio"/> Inflammatory Bowel Disease	
<input type="radio"/> Hiatal Hernia	
<input type="radio"/> Abdominal Hernia	
RENAL	
<input type="radio"/> Kidney Disease	
<input type="radio"/> Urinary Stress Incontinence	
<input type="radio"/> Kidney Stones	
PERIPHERAL VASCULAR DISEASE	
<input type="radio"/> Arterial Vascular Disease	
<input type="radio"/> Pulmonary Embolism	
<input type="radio"/> DVT (Phlebitis)	
<input type="radio"/> Superficial Phlebitis	
<input type="radio"/> Leg Ulcers	
<input type="radio"/> Varicose Veins	
CENTRAL NERVOUS SYSTEM	
<input type="radio"/> Stroke	
<input type="radio"/> Seizure	
<input type="radio"/> Cerebral Aneurysm	
<input type="radio"/> Arteriovenous Malformation	
<input type="radio"/> Pseudotumor Cerebri	
<input type="radio"/> Arterial Vascular Disease	
MUSCULOSKELETAL	
<input type="radio"/> Low back pain	
<input type="radio"/> Diagnosed Osteoarthritis/ DJD	
<input type="radio"/> Painful Joints	

MEDICAL HISTORY	PHYSICIAN
MUSCULOSKELETAL (continued)	
<input type="radio"/> Autoimmune Disease	
<input type="radio"/> Gout	
<input type="radio"/> Gout	
<input type="radio"/> Fibromyalgia	
<input type="radio"/> Abdominal Skin/Pannus	
BLOOD DISORDERS	
<input type="radio"/> Anemia	
<input type="radio"/> Abnormalities with bleeding or clotting	
PSYCHIATRIC DISORDERS	
<input type="radio"/> Depression	
<input type="radio"/> Bipolar Depression	
<input type="radio"/> Anxiety	
<input type="radio"/> Schizophrenia	
<input type="radio"/> Anorexia	
<input type="radio"/> Bulimia	
CANCER	
Type: _____ Treatment: _____	
Type: _____ Treatment: _____	

OBSTETRICAL/GYNECOLOGICAL HISTORY

- History of breast cancer
- Pre-menopausal Post-menopausal
- Menstrual Irregularities
- Polycystic Ovarian Syndrome
- Number of Pregnancies: _____
- Births: Term: _____ Premature: _____ Abortions: _____ Living Children: _____
- Have you ever had a hysterectomy? Yes No
- If yes, indicate procedure Vaginal Abdominal
- Have you ever had a C-Section? Yes No If yes, how many? _____
- Have you ever had a Tubal Ligation? If yes, indicate procedure Open Laparoscopic

PREVIOUS DIAGNOSTIC PROCEDURES

Please indicate which of the following procedures you have had in the last year.

Specify month in which they were performed.

- | | | | |
|---|--|---|-----------------------------------|
| <input type="radio"/> EKG | <input type="radio"/> Chest XRay | <input type="radio"/> Lower GI | <input type="radio"/> Sleep Study |
| <input type="radio"/> Echocardiogram | <input type="radio"/> Abdominal Ultrasound | <input type="radio"/> Upper GI | <input type="radio"/> Other |
| <input type="radio"/> Stess Test | <input type="radio"/> Colonoscopy | <input type="radio"/> Pulmonary Function Test | |
| <input type="radio"/> Heart Catheterization | <input type="radio"/> Upper Endoscopy | <input type="radio"/> CT Scan (Body Area) | |

FAMILY MEMBER	ALIVE	DECEASED	DISEASE
MOTHER			
FATHER			
BROTHER			
SISTER			
GRANDPARENTS			
CHILDREN			
			<input type="radio"/> ADOPTED NO HISTORY OF BIOLOGICAL PARENTS

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

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

