OVERLAKE MEDICAL CENTER & CLINICS Metabolic & Bariatric Surgery

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

☐ Frequent snacking

☐ Daily sweets

☐ Three meals a day

☐ Skipping meals

☐ High-calorie drinks

WEIGHT LOSS METHODS YOU HAVE TRIED

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

OVERLAKE MEDICAL CENTER & CLINICS Metabolic & Bariatric Surgery

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		
☐ Coronary Artery Disease		
☐ MI (Heart Attack)		
☐ Elevated Cholesterol/Triglycerides		
☐ Chest Pain		
☐ Congestive Heart Failure		
☐ Valvular Disease		
☐ Rheumatic Fever		
☐ Heart Murmur		
☐ Heart Arrhythmia (Irregular Heart Beat)		
☐ High Blood Pressure		
LUNGS		
☐ Asthma		
☐ Pneumonia		
☐ Bronchitis		
☐ COPD (Emphysema)		
☐ Tuberculosis		
☐ Obesity Hypoventilation Syndrome		
☐ Pulmonary Hypertension		
☐ Sleep Apnea		
☐ Using CPAP/BiPAP Machine		

OVERLAKE MEDICAL CENTER & CLINICS

Metabolic & Bariatric Surgery

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

MEDICAL HISTORY	YEAR	PHYSICIAN
BLOOD DISORDERS		
☐ Anemia		
☐ Abnormalities with bleeding or clotting		
PSYCHIATRIC DISORDERS		
☐ Depression		
☐ Bipolar Depression		
☐ Anxiety		
☐ Schizophrenia		
☐ Anorexia		
☐ Bulimia		
CANCER		
Type: Treatment:		
Type: Treatment:		
IMPLANTS/FOREIGN SURGICAL DEVICES		
☐ Pacemaker		
☐ Shunt		
☐ Artificial Joint		
☐ Pump/Stimulator		
☐ 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: _____

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	
☐ Laparoscopic	
☐ Open	
ABDOMINAL HERNIA	
☐ Laparoscopic	
☐ Open	
☐ Mesh	
NISSEN REFLUX SURGERY	
COLON REMOVAL	
☐ Laparoscopic	
☐ Open	
HYSTERECTOMY	
HEART SURGERY	
OTHER ABDOMINAL SURGERY:	
OTHER SURGERIES:	

ALLERGY INFORMATION

Please list any known allergies and reactions.

ALLERGY	REACTION

PHARMACY CONTACT INFO

Name of Pharmacy: _____

Phone: (_____) _____ Address: _____

MEDICATIONS

Please list all prescribed and over the counter medications, vitamins and minerals you are currently using.

MEDICATION/VITAMINS	DOSE	TIMES PER DAY	YEAR STARTED	PURPOSE

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			
☐ 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) _____

Please describe in your own words why you are seeking bariatric surgery or medically supervised weight loss.

(This will be part of your medical record.) _____