OVERLAKE MEDICAL CLINICS METABOLIC AND 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.

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?

❍ Compulsive Eating ❍ Eating too much fat/sugar ❍ Nervous Eating

❍ Stress ❍ Lack of Exercise ❍ Lack of Knowledge

❍ Emotional Eating ❍ Portion Size ❍ Sweet Cravings

❍ High Calorie Drinks

WEIGHT LOSS METHODS YOU HAVE TRIED:

DIET	LENGTH OF TIME	YEAR	WEIGHT LOSS
❍ Appetite Suppressant Gum			
❍ Atkins Diet			
❍ Beverly Hills Diet			
❍ BioSlim			
❍ Dexatrim			
❍ Diabetic Diet			
❍ Diuretics			
❍ Herbal Remedies			
❍ Jenny Craig			
❍ Laxatives			
❍ Low Carbohydrate Diet			
❍ Low Fat Diet			
❍ Medifast			
❍ Meridia			
❍ MetaboLife			
❍ Metabolite			
❍ NutriSystem			
❍ Optifast			
❍ Overeaters Anonymous			
❍ 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			
❍ Weight Watchers			
❍ Weight Loss Camp			
❍ Xenical			
❍ Other			
❍ 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 HEATLH 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	
❍ 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	
PULMONARY	
❍ Asthma	
❍ Pneumonia	
❍ Bronchitis	
❍ COPD (Emphysema)	
❍ Tuberculosis	
❍ Obesity Hypoventilation Syndrome	
❍ Pulmonary Hypertension	

MEDICAL HISTORY	PHYSICIAN
PULMONARY (continued)	
❍ Sleep Apnea	
❍ Using CPAP/BiPAP Machine	
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	
RENAL	
❍ Kidney Disease	
❍ Urinary Stress Incontinence	
❍ Kidney Stones	
PERIPHERAL 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	
❍ Painful Joints	

MEDICAL HISTORY		PHYSICIAN
MUSCULOSKELETAL (continued)		
❍ Autoimmune Disease		
❍ Gout		
❍ Gout		
❍ Fibromyalgia		
❍ Abdominal Skin/Pannus		
BLOOD DISORDERS		
❍ Anemia		
❍ Abnormalities with bleeding or clotting		
PSYCHIATRIC DISORDERS		
❍ Depression		
❍ Bipolar Depression		
❍ Anxiety		
❍ Schizophrenia		
❍ Anorexia		
❍ 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

SURGICAL HISTORY:

Please list all surgical procedures and year performed. If relevant specify if the surgery was done laparoscopic or open.

SURGERY	YEAR

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	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 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? ________________

____

PREVIOUS DIAGNOSTIC PROCEDURES

Please indicate which of the following procedures you have had in the last year.
Specify month in which they were performed.

- ❍ EKG
- ❍ Echocardiogram
- ❍ Stess Test
- ❍ Heart Catheterization
- ❍ Chest XRay
- ❍ Abdominal Ultrasound
- ❍ Colonoscopy
- ❍ Upper Endoscopy
- ❍ Lower GI
- ❍ Upper GI
- ❍ Pulmonary Function Test
- ❍ CT Scan (Body Area)
- ❍ Sleep Study
- ❍ Other

FAMILY MEMBER	ALIVE	DECEASED	DISEASE
MOTHER			
FATHER			
BROTHER			
SISTER			
GRANDPARENTS			
CHILDREN			
			❍ 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) ______________________________

Please describe in your own words why you are seeking surgical weight loss.
(This will be part of your medical record) ______________________________