

# Initial Patient Assessment

Name:

Date:

Age:

DOB:

Sex:

BMI:

Height:

Weight:

Enter the names of your doctors:

SPECIALTY	NAME	LOCATION	PHONE
Primary Care Physician			
Endocrinologist			
Gynecologist			
Cardiologist			
Pulmonologist			
Other			

## REFERRAL SOURCE

HOW DID YOU LEARN ABOUT WEIGHT LOSS SURGERY AT COMMONWEALTH SURGICAL ASSOCIATES?

Primary Care Physician       Friend \_\_\_\_\_       INTERNET \_\_\_\_\_

Have you:

attended an information seminar about obesity surgery?

Where:

When:

attended a support group meeting?

Where:

When:

viewed a video about Gastric Bypass surgery:

surfed the internet to find out more about obesity surgery?

I HAVE BEEN LOOKING INTO WEIGHT LOSS SURGERY FOR \_\_\_\_\_ YEARS

*The information requested in this questionnaire is very important. To give you the best care, and obtain your insurance approval, we must have complete answers. Please be thorough.*

## WEIGHT HISTORY

LIFE EVENT	AGE	WEIGHT	
Start of High School			
High School Graduation			
Marriage			
Lowest weight in last 5 years			
Highest weight in last 5 years			
Pregnancy(s)		Before:	After:
Pregnancy(s)		Before:	After:
Pregnancy(s)		Before:	After:
Pregnancy(s)		Before:	After:

## DIETARY HISTORY

Approximate age when you first seriously dieted: \_\_\_\_\_

List diets and diet programs you have tried:

PROGRAM	DATE STARTED	DURATION	M.D. SUPERVISED YES/NO	MAXIMUM WEIGHT LOSS	AMOUNT REGAINED
Jenny Craig					
Nutri-Systems					
Opti/Media Fast					
Fen/Phen Redux					
Weight Watchers					
Meridia					
Xenical					
Lindora					
O. A.					
Acupuncture					
HMR					
ATKINS					
Ornish					
Dietician supervised					
Self-managed					
Other program Name:					

*The information requested in this questionnaire is very important. To give you the best care, and obtain your insurance approval, we must have complete answers. Please be thorough.*





## GASTROINTESTINAL

---

- |                                                        |                                                                     |                                       |
|--------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------|
| <input type="radio"/> No Problems                      | <input type="radio"/> Gallbladder surgery    Year _____             | <input type="radio"/> Liver cirrhosis |
| <input type="radio"/> Gallbladder attacks / disease    | <input type="radio"/> Belching acid or sour fluid in back of throat | <input type="radio"/> Heartburn       |
| <input type="radio"/> Coughing or choking at night     | <input type="radio"/> Barrett's esophagus                           | <input type="radio"/> Hiatal hernia   |
| <input type="radio"/> Esophagitis                      | Year _____                                                          | Finding: _____                        |
| <input type="radio"/> Upper GI Series                  | Year _____                                                          | Finding: _____                        |
| <input type="radio"/> Upper GI endoscopy               | Year _____                                                          | Finding: _____                        |
| <input type="radio"/> Colonoscopy                      | <input type="radio"/> I had a hernia repair with mesh               | <input type="radio"/> Crohn's disease |
| <input type="radio"/> I have a hernia                  | List them here : _____                                              |                                       |
| <input type="radio"/> I had major abdominal surgery(s) | _____                                                               |                                       |

## GENITO-URINARY

---

- |                                   |                                                                       |                                                               |
|-----------------------------------|-----------------------------------------------------------------------|---------------------------------------------------------------|
| <input type="radio"/> No Problems | <input type="radio"/> Leakage of urine<br>with laugh, cough or sneeze | <input type="radio"/> Need to wear pad<br>always / frequently |
|-----------------------------------|-----------------------------------------------------------------------|---------------------------------------------------------------|

## ENDOCRINE PROBLEMS

---

- |                                                            |                                                       |                                                                 |
|------------------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------------------|
| <input type="radio"/> No Problems                          | <input type="radio"/> Year diagnosed _____            | <input type="radio"/> Gestational Diabetes                      |
| <input checked="" type="radio"/> <b>Diabetes mellitus</b>  | <input type="radio"/> Control with oral medications   | <input type="radio"/> Control with insulin                      |
| <input type="radio"/> Control with diet                    | <input type="radio"/> Last Hemoglobin A1C Level _____ | <input checked="" type="radio"/> <b>POLYCYSTIC OVARY (PCOS)</b> |
| <input type="radio"/> Blood sugars taken ___ times per day | <input type="radio"/> Diabetic neuropathy             | <input type="radio"/> Diabetic nephropathy                      |
| <input type="radio"/> Diabetic retinopathy                 | <input type="radio"/> Hypert thyroidism               | <input checked="" type="radio"/> <b>Cushing's Disease</b>       |
| <input checked="" type="radio"/> <b>Hypothyroidism</b>     |                                                       |                                                                 |

Do you currently/or have you ever seen a Certified Diabetes Educator for Diabetes Self Management?     YES     NO

If so: Name of CDE and location: \_\_\_\_\_

## PSYCHIATRIC PROBLEMS

---

- |                                      |                                           |                                                      |
|--------------------------------------|-------------------------------------------|------------------------------------------------------|
| <input type="radio"/> No Problems    | <input type="radio"/> Bipolar disease     | <input type="radio"/> Followed by therapist          |
| <input type="radio"/> Depression     | <input type="radio"/> ADHD                | <input type="radio"/> Post-traumatic stress disorder |
| <input type="radio"/> Anxiety        | <input type="radio"/> Learning disability | <input type="radio"/> schizophrenia                  |
| <input type="radio"/> Panic disorder |                                           |                                                      |

*The information requested in this questionnaire is very important. To give you the best care, and obtain your insurance approval, we must have complete answers. Please be thorough.*

# PAST MEDICAL HISTORY

**CHILDHOOD ILLNESS:**

- Rheumatic Fever
  Heart Murmur
  Bleeding Disorders

--

**ADULT: SERIOUS ILLNESSES AND HOSPITALIZATION**

- Hepatitis
  Blood Transfusion
  AIDS/HIV Exposure  
 Colitis / enteritis
  Kidney Disease
  Bleeding Abnormally  
 Other
  Cancer
 Type: \_\_\_\_\_

Date	Illness	Treatment

**OPERATIONS AND SERIOUS INJURIES**

Date	Operations / injury

*The information requested in this questionnaire is very important. To give you the best care, and obtain your insurance approval, we must have complete answers. Please be thorough.*



## HERBAL/NUTRITIONAL SUPPLEMENTS

---



---



---



---

## WOMEN: OBSTETRIC AND MENSTRUAL HISTORY

---

Age at first period: \_\_\_\_ Date of last period: \_\_\_\_\_

Number of pregnancies: \_\_\_\_ Number of live births: \_\_\_\_ Miscarriages/abortions: \_\_\_\_

Obstetric complications: \_\_\_\_\_

I am on birth control pills       I use IUD (mechanical contraception)       I am on estrogens

## FAMILY HISTORY

---

*(Living/deceased, age, illness or cause of death)*

Father: \_\_\_\_\_ Spouse: \_\_\_\_\_

Mother: \_\_\_\_\_ Children: \_\_\_\_\_

Siblings: \_\_\_\_\_ Others: \_\_\_\_\_

Is there a history of:      Obesity No  Yes       Colon Cancer No  Yes

Stomach Cancer No  Yes       Heart Disease No  Yes       Breast Cancer No  Yes

---

*The information requested in this questionnaire is very important. To give you the best care, and obtain your insurance approval, we must have complete answers. Please be thorough.*

## SOCIAL HISTORY

---

Single  Married  Divorced  Widowed  Other

Children: \_\_\_\_\_

Occupation: \_\_\_\_\_

Tobacco Use: No  Yes  Last date used: \_\_\_\_\_ Started in year: \_\_\_\_\_

How many packs per day? \_\_\_\_\_

Alcohol Use: No  Yes  Last date used: \_\_\_\_\_ How often? \_\_\_\_\_

Use of Recreational Drugs:

No  Yes  Type: \_\_\_\_\_

Amount: \_\_\_\_\_

The above is true and correct to the best of my belief

---

(Patient Signature/ Date)

*The information requested in this questionnaire is very important. To give you the best care, and obtain your insurance approval, we must have complete answers. Please be thorough.*