

Center for Weight Loss and Metabolic Surgery- New Patient Evaluation

Patient Name: _____ Date of Birth: ____/____/____

What are your weight loss goals and why? _____

Weight History:

When did you become overweight?

- Childhood (what age?____) Teens (what age?____) Adulthood Pregnancy
 Menopause

What was your highest adult weight?_____ What was your lowest adult weight?_____

Have you ever had a history of an eating disorder? Yes No if Yes, what kind:_____

During the last 3 months, did you have any episodes of excessive overeating (i.e., eating significantly more than what most people would eat in a similar period of time)?

- Yes No

Do you feel distressed about your episodes of excessive overeating?

- Yes No

As best you can remember, how much did you weigh?

One year ago? _____ Five years ago? _____ 10 years ago? _____

Triggers for your weight gain (check all that apply)

- Stress Marriage Divorce Illness Medication Travel Injury Nightshift work
 Insomnia Quitting (check all that apply: Smoking Alcohol Drugs
 Other _____

Previous Weight Loss Programs:

- Weight Watchers Nutrisystem Jenny Craig LA Weight Loss Atkins South Beach
 Zone Diet Medifast Dash Diet Paleo Diet HCG Noom
 Mediterranean Diet Ornish Diet Keto Diet Intermittent fasting Other: _____

What was your maximum weight loss? _____

What challenges did you have in these previous weight loss programs? _____

PLACE PATIENT LABEL HERE

UW Medicine

Harborview Medical Center – University of Washington Medical Center
UW Medicine Primary Care – Valley Medical Center – UW Physicians

NEW PATIENT EVALUATION WEIGHT LOSS

Page 1 of 6



U3850

UH3850 REV NOV 21

Have you ever taken medication to lose weight? (check all that apply):

- Phentermine (Adipex) Meridia Xenecal/Alli Phen/Fen
- Phendimetrazine (Bontril) Topamax Diethylpropion (Tenuate)
- Bupropion (Wellbutrin) Belviq Qsymia Contrave
- Liraglutide/Victoza/Saxenda Semaglutide/Ozempic/Wegovy

Have you tried anything else?: _____

What worked? _____

What didn't work? _____

Why or why not? _____

Nutritional History

How often do you eat breakfast? _____ days per week at _____:_____ a.m.

Number of times you eat per day: _____

Do you get up at night to eat? Yes No If so, how often? _____ times

Do you have any dietary restrictions or food allergies? _____

Do you drink any sweet beverages and if so, what type and how many times per day? _____

Number of times per week you eat fast food: Breakfast _____ Lunch _____ Dinner _____

Overeating triggers (check all that apply):

- Stress Boredom Anger Seeking Reward Parties Eating Out
- Fast Food Other: _____

Food cravings:

- Sugar Chocolate Starches Salty High Fat Large Portions

Social History

Smoking: Never Current smoker (_____ packs/day) Past smoker (quit _____ years ago)

Vape: Never Current smoker (_____ packs/day) Past smoker (quit _____ years ago)

Alcohol: Never Occasional Regularly (_____ drinks per day)

What type of alcohol? Beer Wine Liquor: _____ If, So, How much? _____ per day

Prior treatment for alcoholism? Yes No

Recreational Drugs: Never Current Past Type of drugs: _____

Marijuana: Never Current user (_____ times/day)

PLACE PATIENT LABEL HERE

UW Medicine
Harborview Medical Center – University of Washington Medical Center
UW Medicine Primary Care – Valley Medical Center – UW Physicians

NEW PATIENT EVALUATION WEIGHT LOSS

Page 2 of 6



U3850



Who do you live with? Alone Spouse Spouse and Child(ren) Partner
 Children (not spouse) Other

Occupation: _____ Employer: _____

Employment/Work (job/school) Full time Part time Other _____
 Student Retired Unemployed Disabled

Gynecologic History (if applicable):

Sexually active Yes No Are you using birth control? Yes No If yes, what kind _____

Are you planning to get pregnant in the next 1-2 years? Yes No

Physical Activity:

Have you been told by a medical provider that you should not exercise at this time? Yes No

Are you currently able to walk up two flights of stairs? Yes No

Are you currently exercising? Yes No

Exercise type:

Duration: _____ hours _____ minutes Number of times per week: _____

What prevents you from exercising?

Do you track steps and if so how many steps per day?

Sleep Hygiene:

How many hours do you sleep per night? _____ How many times do you get up during the night?

Do you feel rested in the morning? Yes No What time do you go to bed at night:

Do you have Sleep Apnea? Yes No If so, do you wear a CPAP? _____

PLACE PATIENT LABEL HERE

UW Medicine
 Harborview Medical Center – University of Washington Medical Center
 UW Medicine Primary Care – Valley Medical Center – UW Physicians

NEW PATIENT EVALUATION WEIGHT LOSS

Page 3 of 6



U3850

UH3850 REV MAR 22



REVIEW OF SYMPTOMS AND PAST MEDICAL HISTORY

SYMPTOMS: Please mark (x) in the available blanks if any of the following apply to you NOW or in the PAST 2 weeks

NOW	PAST	HEAD, EYES, EARS, NOSE, THROAT
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches
<input type="checkbox"/>	<input type="checkbox"/>	Double vision
<input type="checkbox"/>	<input type="checkbox"/>	Ear or hearing trouble _____
<input type="checkbox"/>	<input type="checkbox"/>	Persistent hoarseness
<input type="checkbox"/>	<input type="checkbox"/>	Teeth trouble
LUNGS		
<input type="checkbox"/>	<input type="checkbox"/>	Daily cough
<input type="checkbox"/>	<input type="checkbox"/>	Coughing blood
<input type="checkbox"/>	<input type="checkbox"/>	Persistent wheezing
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain when breathing
HEART - CIRCULATION		
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	Chest pressure
<input type="checkbox"/>	<input type="checkbox"/>	Heart palpitation
<input type="checkbox"/>	<input type="checkbox"/>	Leg vein trouble
<input type="checkbox"/>	<input type="checkbox"/>	Leg pain when walking
<input type="checkbox"/>	<input type="checkbox"/>	Ankle swelling
STOMACH - INTESTINAL		
<input type="checkbox"/>	<input type="checkbox"/>	Trouble swallowing
<input type="checkbox"/>	<input type="checkbox"/>	Frequent or severe nausea
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn
<input type="checkbox"/>	<input type="checkbox"/>	Frequent or severe stomach pain
<input type="checkbox"/>	<input type="checkbox"/>	Frequent or severe vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting blood
<input type="checkbox"/>	<input type="checkbox"/>	Yellow jaundice
<input type="checkbox"/>	<input type="checkbox"/>	Prolonged or frequent diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Blood in bowel movements
<input type="checkbox"/>	<input type="checkbox"/>	Black bowel movements
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids (piles)
URINARY		
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	<input type="checkbox"/>	Trouble starting urine
<input type="checkbox"/>	<input type="checkbox"/>	Urinate more than two times a night
<input type="checkbox"/>	<input type="checkbox"/>	Trouble holding urine

NOW	PAST	BONES, JOINTS, MUSCLES
<input type="checkbox"/>	<input type="checkbox"/>	Joint pains or swelling
Which joints? _____		
<input type="checkbox"/>	<input type="checkbox"/>	Back pain
NERVOUS SYSTEM/MENTAL HEALTH		
<input type="checkbox"/>	<input type="checkbox"/>	Frequent loss of balance
<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells (blackouts)
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions (seizures, fits, epilepsy)
<input type="checkbox"/>	<input type="checkbox"/>	Paralysis (or weakness of any body part)
<input type="checkbox"/>	<input type="checkbox"/>	Numbness (body parts "go to sleep")
<input type="checkbox"/>	<input type="checkbox"/>	Excessive worry/Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Trouble sleeping
<input type="checkbox"/>	<input type="checkbox"/>	Depression (feeling blue)
<input type="checkbox"/>	<input type="checkbox"/>	Feelings of worthlessness
MALES		
<input type="checkbox"/>	<input type="checkbox"/>	Problem with fertility
<input type="checkbox"/>	<input type="checkbox"/>	Low libido (sex drive)
<input type="checkbox"/>	<input type="checkbox"/>	Erectile dysfunction
FEMALES		
<input type="checkbox"/>	<input type="checkbox"/>	Breast lumps or nipple discharge
<input type="checkbox"/>	<input type="checkbox"/>	Unusual bleeding from vagina
<input type="checkbox"/>	<input type="checkbox"/>	Problem with fertility
GENERAL		
<input type="checkbox"/>	<input type="checkbox"/>	Unexplained fever
<input type="checkbox"/>	<input type="checkbox"/>	Night sweats
<input type="checkbox"/>	<input type="checkbox"/>	Can't stand hot weather
<input type="checkbox"/>	<input type="checkbox"/>	Can't stand cold weather
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies
SKIN		
<input type="checkbox"/>	<input type="checkbox"/>	Persistent skin rash or itching
<input type="checkbox"/>	<input type="checkbox"/>	Unexplained bruising
<input type="checkbox"/>	<input type="checkbox"/>	Broad or purplish stretch marks
<input type="checkbox"/>	<input type="checkbox"/>	Hives
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal wound healing
HEME		
<input type="checkbox"/>	<input type="checkbox"/>	Blood clots
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problem

PLACE PATIENT LABEL HERE

UW Medicine
 Harborview Medical Center – University of Washington Medical Center
 UW Medicine Primary Care – Valley Medical Center – UW Physicians

NEW PATIENT EVALUATION WEIGHT LOSS

Page 4 of 6



HEALTH HISTORY: Do you have a history of (please check Yes or No):

- Yes No **Weight Loss Surgery in the past?** (Gastric Bypass, Lap band or Sleeve Gastrectomy, Balloon, etc.)
If so what surgery did you have? _____
When was your surgery? _____
- Yes No Endoscopic Interventions (Upper Endoscopy, Plication, Balloon, etc)
Procedure: _____
- Yes No Past stomach/Nissen surgery? _____
- Yes No Other bowel surgery or removal of any of your bowel?
- Yes No Anxiety or Depression or other Mental Illness? _____
- Yes No Are you currently seeing a Mental health care provider/Therapist?
If so, who? _____
- Yes No Heart Disease
- Yes No Heart Murmur
- Yes No Heart Valve Replacement
- Yes No Stroke
- Yes No Prediabetes
- Yes No Diabetes
- Yes No High Cholesterol
- Yes No High Blood Pressure
- Yes No Heart burn/Reflux
- Yes No Liver Disease (cirrhosis, jaundice, hepatitis, fatty liver)
- Yes No Gallstones/Gallbladder problem
- Yes No Kidney stones
- Yes No Kidney disease
- Yes No Arthritis (which joint(s)) _____
- Yes No Thyroid disease or thyroid cancer (Please explain): _____
- Yes No Vitamin D deficiency
- Yes No Pancreatitis
- Yes No Glaucoma
- Yes No Seizures
- Yes No Cancer (Type) _____

PLACE PATIENT LABEL HERE

UW Medicine
Harborview Medical Center – University of Washington Medical Center
UW Medicine Primary Care – Valley Medical Center – UW Physicians

NEW PATIENT EVALUATION WEIGHT LOSS

Page 5 of 6



U3850

UH3850 REV MAR 22

7

Family History: Check all that apply to you and your family members

FAMILY HISTORY

Illnesses: **Family** **Which family member(s)**

Diabetes

Heart Disease/Heart Attack

Obesity

Medullary Thyroid Cancer

If you have other significant

personal or family history,

please specify:

PLACE PATIENT LABEL HERE

UW Medicine
Harborview Medical Center – University of Washington Medical Center
UW Medicine Primary Care – Valley Medical Center – UW Physicians

NEW PATIENT EVALUATION WEIGHT LOSS

Page 6 of 6



U3850

UH3850 REV MAR 22

L