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?_____

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)

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 to you go to bed at night:
_____
Do you have Sleep Apnea? ☐ Yes ☐ No If so, do you wear a CPAP?_____

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
☐	☐	Dizziness
☐	☐	Severe headaches
☐	☐	Double vision
☐	☐	Ear or hearing trouble_____
☐	☐	Persistent hoarseness
☐	☐	Teeth trouble
		LUNGS
☐	☐	Daily cough
☐	☐	Coughing blood
☐	☐	Persistent wheezing
☐	☐	Shortness of breath
☐	☐	Chest pain when breathing
		HEART - CIRCULATION
☐	☐	Chest pain
☐	☐	Chest pressure
☐	☐	Heart palpitation
☐	☐	Leg vein trouble
☐	☐	Leg pain when walking
☐	☐	Ankle swelling
		STOMACH - INTESTINAL
☐	☐	Trouble swallowing
☐	☐	Frequent or severe nausea
☐	☐	Heartburn
☐	☐	Frequent or severe stomach pain
☐	☐	Frequent or severe vomiting
☐	☐	Vomiting blood
☐	☐	Yellow jaundice
☐	☐	Prolonged or frequent diarrhea
☐	☐	Constipation
☐	☐	Blood in bowel movements
☐	☐	Black bowel movements
☐	☐	Hemorrhoids (piles)
		URINARY
☐	☐	Frequent urination
☐	☐	Trouble starting urine
☐	☐	Urinate more than two times a night
☐	☐	Trouble holding urine

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

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)_____

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