Tufts Medical Center Community Care

Commonwealth weight loss center

ww.commonweight.com

Initial Patient Assessment

Name: **Date:**

Age: **DOB:** **Sex:** **e-mail:**

Height **Weight:** **BMI:**

Enter the names of your doctors:

SPECIALTY	NAME
Primary Care Physician	
Endocrinologist	
Gynecologist	
Cardiologist	
Pulmonologist	
Other	

REFERRAL SOURCE

HOW DID YOU LEARN ABOUT WEIGHT LOSS SURGERY AT TUFTS MEDICAL CENTER COMMUNITY CARE?

□ Primary Care Physician □ Friend _____ □ INTERNET _____

Have you:

□ Watched the ONLINE INFORMATION SEMINAR about medical and surgical weight management?

When:

□ attended a support group meeting?

Where: When:

□ viewed a video about Sleeve Gastrectomy and/or 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

When I was at this age ,	*I was*	
Toddler	☐ Normal weight	☐ Overweight
Preschool	☐ Normal weight	☐ Overweight
Kidergarten	☐ Normal weight	☐ Overweight
Elementary School	☐ Normal weight	☐ Overweight
For females:	My menstrual periods were always ☐ NORMAL	☐ IRREGULAR

LIFE EVENT	YOUR AGE	YOUR APPROXIMATE WEIGHT (lb)	
Start of High School	14		
High School Graduation	18		
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:

In your own words, please describe at what point in your life did you start gaining weight and what do you think might have triggered this:

_____
_____
_____
_____

Approximate age when you first seriously dieted: _____

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List diets and diet programs you have tried:

PROGRAM	YEAR STARTED	DURATION (months)	MAXIMUM WEIGHT LOSS (lb)	AMOUNT REGAINED (lb)
☐ Jenny Craig				
☐ Nutri-Systems				
☐ Opti/Media Fast				
☐ Fen/Phen Redux				
☐ Weight Watchers				
☐ MEDI-Weight Loss				
☐ Xenical				
☐ Lindora				
☐ O. A.				
☐ Acupuncture				
☐ HMR				
☐ ATKINS				
☐ Ornish				
☐ Dietician supervised				
☐ Self-managed				
☐ OZEMPIC				
☐ RYBELSUS				
☐ WEGOVY				
☐ MOUNJARO				
☐ TRULICITY				
☐ METFORMIN				
☐ BYETTA				
☐ Other program Name:				
☐ Other program Name:				
☐ Other program Name:				

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In your own words, please describe what you hope to accomplish and how you believe your life will change by losing weight:

_____

_____

_____

_____

Do you consider yourself:

A sweet eater? ☐ **YES** ☐ **NO** **Liking:** ☐ **Cakes / pies** ☐ **Cookies** ☐ **Chocolate / Candy** ☐ **Ice cream**

A sweet drinker? ☐ **YES** ☐ **NO** **Liking:** ☐ **Soda / soft drinks** ☐ **Coffee with cream** ☐ **fraps**

A grazer or snacker? ☐ **YES** ☐ **NO** **Liking:** ☐ **Chips / salty snacks** ☐ **Popcorn** ☐ **Fruits** ☐ **Nuts**

Do you ever skip meals? ☐ **YES** ☐ **NO**
I skip sometimes ☐ **Breakfast** ☐ **Lunch** ☐ **Dinner**

Do you have a problem with portion control? ☐ **YES** ☐ **NO**

Do you eat a lot of takeout / fast food / fried food? ☐ **YES** ☐ **NO**

Do you tend to eat late at night? ☐ **YES** ☐ **NO**

Do you eat a lot of carbohydrates (pizza, rice, pasta, bread)? ☐ **YES** ☐ **NO**

Do you eat more when you are stressed out? ☐ **YES** ☐ **NO**

Have you ever been diagnosed with an eating disorder like bulimia or anorexia ☐ **YES** ☐ **NO**

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Have you had or do you have any of the following illnesses or symptoms?

CARDIAC/HEART DISEASE

O **No problems**

O High Cholesterol
O High triglycerides
O High Blood Pressure
Year diagnosed _____
Treatment (Diet/Medication) _____
O Abnormal EKG/Stress Test
O Angina/chest pain
O MI (*Heart attack*) / Year _____
O Cardiac cath/Year _____
O Bypass/Year _____
O Atrial fibrillation
O Pacemaker
O Other problem _____

RESPIRATORY

O **No Problems**

O Asthma
Emergency Room visits in last 2 years ____
Hospitalizations in last 2 yr ___
O Shortness of breath
Can walk ____ blocks on level ground or ____ flight/s of stairs
O Obesity/Hypoventilation synd
O Sleep Apnea Syndrome
Year Diagnosed _____
O Sleep study
O CPAP used? _____ cm
O Morning headaches
O Restless sleep
O Snoring
O Daytime drowsiness
O frequent awakenings at night
O Observed apneic episodes

VASCULAR/CIRCULATION

O **No problems**

O Venous stasis disease
O Varicose Veins
O Vein surgery
O Leg swelling
O Blood clots
O Pulmonary embolus
O Family history of blood clots
O on Aspirin _____ mg
O on Plavix
O on Coumadin
O other blood thinner … Name: _____

MUSCULAR/SKELETAL

O **No Problems**

O Low back pain/sciatica
O Seen by chiropractor
O Orthopedic surgeon
O PCP / Family doctor
O Pain in hips
O knees
O ankles
O foot
O Takes pain/anti-inflammatory medication _____ times per week
O Arthritis
O Weight-related injuries and/or trauma
O Hip or knee replacement
O Other orthopedic surgeries

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GASTROINTESTINAL

O **No Problems**

O Gallbladder attacks / disease	O Gallbladder surgery Year _____	O Liver cirrhosis
O Coughing or chocking at night	O Belching acid or sour fluid in back of throat	O Heartburn
O Esophagitis	O Barrett's esophagus	O Hiatal hernia
O Upper GI Series	Year _____	Finding: _____
O Upper GI endoscopy	Year _____	Finding: _____
O Colonoscopy	Year _____	Finding: _____
O I have a hernia	O I had a hernia repair with mesh	O Crohn's disease
O I had major abdominal surgery(s)	List them here : _____	
	_____	

GENITO-URINARY

O **No Problems**	O Leakage of urine with laugh, cough or sneeze	O Need to wear pad always / frequently

ENDOCRINE PROBLEMS

O **No Problems**

O **Diabetes mellitus**	O Year diagnosed _____	O Gestational Diabetes
O Control with diet	O Control with oral medications	O Control with insulin
O Blood sugars taken ___ times per day	O Last Hemoglobin A1C Level _____	O **POLYCYSTIC OVARY (PCOS)**
O Diabetic retinopathy	O Diabetic neuropathy	O Diabetic nephropathy
O **Hypothyroidism**	O Hyperthyroidism	O **Cushing's Disease**

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

O **No Problems**

O Depression	O Bipolar disease	O Followed by therapist
O Anxiety	O ADHD	O Post-traumatic stress disorder
O Panic disorder	O Learning disability	O schizophrenia

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PAST MEDICAL HISTORY

CHILDHOOD ILLNESS:

o Rheumatic Fever o Heart Murmur o Bleeding Disorders

Other childhood medical problems:

ADULT: SERIOUS ILLNESSES AND HOSPITALIZATION

o Type 1 Diabetes
o Type 2 Diabetes
o Using home oxygen
o Obstructive Sleep Apnea
o Osteoarthritis KNEE
o Osteoarthritis HIP
o Back Pain
o PCOS
o COPD
o High Blood Pressure
o Coronary Artery Disease
o Migraine headaches
o Hepatitis
o Blood Transfusion
o AIDS/HIV Exposure
o Colitis / enteritis
o Kidney Disease
o Bleeding Abnormally
o GERD
o Hiatal Hernia
o Cancer
Type: _____

YEAR	Illness	Treatment

OPERATIONS AND SERIOUS INJURIES

YEAR	Operations / injury

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ALLERGIES

o None

Medications	Reaction

I am allergic to o **surgical tape** o **latex** o **iodine**

CURRENT MEDICATIONS

List all (including over the counter drugs, aspirin, laxatives, vitamins, or tranquilizers)

MEDICATIONS:

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HERBAL/NUTRITIONAL SUPPLEMENTS (if any)

WOMEN: OBSTETRIC AND MENSTRUAL HISTORY

Age at first period: _____ Date of last period: _____

Number of pregnancies: _____ Number of live births: ____ Miscarriages/abortions: ____

Obstetric complications: _____

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

ENTER MEDICAL PROBLEMS IN YOUR FAMILY:

(Enter information about illnesses or cause of death if applies next to your relative)

Father:	Spouse:
Mother:	Children:
Siblings:	Others:

Is there a history of: Obesity in your family O NO O Yes

Comment:_____

THYROID cancer? O NO O Yes PANCREAS cancer? O NO O Yes

Comment: _____ Comment: _____

COLON cancer? O NO O Yes STOMACH cancer? O NO O Yes

Comment: _____ Comment: _____

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SOCIAL HISTORY

Single o Married o Divorced o Widowed o Other o

Children: _____

Occupation: _____

Tobacco Use: o NO o Yes Last date used: _____ Started in year: _____

How many packs per day? _____

Alcohol Use: o NO o Yes Last date used: _____ How often? _____

Use of Recreational Drugs: o NO o Yes

Type: _____

Frequency: _____

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

_____

(Patient Signature/ Date)

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