TuftsMedicine
Weight & Wellness Center

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.

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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				
☐ QSYMIA				
☐ Other program Name:				
☐ Other program Name:				
☐ Other program Name:				

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

____

____

____

MY GOAL WEIGHT IS: __________

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 ☐ No problems

☐ High Cholesterol ☐ High triglycerides

☐ High Blood Pressure Year diagnosed ________ Treatment (Diet/Medication) ________________

☐ Abnormal EKG/Stress Test ☐ Angina/chest pain ☐ MI (*Heart attack*) / Year __________

☐ Cardiac cath/Year ______ ☐ Bypass/Year ________

☐ Atrial fibrillation ☐ Pacemaker ☐ Other problem _________________________

RESPIRATORY ☐ No problems

☐ Asthma Emergency Room visits in last 2 years ____ Hospitalizations in last 2 yr ___

☐ Shortness of breath Can walk ____ blocks on level ground or ____ flight/s of stairs ☐ Obesity/Hypoventilation

☐ Sleep Apnea Syndrome Year Diagnosed _____ ☐ Sleep study ☐ CPAP used? ______ cm

I usually go to bed at _______ **I usually get up at _______** **I get up well rested:** ☐ **YES** ☐ **NO**

☐ Morning headaches ☐ Restless sleep ☐ Snoring ☐ Daytime drowsiness

☐ frequent awakenings at night ☐ Observed apneic episodes ☐ NECK circumference greater than 16 in *(use a measuring tape if you have one)*

☐ **I have a night job / I work night shifts frequently**

VASCULAR/CIRCULATION/OCULAR (EYE) ☐ No problems

☐ Venous stasis disease ☐ Varicose Veins ☐ Vein surgery ☐ Leg swelling

☐ Blood clots ☐ Pulmonary embolus ☐ Family history of blood clots

☐ Macular degeneration ☐ Glaucoma ☐ Diabetic retinopathy

☐ on Aspirin _____ mg ☐ on Plavix ☐ on Coumadin ☐ other blood thinner … Name: ________________

MUSCULAR/SKELETAL ☐ No problems

☐ Low back pain/sciatica ☐ Seen by chiropractor ☐ Orthopedic surgeon ☐ PCP / Family doctor

☐ Pain in hips ☐ knees ☐ ankles ☐ foot

☐ I take pain/anti-inflammatory medication ______ times per week ☐ Arthritis

☐ Weight-related injuries and/or trauma ☐ Hip or knee replacement ☐ Other orthopedic surgeries

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GASTROINTESTINAL ☐ **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 Swallow Study 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 ☐ **No problems**

- O Leakage of urine with laugh, cough or sneeze
- O Need to wear pad always / frequently

ENDOCRINE PROBLEMS ☐ **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 ☐ **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:

- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ 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

☐ None

Medications	Reaction

I am allergic to ☐ **surgical tape** ☐ **latex** ☐ **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** ☐ **NO** ☐ **Yes**

Comment:____

Any family members had weight loss surgery? ☐ **NO** ☐ **Yes**

Comment:____

THYROID cancer? ☐ **NO** ☐ **Yes**
Comment: ___________________________

PANCREAS cancer? ☐ **NO** ☐ **Yes**
Comment: ___________________________

COLON cancer? ☐ **NO** ☐ **Yes**
Comment: ___________________________

STOMACH cancer? ☐ **NO** ☐ **Yes**
Comment: ___________________________

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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: ____

Frequency: ____

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

____

(Patient Signature/ Date)

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