

# Initial Evaluation Form

## Northwest Obesity Surgery

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The following information is very important to your health. It helps us to give you the best possible medical/surgical care. Please take time to fully and completely fill out this important information.

**PLEASE NOTE: GREY HIGHLIGHTED TEXT RESERVED FOR STAFF USE ONLY**

Date: \_\_\_\_\_  
Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Height \_\_\_\_\_ Present weight \_\_\_\_\_

Primary care physician or internist \_\_\_\_\_

Have you been referred to us? Yes No

If yes, by whom? \_\_\_\_\_

What is your primary reason for making an appointment? \_\_\_\_\_

Are you seeking evaluation for weight loss surgery for morbid obesity? \_\_\_\_\_

If so, when would you like to be evaluated? \_\_\_\_\_

Why? \_\_\_\_\_

How did you hear about us?

Primary Care Physician Friend/Family \_\_\_\_\_ Television

Comcast Arena at Everett Internet(specify which website): \_\_\_\_\_

Radio Weight Management Center Magazine(please specify): \_\_\_\_\_

Other \_\_\_\_\_

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At what age did you develop a significant weight problem? \_\_\_\_\_

Are there events that are related to your weight gain? If so, what are they? \_\_\_\_\_

Have you ever received treatment to lose weight? Yes No

If yes, when and where? \_\_\_\_\_

Do you use supplements or medications for appetite control? Yes No

If yes, list any medications, vitamin, mineral, nutritional supplements, or appetite control drugs you currently use or used: \_\_\_\_\_

Are you on a restricted or special diet for any medical reasons? Yes No

If yes, explain: \_\_\_\_\_

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

*Patient Signature*

Record major diets that resulted in weight loss of 10 pounds or more. (Use additional pages as needed.)

Year	Length of diet	Starting weight	# of lbs lost	Length of time weight stayed off	Type of diet program

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Do you snore?	Yes	No
Do you ever wake at night gasping for breath?	Yes	No
Has anyone ever told you that you stop breathing while asleep?	Yes	No
Is it hard to fall asleep?	Yes	No

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Are you currently being treated for depression?	Yes	No
Have you ever been treated for depression?	Yes	No
If yes to either, name of psychiatrist or mental health provider: _____		
Do you feel sad most of the time?	Yes	No
Do you have or have you been treated for an eating disorder?	Yes	No
Has your appetite changed over the past six months?	Yes	No
Has your interest in sex changed over the past six months?	Yes	No

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Do you exercise regularly?	Yes	No
If so, what type of exercise do you perform? _____		
How many times a week do you exercise? _____		
How long do you exercise each time? _____		

In your opinion, what contributes to your excess weight?

- |                   |                           |                  |               |
|-------------------|---------------------------|------------------|---------------|
| Compulsive Eating | Eating too much fat/sugar | Nervous Eating   | Stress        |
| Lack of exercise  | Lack of knowledge         | Emotional Eating | Portion Sizes |

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

*Patient Signature*

Have you or one of your relatives ever had bariatric surgery?      Yes                              No  
 (*weight-reduction surgery*)

If yes, what relationship are they to you?

Self    Year \_\_\_\_\_    Original Weight \_\_\_\_\_    Lowest Weight Achieved \_\_\_\_\_  
 Mother    Father    Spouse    Brother    Sister    Other: \_\_\_\_\_

If yes, what type of procedure was performed?

Gastric Banding    Roux-en Y Gastric Bypass    Distal Bypass    Don't know  
 Other: \_\_\_\_\_

If yes, which doctor performed the surgery? \_\_\_\_\_  
 Name of relative \_\_\_\_\_

**Allergy Information**

Please list any known allergies.

- 1.) \_\_\_\_\_ What allergic reaction did you have? \_\_\_\_\_
- 2.) \_\_\_\_\_ What allergic reaction did you have? \_\_\_\_\_
- 3.) \_\_\_\_\_ What allergic reaction did you have? \_\_\_\_\_
- 4.) \_\_\_\_\_ What allergic reaction did you have? \_\_\_\_\_
- 5.) \_\_\_\_\_ What allergic reaction did you have? \_\_\_\_\_

**Medical Information**

Please list all prescribed and over-the-counter medications, vitamins and minerals that you are currently using:

	Medication	Dose	Times per day	Year Started	Purpose
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

The above is true and correct to the best of my belief \_\_\_\_\_  
*Patient Signature*

**Pharmacy Information**

Name of Pharmacy: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_

**Surgical Information**

**Part I.** Please list any surgical procedure, reason and year. If relevant, please specify if the surgery was performed laparoscopic or open.

Type of Surgery _____	Reason _____	Year _____
Type of Surgery _____	Reason _____	Year _____
Type of Surgery _____	Reason _____	Year _____
Type of Surgery _____	Reason _____	Year _____
Type of Surgery _____	Reason _____	Year _____
Type of Surgery _____	Reason _____	Year _____
Type of Surgery _____	Reason _____	Year _____
Type of Surgery _____	Reason _____	Year _____
Type of Surgery _____	Reason _____	Year _____

**Part II.** For **FEMALE** patients only.

- |   |             |                    |
|---|-------------|--------------------|
| 1. Have you ever had a hysterectomy?<br>If yes, please indicate: Vaginal or Abdominal<br>If yes, please indicate year: _____<br>If yes, were the ovaries removed? | Yes         | No                 |
| 2. Have you ever had a Cesarean Section?<br>If yes, please indicate how many: _____<br>If yes, please indicate year(s) _____                                      | Yes         | No                 |
| 3. Have you ever had a Tubal Ligation?<br>If yes, please indicate how the procedure was performed   | Yes<br>Open | No<br>Laparoscopic |

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

*Patient Signature*

**Medical Health Information**

Please indicate if any of the following conditions have ever been significant problems for you. Please specify the year diagnosed and the physician who currently manages the problem.

**CARDIAC:**

Coronary Artery Disease Yes No

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

MI (Heart Attack): Yes No

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

If yes, treatment \_\_\_\_\_

- Abnormal ECG, no active ischemia
- Hx of MI or anti-ischemic medication
- PCI, CABG
- Active Ischemia

Elevated Cholesterol/ Triglycerides Yes No

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

- No treatment required
- Controlled with lifestyle
- Controlled with single medication
- Controlled with multiple medications
- Not controlled

Chest Pain Yes No

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

- Extreme exertion
- Moderate
- Minimal
- Unstable Angina

Congestive Heart Failure Yes No

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

- Class I
- Class II
- Class III
- Class IV

Valvular Heart Disease Yes No

(Mitral Valve Prolapse, Mitral Valve Regurgitation, etc.)

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Rheumatic Fever: Yes No

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Heart Murmur: Yes No

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

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

*Patient Signature*

Heart Arrhythmia (*Irregular Heart Beat*) Yes No  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

High Blood Pressure/ Hypertension Yes No  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

- No medication*
- Single medication*
- Multiple medications*
- Poorly controlled with medications*

**PULMONARY:**

Asthma Yes No  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

- Mild symptoms, no medications*
- Symptoms controlled with oral inhaler*
- Not well controlled, steroids, anticholinergics*

Pneumonia Yes No  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Bronchitis Yes No  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

COPD (Emphysema) Yes No  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Tuberculosis Yes No  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Diagnosed Sleep Apnea Yes No  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

- Requiring no oral appliance*
- Requiring oral appliance*
- Significant Hypoxemia, oxygen dependent*
- Complications (Pulm Hypertension)*

Obesity Hypoventilation Syndrome Yes No

- Hypoxemia/hypercarbia on room air*
- Sever hypoxemia/hypercarbia*
- Pulmonary hypertension*
- Right heart failure*
- Right hear failure/left ventricular dysfunction*

Pulmonary Hypertension Yes No

- Symptoms associated with PH*
- Controlled on anticoagulants and/or calcium channel blockers*
- Requiring stronger medications and oxygen*

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

*Patient Signature*

**ENDOCRINE:**

Diabetes Mellitus Yes No  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
If yes, do you currently treat with insulin? Yes No  
Do you currently treat with oral medication? Yes No  
Do you currently treat with both? Yes No

Hyperthyroid Yes No  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Hypothyroid Yes No  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Adrenal (Cushings) Yes No  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

**GASTROINTESTINAL**

Reflux Disease (Heartburn) Yes No  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
 Intermittent medication  
 H2 Blockers or low dose PPI  
 High dose PPI  
 Prior surgery for GERD

Peptic Ulcer Disease Yes No  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Gallbladder Disease Yes No  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
 Gallstones with no symptoms  
 Gallstones with intermittent symptoms  
 Gallstones with severe symptoms or h/o cholecystectomy  
 Gallstones with complications requiring surgery prior to gastric bypass

Liver Disease Yes No  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
 Hepatomegaly modest, normal LFT's, fatty change Category 1  
 Modest or greater hepatomegaly, LFT alteration, fatty change Category 2  
 Moderate to marked hepatomegaly, Category 3, mild inflammation, mild fibrosis  
 Definite NASH, cirrhosis, hepatic dysfunction by LFT's  
 Hepatic Failure, transplant indicated or done

Inflammatory Bowel Disease (Crohn's, colitis, etc.) Yes No  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Hiatal Hernia Yes No  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Abdominal Hernia Yes No  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
Successful repair Recurrent

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

*Patient Signature*

**CANCER:**

Type/Organ(s) Affected: \_\_\_\_\_ Treatment: \_\_\_\_\_

**PERIPHERAL VASCULAR DISEASE:**

Arterial Vascular Disease Yes No

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Pulmonary Embolism Yes No

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

DVT (Phlebitis) Yes No

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

- Resolved with anticoagulation
- Recurrent DVT LT anticoagulation
- Previous PE
- Recurrent PE, decrease function, hospitalization
- Vena Cava filter

Superficial Phlebitis Yes No

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Peripheral Edema (swelling of legs, ankles) Yes No

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

If yes, do you currently treat with Diuretics? Yes No

Leg Ulcers Yes No

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

If yes, do you have ulcers currently? Yes No

Varicose Veins Yes No

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

**RENAL:**

Kidney Disease Yes No

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Urinary Stress Incontinence Yes No

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Minimal Frequent Daily (requiring pad) Disabling

Kidney Stones Yes No

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

**CENTRAL NERVOUS SYSTEM:**

Stroke Yes No

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Seizure Yes No

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Cerebral Aneurysm Yes No

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Arteriovenous Malformation Yes No

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Pseudotumor Cerebri Yes No

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Headaches with dizziness, nausea, pain behind the eyes Visual Symptoms

Controlled with diuretics Controlled with narcotics

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

*Patient Signature*

**MUSCULOSKELETAL:**

Functional Status

No impairment    Able to walk 200ft with cane or crutch  
Unable to walk 200ft with cane or crutch    Require Wheelchair

Lower Back Pain    Yes    No

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Intermittent symptoms not requiring medical treatment  
Symptoms requiring non-narcotic treatment  
Symptoms requiring narcotic treatment  
Surgical intervention done or recommended pending weight loss  
Surgical intervention failed

Diagnosed Osteoarthritis/DJD    Yes    No

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

If yes, joints involved:    Neck    Shoulders    Back    Hips    Hands/Wrist    Knees  
Ankles    Feet    Heels

Painful Joints (*Without Osteoarthritis/DJD*)    Neck    Shoulders    Back    Hips    Hands/Wrist  
Knees    Ankles    Feet    Heels

Autoimmune Disease    Yes    No

(*ex., Lupus, Rheumatoid Arthritis, Connective Tissue, etc.*)

Explain Further \_\_\_\_\_

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Gout    Yes    No

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

- Hyperuricemia, no symptoms*
- Hyperuricemia, medications*
- Arthropathy*
- Destructive Joints*
- Disability, unable to walk*

Fibromyalgia    Yes    No

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Treatment with exercise    Non narcotic medications    Narcotics

Abdominal Skin/Pannus

No symptom    Irritation    Interferes with ambulation  
Recurrent cellulitis and ulceration

**BLOOD DISORDERS:**

Anemia    Yes    No

Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

If yes, type if known \_\_\_\_\_

Do you have or have you had any abnormalities with bleeding or clotting?

If yes, explain

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

*Patient Signature*

**PSYCHIATRIC DISORDERS:**

Depression Yes No  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
Mild no treatment Moderate with treatment Severe with intensive treatment  
Severe requiring hospitalization

Bipolar Depression Yes No  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Anxiety Yes No  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Schizophrenia Yes No  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Eating Disorder Yes No  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_  
If yes, what type \_\_\_\_\_

Other \_\_\_\_\_  
Year Diagnosed \_\_\_\_\_ Physician \_\_\_\_\_

Are you currently receiving therapy or medications? Yes No

**OBSTETRICAL/GYNECOLOGICAL:**

Do you have a history of breast cancer? Yes No  
If applicable:

Please indicate the number of pregnancies to term \_\_\_\_\_

Please indicate the number of deliveries \_\_\_\_\_

Please indicated whether you are Pre Menopausal Post Menopausal

Menstrual Irregularities Yes No

- Oligomenorrhea*
- Menorrhagis*
- Amenorrhea*
- Prior total abdominal hysterectomy*

Polycystic Ovarian Syndrome Yes No

- Symptoms, no treatment*
- OCP's or anti-androgen treatment*
- Metformin or TZD*
- Combination therapy*
- Infertility*

**OTHER MEDICAL DISORDERS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

*Patient Signature*



**Smoking/Drug/Alcohol History (cont'd):**

Do you currently drink alcohol? Yes No

If you answered yes to the above question:

a. What type(s) of alcohol are you drinking? Wine Beer Liquor

Mixed drinks Other: \_\_\_\_\_

b. Please indicate how many drinks you currently consume:

per month? \_\_\_\_\_

per week? \_\_\_\_\_

per day? \_\_\_\_\_

Have you ever had a problem with alcohol in the past? Yes No

If you answered yes to the above question:

a. Please indicate when and how long: \_\_\_\_\_ Treatment: \_\_\_\_\_

b. What type(s) of alcohol do/did you drink? Wine Beer Liquor

Mixed drinks Other: \_\_\_\_\_

c. Please indicate how many drinks you have drunk each day? 2-5 6-10 11+

Have you ever used any illicit drugs? Yes No

(Example: Marijuana, Cocaine, Heroin, Amphetamine, etc...)

If you answered yes, please indicate how long ago? 5 months or less 6 months- 1 year

1 year more

**Previous Diagnostic Procedures:**

Please check any of the following diagnostic procedures performed within the last year and indicate what month they were performed.

EKG \_\_\_\_\_

Stress Test \_\_\_\_\_

Abdominal US \_\_\_\_\_

Colonoscopy \_\_\_\_\_

CT Scan (body area) \_\_\_\_\_

Other \_\_\_\_\_

Chest X-ray \_\_\_\_\_

Heart Catheterization \_\_\_\_\_

Upper GI \_\_\_\_\_

Pulmonary Function Test \_\_\_\_\_

Echocardiogram \_\_\_\_\_

Upper Endoscopy \_\_\_\_\_

Lower GI \_\_\_\_\_

Sleep Study \_\_\_\_\_

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

*Patient Signature*

**Family History:**

In this section, please complete this chart to the best of your knowledge.

*If adopted and have no history of your biological family please place an X in the box*      Adopted

Family Member	Approximate Weight	Present Age	If Deceased, age of death	If Deceased, list the cause of death	List any medical problems (ex. heart disease, cancer, diabetes, hypertension, etc.)
1. Mother					
2. Father					
3. Maternal Grandmother					
4. Maternal Grandfather					
5. Paternal Grandmother					
6. Paternal Grandfather					
7. Brother(s)					
8. Sister(s)					

Please list any specific questions or concerns that you may have, so that Dr. Chebli can address them at your consultation.

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

*Patient Signature*

*Physician signature:*

*Date:*