SURGICAL WEIGHT LOSS
at University Medical Center

# Consultation Form

**Patient Name:** _____ **Date:** _____

**Please answer the following questions so that we can better meet your needs.**

## DEMOGRAPHICS

**Referring Physician:** _____ **Phone:** _____

**Practice Name:** _____

**Address:** _____

**Primary Care Physician:** _____ **Phone:** _____

**Practice Name:** _____

**Address:** _____

**Social Security#:** _____ **Date of Birth** *(mm/dd/yyyy)*: _____

**What is your current:** **Height***(feet, inches)*: _____ **Weight** *(lbs.)*: _____ **BMI:** _____ (office use)

**Duration of Obesity:** **years:** _____ **Maximum Weight:** _____ **lbs.** **Age:** _____ **years**

**Have you had any prior Gastric Surgery (e.g. gastric bypass)?** *(check one)* ☐ **YES** ☐ **NO**

**If "YES"** 1) **What was the procedure?** _____

2) **When was the procedure performed?**

## PERSONAL/SOCIAL HISTORY

**Occupation:** _____

**Tobacco Use:** ☐ **YES** ☐ **NO** *If "yes", specify frequency* _____

**Alcohol Use:** ☐ **YES** ☐ **NO** *If "yes", specify frequency* _____

**Marital Status** *(married/single)*: _____ **Number of Children:** _____

**Children Overweight:** ☐ **YES** ☐ **NO** **Family Support for Weight Loss:** ☐ **YES** ☐ **NO**

## EXERCISE HISTORY

| | MON | TUES | WED | THURS | FRI | SAT | SUN |
|---|---|---|---|---|---|---|---|
| **Average total hours per week of exercise:** _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |

**Exercise preferences** *(e.g., walking, running, tennis, swimming)*: _____

**Barriers to exercise** *(e.g., time, pain, fatigue, lack of interest)*: _____

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## DIET HISTORY

**Eating habits** *(Please fill in your typical dietary intake (all foods/beverages) in a 24-hour period)*:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____ Beverages: _____

Who buys the groceries? _____ How much do you spend a week on groceries? $ _____

Do you read food ingredient and/or nutrition labels? ☐ **YES** ☐ **NO**

How many restaurant meals per week? _____

List Specific Food Cravings: _____

_____

_____

**Emotional Eating** *(eating in response to stress/anxiety, anger…please specify):* _____

_____

| *(Please check "YES" or "NO")* | YES | NO |
|---|---|---|
| **Binge-Eating Disorder**: | | |
| Eat more food than others in a 2-hour period | ☐ | ☐ |
| Unable to stop eating or unable to control what or how much is eaten | ☐ | ☐ |
| Eat rapidly | ☐ | ☐ |
| Eat until stuffed | ☐ | ☐ |
| Eat when NOT hungry | ☐ | ☐ |
| Eat alone because embarrassed to eat amount in front of others | ☐ | ☐ |
| Other (candy) | ☐ | ☐ |
| Frequency (____ days/week) | ☐ | ☐ |
| **Compensatory Behavior** | | |
| Purge | ☐ | ☐ |
| Fast | ☐ | ☐ |
| Laxatives | ☐ | ☐ |
| Excessive exercise | ☐ | ☐ |
| Other (lays down) | ☐ | ☐ |

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**Prior Dieting Methods**: *Duration & total weight loss (*Please check off and fill in all the dieting methods you have tried.)*

| | Time on program *(months)* | Weight lost *(pounds)* | Weight loss maintained *(months)* |
|---|---|---|---|
| **Self-directed** | | | |
| ☐ Reducing portions | | | |
| ☐ Decreasing snacks | | | |
| ☐ Decrease sweets | | | |
| ☐ Exercise | | | |
| **Diets** | | | |
| ☐ Atkins | | | |
| ☐ Carbohydrates | | | |
| ☐ Cabbage Soup | | | |
| ☐ Other _____ | | | |
| **Group** | | | |
| ☐ Weight Watchers | | | |
| ☐ Overeaters | | | |
| ☐ Jenny Craig | | | |
| ☐ Other _____ | | | |
| **RX (Physician supervised medication)** | | | |
| ☐ Meridia | | | |
| ☐ Xenical | | | |
| ☐ Phen-fen | | | |
| ☐ Other _____ | | | |
| **Surgery** | | | |
| ☐ Stapling | NA | | |
| ☐ VBG | NA | | |
| ☐ Roux-N-Y | NA | | |
| ☐ Other | NA | | |
| **Other** | | | |
| ☐ SlimFast | | | |
| ☐ Other _____ | | | |
| ☐ Other _____ | | | |

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## MEDICAL HISTORY

| *Please check "YES" or "NO"* | YES | NO | Duration of frequency of disease |
|---|---|---|---|
| **Obesity-Related Diseases** | | | |
| Type II Diabetes | ☐ | ☐ | |
| Hypertension | ☐ | ☐ | |
| Joint Pains/Disability Level | ☐ | ☐ | |
| Heart Disease | ☐ | ☐ | |
| Stroke | ☐ | ☐ | |
| Asthma (COPD) | ☐ | ☐ | |
| Sleep Apnea | ☐ | ☐ | |
| GERD (heartburn) | ☐ | ☐ | |
| Hypertriglycerdemia | ☐ | ☐ | |
| Hypercholesterolemia | ☐ | ☐ | |
| Mentrual Irregularity | ☐ | ☐ | |
| **Past Medical History** | | | |
| Thyroid Disease | ☐ | ☐ | |
| Glaucoma | ☐ | ☐ | |
| Past Surgery: _____ | ☐ | ☐ | |
| Past Surgery #2 _____ | ☐ | ☐ | |
| Other: _____ | ☐ | ☐ | |
| Allergies | ☐ | ☐ | |
| **Family History** | | | |
| Obesity | ☐ | ☐ | |
| Hypertension | ☐ | ☐ | |
| Type II Diabetes | ☐ | ☐ | |
| Coronary Artery Disease | ☐ | ☐ | |
| Other: _____ | ☐ | ☐ | |

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**(please list all medications you are currently taking)**