CSA Commonwealth Surgical Associates
Tel: 781 279-1123
www.commonwealthsurgical.com

Initial Patient Assessment

Name:			**Date:**
Age:	**DOB:**	**Sex:**	**BMI:**
Height:	**Weight:**		

Enter the names of your doctors:

SPECIALTY	NAME	LOCATION	PHONE
Primary Care Physician			
Endocrinologist			
Gynecologist			
Cardiologist			
Pulmonologist			
Other			

REFERRAL SOURCE

HOW DID YOU LEARN ABOUT WEIGHT LOSS SURGERY AT COMMONWEALTH SURGICAL ASSOCIATES?

O Primary Care Physician O Friend _____ O INTERNET _____

Have you:
O attended an information seminar about obesity surgery?

Where: When:

O attended a support group meeting?

Where: When:

O viewed a video about Gastric Bypass surgery:
O surfed the internet to find out more about obesity surgery?

I HAVE BEEN LOOKING INTO WEIGHT LOSS SURGERY FOR _____ YEARS

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WEIGHT HISTORY

LIFE EVENT	AGE	WEIGHT	
Start of High School			
High School Graduation			
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:

DIETARY HISTORY

Approximate age when you first seriously dieted: _____

List diets and diet programs you have tried:

PROGRAM	DATE STARTED	DURATION	M.D. SUPERVISED YES/NO	MAXIMUM WEIGHT LOSS	AMOUNT REGAINED
Jenny Craig					
Nutri-Systems					
Opti/Media Fast					
Fen/Phen Redux					
Weight Watchers					
Meridia					
Xenical					
Lindora					
O. A.					
Acupuncture					
HMR					
ATKINS					
Ornish					
Dietician supervised					
Self-managed					
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**
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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WEIGHT RELATED ILLNESSES

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

ADULT: SERIOUS ILLNESSES AND HOSPITALIZATION

o Hepatitis o Blood Transfusion o AIDS/HIV Exposure
o Colitis / enteritis o Kidney Disease o Bleeding Abnormally
o Other o Cancer Type: _____

Date	Illness	Treatment

OPERATIONS AND SERIOUS INJURIES

Date	Operations / injury

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ALLERGIES

None o | 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)

MEDICATION | DOSE | FREQUENCY

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HERBAL/NUTRITIONAL SUPPLEMENTS

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

FAMILY HISTORY

(Living/deceased, age, illness or cause of death)

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

Is there a history of:	Obesity No o Yes o	Colon Cancer No o Yes o
Stomach Cancer No o Yes o	Heart Disease No o Yes o	Breast Cancer No o Yes o

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SOCIAL HISTORY

Single o Married o Divorced o Widowed o Other o

Children: _____

Occupation: _____

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

How many packs per day? _____

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

Use of Recreational Drugs:

No o Yes o Type: _____

Amount: _____

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

(Patient Signature/ Date)

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