Penn Medicine
Lancaster General Health

Healthy Weight Management & Bariatric Surgery

NEW PATIENT HEALTH ANALYSIS

Name: _____ DOB: _____ Date: _____

Which program are you interested in?
- ☐ Unsure
- ☐ Medical Weight Management (Non-surgical)
- ☐ Bariatric Surgery (See options below)
  - ☐ Roux-En-Y Gastric Bypass
  - ☐ Sleeve Gastrectomy
  - ☐ Other
  - ☐ Unsure

Please answer all of the questions below:

ALLERGIES

Yes	No	
☐	☐	Are you allergic to any medications? If yes, please list with the adverse reaction such as rash, hives, shortness of breath, or anaphylaxis:

_____

_____

CANCER		
Yes	No	
☐	☐	Have you ever been diagnosed with cancer other than skin cancer? If yes, what kind of cancer? _____ If yes, when were you diagnosed? _____
☐	☐	Are you currently being treated with chemotherapy or radiation?

ENDOCRINE		
Yes	No	
☐	☐	Do you currently have diabetes or prediabetes? (Circle one if applies)
☐	☐	Do you take medication for thyroid disease?
☐	☐	Have you used steroids for any medical problem(s) in the past year?
		If yes, why? _____

PULMONARY		
Yes	No	
☐	☐	Have you been under the care of a lung specialist (pulmonologist) in the last 2 years?
☐	☐	Do you get short of breath walking up a flight of steps, or walking a city block?
☐	☐	Do you have asthma?
☐	☐	Have you ever been diagnosed with sleep apnea?
		If yes, check one: ☐ Oral appliance ☐ CPAP ☐ BiPAP ☐ Nighttime oxygen ☐ Surgical treatment
☐	☐	Have you ever been diagnosed with COPD or emphysema?
☐	☐	Have you ever been diagnosed with sarcoidosis?

CARDIAC (HEART)		
Yes	No	
☐	☐	Have you been under the care of a heart specialist (cardiologist) in the last 5 years?
☐	☐	Do you have high blood pressure?
☐	☐	Do you currently have chest pain (angina)? Explain: _____
☐	☐	Have you ever had a heart attack?
☐	☐	Have you ever had a cardiac (heart) catheterization?
☐	☐	Have you ever had a heart treadmill or chemical stress test?
☐	☐	Have you ever been told that you have congestive heart failure?
☐	☐	Have you ever had blood clots in your legs (DVT)? Or lungs (Pulmonary Embolus)? (circle any that apply)
☐	☐	Have you ever had a stroke?
☐	☐	Have you ever been told that your cholesterol level was high?
☐	☐	Do you have persistent swelling (edema) in your lower legs?
☐	☐	Do you have skin discoloration of your lower legs?

HEENT/NEURO (HEAD)		
Yes	No	
☐	☐	Have you ever had a seizure?
☐	☐	Have you ever been diagnosed with multiple sclerosis (MS)?
☐	☐	Have you ever been diagnosed with pseudotumor cerebri?

GENITOURINARY (BLADDER/KIDNEY)		
Yes	No	
☐	☐	Have you ever been diagnosed with kidney disease?
☐	☐	Have you ever had a kidney stone?
☐	☐	Do you have leakage of urine with laughing/coughing/sneezing?

GASTROINTESTINAL (STOMACH/INTESTINES)		
Yes	No	
☐	☐	Have you been under the care of a GI specialist (gastroenterologist) in the past two years?
☐	☐	Do you suffer from difficulty having bowel movements (constipation)?
☐	☐	Do you have frequent loose stools (diarrhea)?
☐	☐	Have you ever had an upper endoscopy (EGD)?
☐	☐	Have you ever had a colonoscopy?
☐	☐	Do you suffer from heartburn (acid reflux)?
☐	☐	Have you ever had a stomach or duodenal ulcer?
☐	☐	Have you ever been diagnosed with irritable bowel syndrome?
☐	☐	Have you ever been diagnosed with Crohn's disease or ulcerative colitis?
☐	☐	Have you ever been diagnosed with fatty liver disease (NASH)?
☐	☐	Have you ever been diagnosed with celiac disease?
☐	☐	Have you ever been treated for pancreatitis?

MUSCULOSKELETAL (BONES/JOINTS/MUSCLES)		
Yes	No	
☐	☐	Are you currently under the care of an orthopedic surgeon or neurosurgeon?
☐	☐	Have you ever been diagnosed with gout?
☐	☐	Have you ever been diagnosed with scleroderma?
☐	☐	Have you ever been diagnosed with fibromyalgia?
☐	☐	Have you ever been diagnosed with lupus?
☐	☐	Have you ever been diagnosed with arthritis?

PSYCHOLOGICAL		
Yes	No	
☐	☐	Have you ever been or are you currently under the care of a psychologist or psychiatrist?
☐	☐	Have you ever been hospitalized for psychiatric reasons?

☐	☐	Have you ever been diagnosed with depression?
☐	☐	Have you ever been diagnosed with anxiety/panic attacks?
☐	☐	Have you ever been diagnosed with having a bipolar disorder?
☐	☐	Do you have a personal history of eating disorder? If so, please circle below Anorexia Bulimia Binge eating Purging Nighttime eating Other
FOR WOMEN ONLY		
Yes	No	
☐	☐	Are you currently pregnant?
☐	☐	Have you ever been diagnosed with gestational diabetes or pre-eclampsia while pregnant?
☐	☐	Are your periods irregular?
☐	☐	Are you currently ☐ going through or ☐ in menopause?
☐	☐	Are you currently using oral contraceptives?
☐	☐	Are you currently using any other form of contraception?
☐	☐	Have you ever been diagnosed with polycystic ovarian disease (PCOS)?
☐	☐	Have you had a Pap test done in the last two years?
☐	☐	Have you had a mammogram in the last two years?

SURGICAL HISTORY			
Please indicate if you have ever had any of the following types of surgery?			
☐	Anti-reflux procedure	☐	Orthopedic surgery
☐	Appendix removal (appendectomy)	☐	Peripheral vascular (blood vessels of arms & legs) procedures
☐	Bowel resection	☐	C-Section from pregnancy
☐	Breast surgery	☐	Tubal ligation
☐	Gallbladder removal (cholecystectomy)	☐	Hysterectomy
☐	Open heart surgery	☐	Previous bariatric surgery
☐	Other: _____		

FAMILY HISTORY

Please check the box(s) if there is a family history of:

☐	Obesity	☐	Heart disease	☐	Blood clotting or bleeding disorders
☐	Diabetes	☐	High blood pressure	☐	Pulmonary embolus (clot in lungs)
☐	High cholesterol	☐	Gastric cancer	☐	Asthma
☐	Breast cancer	☐	Colon cancer	☐	Lung disease
☐	Psychiatric disorder	☐	Malignant Hyperthermia (severe reaction to anesthesia)		

SUBSTANCE USE HISTORY

Yes	No	
☐	☐	Do you currently use tobacco products? If yes, please specify type: _____ How many packs per day? _____ How long have you used tobacco products? _____
☐	☐	Have you used tobacco products in the past? If you do not currently use tobacco products but have in the past, when did you quit? _____
☐	☐	Do you drink alcohol? If yes, how many drinks? _____ If yes, how often? _____
☐	☐	Do you, or have you ever, used illegal or street drugs?

SOCIAL HISTORY

***Family*:**

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed

Number and ages of children in household: _____

Are any other members of your household overweight? ☐ Yes ☐ No

If so, by how much is he or she overweight? _____

Occupation:

What is your occupation? _____

Please describe your work schedule/hours: _____

Would you describe your job activity as?

☐ Sedentary ☐ Light Activity ☐ Moderate Activity ☐ Heavy Activity

How long is your commute to work each way? _____

Does your job require overnight travel? ☐ Yes ☐ No

If yes, how often? _____

Do you have financial concerns at this time? _____

WEIGHT HISTORY

Height (no shoes): _____ Current weight: _____ Weight at age 20: _____

Weight 5 years ago: _____ Weight 1 year ago: _____ Highest adult weight: _____

Lowest adult weight: _____ Goal weight: _____

Over the past year has your weight: ☐ Increased ☐ Decreased ☐ Remained the same

Are there any life events you can attribute to weight gain?

☐ Schooling ☐ Relationship change ☐ Life stressor ☐ Change in activity level

☐ New medical condition or injury ☐ New medications

What is your main reason for your decision to lose weight? _____

_____

Are there any barriers or reasons that could prevent you from weight loss? _____

_____

DIET ATTEMPT HISTORY

Name of Diet	Year attempted	Length of diet	Amount lost	How long were you able to keep weight off?	Reason for discontinuing program?
Physician Supervised					
Dietitian Supervised					
Weight Watchers					
LA Weight Loss					
Jenny Craig					
Nutrisystem					
Medifast/Optifast					
Overeater's Anonymous					
Atkins Diet					
Medications (over the counter or prescribed)					
South Beach Diet					
Herbalife/Isagenix					
Other:					
Other:					
Other:					

PATIENTS INTERESTED IN BARIATRIC SURGERY:

Have you previously been enrolled in a bariatric surgery program? ☐ Yes ☐ NO

If yes, where? _____

Please explain reason for discontinuing program _____

_____

_____

CURRENT DIETARY BEHAVIORS

Would you rate your current nutrition knowledge as: ☐ Excellent ☐ Good ☐ Fair ☐Poor

Would you rate your current diet and eating habits as: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you currently follow a special diet? If yes, indicate below

☐ Vegan	☐ Vegetarian	☐ Gluten free
☐ Dairy free	☐ Low sodium	☐ Other:

Of the following, check all the items that you feel help explain or describe your eating habits:

☐ I eat high calorie foods	☐ I eat large amounts of food
☐ I eat sweets and snacks	☐ I eat too quickly
☐ I rely on convenience food	☐ I have uncontrollable binges
☐ I eat in reaction to stress and/or depression	☐ I use food as a reward
☐ I eat out of boredom	☐ I snack outside of meals
☐ I'm always hungry and never satisfied	☐ Lack of exercise
☐ Compulsive eating	☐ Using food as comfort
☐ Not paying attention to what I'm eating	☐ I eat late at night
☐ I forget to eat	☐ Other:

Would you describe your appetite as: ☐ Hearty ☐ Moderate ☐ Poor

Would you describe your portions as: ☐ Large ☐ Average ☐ Small

Does it typically take longer than 10 minutes to eat a meal? ☐ Yes ☐ No

Do you frequently go back for seconds? ☐ Yes ☐ No

What makes you stop eating?

☐ When my plate is empty ☐ When I feel satisfied ☐ When I feel overly full

☐ Other: _____

How many times a day do you eat? _____

Where do you eat your meals?

☐ Kitchen table ☐ In front of TV/Computer ☐ In the car ☐ At my desk ☐ Other: _____

Do you skip meals? ☐ Yes ☐ No

If so, which meal? ☐ Breakfast ☐ Lunch ☐ Dinner

Reason for skipping? _____

Do you snack outside of meals? ☐ Yes ☐ No

If yes, what do you eat? _____

When do you eat snacks? ☐ Between breakfast and lunch ☐ Between lunch and dinner

☐ After dinner ☐ No specific time, I snack throughout the entire day

I eat snacks because:

☐ I'm hungry ☐ I was told to eat snacks ☐ Habit

☐ I'm bored ☐ I'm stressed ☐ Other

Where do you eat snacks? _____

How many times a week do you eat out or take out? _____

Is it normally: ☐ Breakfast ☐ Lunch ☐ Dinner

What is the reason you are eating out?

☐ Social enjoyment ☐ Convenience ☐ Work obligations ☐ I dislike cooking

☐ Lack of energy ☐ Lack of preparation ☐ Other _____

What restaurants do you frequent? _____

Beverage Consumption History

How much and how often do you consume the following drinks?

☐ Water_____	☐ Soda _____	☐ Diet Soda _____
☐ Milk _____	☐ Fruit Juice _____	☐ Energy Drinks_____
☐ Iced Tea_____	☐ Hot Tea _____	☐ Coffee _____
☐ Gatorade _____	☐ Wine _____	☐ Liquor _____
☐ Beer _____	☐ Other: _____	☐ Other: _____

Food Preparation

Do you prepare or plan meals ahead of time? ☐ Yes ☐ No

Who plans meals? _____ Who prepares food? _____

Who shops for food and where do you shop for food?

_____

How is food usually prepared? ☐ Baked ☐ Broiled ☐ Grilled ☐ Fried ☐ Other:_____

Which of the following do you regularly use for cooking/seasoning foods?

☐ Oil ☐ Butter ☐ Margarine ☐ Cooking Spray ☐ Sauces

☐ Sugar ☐ Salt ☐ Sugar substitute ☐ Cream ☐ Other:_____

Food Preferences

What foods do you crave? _____

Is there any specific time which you have these cravings? _____

Are there foods you cannot eat? ☐ Yes ☐ No

If yes, what foods? _____

What happens when you eat this food? _____

Do you have any foods which you have a strong dislike for? _____

Are there any strong religious or cultural influences on your eating habits? ☐ Yes ☐ No

If yes, how do they affect your eating habits or diet? _____

_____

Exercise History

Have you ever participated in an exercise program? ☐ Yes ☐ No

If yes, please describe: _____

_____

Are you currently participating in an exercise program? ☐ Yes ☐ No

If yes, please describe: _____

_____

Do you have any medical or physical limitations which prevent you from exercising? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

What barriers interfere with exercising?

☐ Time	☐ Convenience	☐ Medical
☐ Motivation	☐ Financial	☐ Other:

How long can you walk continuously at any given time?

☐ Less than 10 minutes	☐ 30-60 minutes
☐ 10-20 minutes	☐ More than 60 minutes
☐ 20-30 minutes	

Medication Sheet

Instructions: Please list all prescription medications, vitamins, herbal supplements and any other over-the-counter medication you are taking (**PLEASE LIST EVERY PILL YOU TAKE**). You are welcome to bring in your medication/vitamin bottles at your first visit.

Name of medication/ Vitamin/ Over-the-counter pill	**Dosage in one pill?** This can be found on the pill bottle. *For example: 2.5 mg, 160 mg, etc.*	**Volume taken** *For example: one pill, ½ pill, 2 pills, etc.*	**How often do you take this pill?** *For example: once a day, twice a day, with each meal, before bedtime, etc.*	**What time do you take this medication?** *For example: 5:30 a.m., 10:00 p.m., etc.*

EPWORTH SLEEPINESS SCALE

This is a sleep apnea screening test. If you have already been diagnosed with sleep apnea, do not complete this form.

☐ I have already been diagnosed with sleep apnea.

How likely would you doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:

0=would never doze

1=slight chance of dozing

2=moderate chance of dozing

3=high chance of dozing

Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place like a theater or meeting	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (when you have had no alcohol)	0	1	2	3
In a car while stopped at traffic	0	1	2	3

TOTAL SCORE_____