



UPMC | University of Pittsburgh  
Medical Center

Weight Management Center

Office Use Only

Date received \_\_\_\_\_

BMI \_\_\_\_\_

Today's date \_\_\_\_\_

**Initial Evaluation Form** (All questions MUST be answered to assure a rapid evaluation. Use additional pages as needed.)

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Preferred number  Home  Work  Other \_\_\_\_\_

Occupation (Optional) \_\_\_\_\_

Social Security No. \_\_\_\_\_ E-mail address (Optional) \_\_\_\_\_

**Insurance Information**

Primary \_\_\_\_\_ Secondary \_\_\_\_\_

Primary care physician \_\_\_\_\_ Phone number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Have you been referred to the UPMC Weight Management Center?  Yes  No

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

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

Present weight \_\_\_\_\_ Present height \_\_\_\_\_

Gender  Male  Female

I would like more information about:  Nonsurgical weight loss  Surgical weight loss  Treatment for obesity related illness  
(Please check all that apply)

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

In your opinion, what contributes to your excess weight?

- Portion sizes
- Emotional eating
- Medications (Please list below)
- Eating too much fat and sugar
- Compulsive eating
- Nervous eating
- Stress eating
- Lack of exercise
- Lack of knowledge about healthful eating and exercise

Please describe any events you believe are related to your weight gain

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

**Weight loss history**

Has your primary care physician discussed weight loss options with you?  Yes  No  
If yes, what treatment was recommended? (Check all that apply)  Lifestyle  Medication  Surgery

**Lifestyle (Diet and exercise)**

Name of program	Year started	How long	Starting weight	Number of pounds lost	Length of time weight stayed off	How much weight regained

**Weight Loss Medications (Prescription, Over-the-counter, Herbal)**

Name of medication	Year started	How long	Starting weight	Number of pounds lost	Length of time weight stayed off	How much weight regained

Have you previously had surgery for weight loss?  Yes  No  
If yes, type of surgery, where and when \_\_\_\_\_

Have you had nutrition counseling?  Yes  No  
If yes, please describe \_\_\_\_\_

**Personal Medical History**

- Heart disease
- High blood pressure
- High cholesterol
- Sleep apnea
- Asthma
- Thyroid disorder
- Diabetes
- GI disorder
- Gout
- Arthritis
- Osteoporosis
- Urinary incontinence
- Polycystic ovarian syndrome
- Anemia
- Clotting/bleeding disorder
- Cancer
- Other \_\_\_\_\_

Are you currently on a diet for a medical reason?  Yes  No

Have you ever had surgery  Yes  No  
If yes, please list ALL surgical procedures and the approximate date \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you receiving any psychiatric/psychological services at this time?  Yes  No  
If yes, by whom \_\_\_\_\_

Are you currently being treated for depression?  Yes  No  
If yes, by whom \_\_\_\_\_

Have you ever been diagnosed with an eating disorder?  Yes  No  
If yes, please describe \_\_\_\_\_

**Current non weight loss medications and supplements**

Name	Dose	How often	Starting Date	Vitamin/Mineral (e.g. Multivitamin)	Over-the-counter (e.g. Aspirin)	Over-the-counter Herbal (e.g. St. John's Wort)
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list allergies to medications and your reaction

\_\_\_\_\_

**Family history**

	Age	Approx. height/weight	Significant illnesses	Deceased?	Age and cause of death
Mother					
Father					
Maternal grandmother					
Maternal grandfather					
Paternal grandmother					
Paternal grandfather					
Siblings					

Are you adopted?     Yes                       No

**Current lifestyle**

Please check the appropriate box:

Single                       Married                       Divorced                       Widow                       Significant other

Do you live alone?                       Yes                       No

Do you have children?                       Yes                       No                      If yes, please list ages \_\_\_\_\_

Do your children live at home?                       Yes                       No                       N/A

Is your family supportive of your weight loss?     Yes                       No

Do you smoke?                       Yes                       No

If yes, number of packs per day \_\_\_\_\_ number of years \_\_\_\_\_ when did you quit \_\_\_\_\_

Do you drink alcohol?                       Yes                       No

If yes, type of drink \_\_\_\_\_ how many drinks \_\_\_\_\_ how often \_\_\_\_\_

Do you currently use or have you ever used illicit drugs?     Yes                       No

If yes, please describe drug, method, and frequency of use (e.g., IV, smoke, snort, etc.) \_\_\_\_\_

Do you currently exercise regularly?                       Yes                       No

If yes, what exercise do you perform? \_\_\_\_\_

How many times a week? \_\_\_\_\_ How long do you exercise each time? \_\_\_\_\_

Do you feel sad most of the time?                       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

**How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?**

	No chance	Slight	Moderate	High
Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting inactive in a public place (e.g., a theater or in a meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**For Women**

What was the first day of your last menstrual period? \_\_\_\_\_

Is your cycle regular?  Yes  No  Postmenopausal  Hysterectomy

If no, please describe \_\_\_\_\_

Have you experienced any abnormal vaginal bleeding?  Yes  No

If yes, please describe \_\_\_\_\_

How many times have you been pregnant? \_\_\_\_\_ How many pregnancies have you delivered? \_\_\_\_\_

Do you use hormonal birth control?  Yes  No If so, what type? \_\_\_\_\_

Do you perform breast self-exams?  Yes  No

If yes, how often? \_\_\_\_\_

When was your last Pap smear? \_\_\_\_\_ When was your last mammogram? \_\_\_\_\_

The UPMC Weight Management Center provides a broad range of primary screening and tertiary treatments as well as consultations, second opinions, and triage. **Please answer all questions to facilitate treatment and return all pages as soon as possible to:**

Madelyn H. Fernstrom, PhD  
Director, UPMC Weight Management Center  
3811 O'Hara St., Suite 1617  
Pittsburgh, PA 15213-2582

412-246-6472  
<http://weightloss.upmc.com>

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**Please do not write below this line**

Assessment/Plan \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Office Notes \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_