Magee-Womens Hospital of UPMC

Division of Minimally Invasive
Bariatric and General Surgery

INITIAL EVALUATION FORM

(Please answer ALL questions before submitting)

PATIENT INFORMATION

For Office Use Only: _____ Date Received _____ BMI

Name: _____ Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Preferred Number: ☐ Home ☐ Work ☐ Other: _____

Email Address: _____

Employment Status: ☐ Full-time ☐ Part-time ☐ Unemployed Place of Employment: _____

Gender: ☐ Male ☐ Female

Race: ☐ Caucasian ☐ African-American ☐ Other _____

Weight: _____ Height: _____

Insurance Type: _____

1. How did you hear about our Magee-Womens Hospital bariatric program and/or Information Session?

   ☐ Newspaper ☐ Website ☐ Radio ☐ TV ☐ Family/Friend ☐ Physician ☐ Other: _____

2. How did you receive this Initial Evaluation Form?

   ☐ From attending an Information Session ☐ From accessing our official website

3. If you accessed this Initial Evaluation Form via our website, did you view the Online Video Session? ☐ Yes ☐ No

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Do you have a preference for a Surgeon? ☐ Yes ☐ No If so, please name: _____

Surgery of interest to you: ☐ Gastric bypass ☐ Lap-band ☐ Gastric Sleeve ☐ Other: _____ ☐ Undecided

Have you had previous surgery for weight loss? ☐ Yes ☐ No If yes, what type? _____

In your opinion, what contributes to your excess weight?

☐ Portion sizes	☐ Eating too much fat and sugar	☐ Stress eating
☐ Emotional eating	☐ Compulsive eating	☐ Lack of exercise
☐ Medications	☐ Nervous eating	☐ Lack of knowledge about healthful eating/exercise

Primary Care Physician Name: _____ Phone: _____

Has your Primary Care Physician discussed weight loss options with you? ☐ Yes ☐ No

If yes, what treatment was recommended (check all that apply): ☐ Lifestyle ☐ Surgery ☐ Medication

MEDICAL HISTORY:

☐ Heart disease	☐ Diabetes	☐ Heavy snoring
☐ High blood pressure	☐ Reflux	☐ Polycystic ovarian syndrome
☐ High cholesterol	☐ High cholesterol	☐ Clotting/bleeding disorder
☐ Sleep apnea	☐ Arthritis	☐ Cancer (last treatment date): _____
☐ Thyroid disorder	☐ Osteoporosis	☐ On dialysis
☐ Asthma	☐ Urinary	☐ On transplant list
☐ Anorexia and/or bulimia	☐ Incontinence	☐ Oxygen-dependent at home
☐ Wheelchair/scooter dependent	☐ Depression Anxiety	☐ Other _____

SURGICAL HISTORY (type of surgery and approximate date)

Procedure	Date

Current prescription and over-the counter medications

Name	Dose	How

If completing this form via our website, please return to:

Bariatric Surgical Coordinator
3380 Blvd. of the Allies
Pittsburgh, PA 15213
Phone: 412-641-3632
Fax: 412-641-3640

For Office Use Only – Please do not write below this line

Assessment: ☐ S ☐ HRM ☐ HRP ☐ MWL ☐ A ☐ REV ☐ BBMI

BMI: ☐ < 35 ☐ 35-39 ☐ > 70

Patient Contacted Date: _____ Name: _____

Reviewed By: _____ Date: _____

NAME _____

The Bariatric Surgery Program at Magee-Womens Hospital of UPMC is a leader in studying the impact and importance of weight loss surgery.

We conduct many interesting and informative studies with interested and able patients. If you wish to move forward in considering a surgical option and would like to be contacted to hear about voluntary participation in some or any of these studies, please answer "yes" below. Your care and progress toward surgery will NOT be affected by your answer.

May a representative from our program contact you to tell you about ongoing studies?

☐ **Yes** ☐ **No**