UPMC Hamot

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 the UPMC Hamot Bariatric Surgery and Weight Management Center 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

---

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:
UPMC Hamot Bariatric Surgery and Weight Management Center
300 State Street, Suite 400A
Erie, PA 16507
Phone: 814-877-6997
Fax: 814-877-6356

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: _____