Sentara Surgery Specialists

2280 Opitz Blvd., Suite 320
Woodbridge, VA 22191

2761 Jefferson Davis Hwy., Suite 207
Stafford, VA 22554

Name: _____ DOB: _____ Age: _____
Date: _____ MRN: _____

Weight Loss Surgery Follow-Up Data

Height _____ Weight _____LB WL _____ BMI _____ EBW _____ %EWL _____

How many meals per day do you eat?	On average, how long does it take you to eat a meal?
How many times a day do you snack?	How many 8 oz. glasses of water do you drink per day?
What is your usual portion size?	☐ ½ Cup ☐ ¾ Cup ☐ 1 Cup ☐ More than 1 Cup
Which Beverages do you drink daily?	☐ Coffee ☐ Tea ☐ Soda ☐ Diet Soda ☐ Fruit Juice ☐ Water ☐ Other
Do you take any of the following supplements on a regular basis?	☐ Iron ☐ Calcium ☐ B12 ☐ Multivitamin ☐ Other
What type of exercise do you perform on a regular basis?	How often do you exercise?
How often are you experiencing any of the following symptoms: ☐ Nausea _____ ☐ Night Cough _____ ☐ Reflux or heartburn _____ ☐ Pain when eating _____ ☐ Vomiting or regurgitation _____	
Have your comorbidities changed? Please use the following key: R= Resolved I= Improved U= Unchanged _____ Diabetes _____ High Blood Pressure _____ Sleep Apnea _____ GERD _____ Arthritis _____ Other	
Have any of your medications changed? ☐ Yes ☐ No If yes, please list changes: _____ _____ _____ _____ _____	

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Please place a check in the column below that best describes how often you eat the following foods:

Food	Daily	2-3/ wk	1/ wk	1-2/ mo	1-2/ yr	never
Meat (beef or pork)						
Poultry (chicken or turkey)						
Solid Fruit (e.g. apple)						
Raw or lightly steamed vegetables						
☐ Bread ☐ Rice						
Cooked Vegetables						
Casseroles						
Pasta						
Eggs						
Yogurt, dairy or cheese						
Fish						
Fried foods						
Crackers or chips						
Soups						
Ice cream						
Alcohol						

Initial Evaluation for Weight Loss Surgery

Employed: F/T – P/T – Self – Retired – Not Employed

Height _____ Present Weight _____

Referring Physician: _____

Primary Care Physician: _____

Medical History (Check all that apply)

☐ High Blood Pressure ☐ Diabetes ☐ High Cholesterol ☐ Arthritis ☐Hear Disease ☐ Snoring
☐ Acid Reflux/ Stomach Disorders [GERD] ☐ Thyroid Problem ☐ Ankle/ leg Swelling ☐ Depression
☐ Urinary Incontinence ☐ High Triglycerides ☐ Asthma ☐ Shortness of Breath ☐ Hiatal Hernia
☐ Other _____

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Record below major diets that resulted in a weight loss of 10 pounds or more. [Use additional pages as needed]

Year	Length of Diet	Starting Wt.	# of lbs. lost	Length of time weight stayed off	Type of diet program

At what age did you develop a significant weight problem? _____

Are there events that are related to your weight gain? If so, what are they?

_____

_____

_____

Are you receiving any medical or psychological services at this time? ☐ Yes ☐ No
(i.e. repeated doctor visits for the same problems)

Are you currently being treated or have you ever been treated for depression? ☐ Yes ☐ No

Do you have or have you been treated for an eating disorder? ☐ Yes ☐ No
(Anorexia, bulimia, binge-eating disorder, compulsive overeating)

Counseling Services (type of program) _____

Name of Psychiatrist or mental health provider _____

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Do you snore? ☐ Yes ☐ No

Do you ever wake at night gasping for breath? ☐ Yes ☐ No

Has anyone ever told you that you stop breathing while asleep? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No
If so, what type of exercise do you perform? _____
How many times a week do you exercise? _____
How long do you exercise each time? _____

In your opinion, what contributes to your excess weight?
☐ Portion sizes ☐ eating too much fat/sugar ☐ Nervous eating ☐ Lack of exercise ☐ Emotional eating ☐ Compulsive eating ☐ Stress ☐ Lack of knowledge about healthful eating and exercise

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Have you or one of your relatives/ spouse ever had bariatric surgery? ☐ Yes ☐ No
(Weight reduction surgery)

If yes, what relationship are they to you?
☐ Self ☐ Mother ☐ Father ☐ Spouse ☐ Brother ☐ Sister ☐ Other _____

If yes, what type of procedure was performed?
☐ Gastric Banding ☐ Roux-en-Y Gastric Bypass ☐ Distal Bypass ☐ Sleeve Gastrectomy ☐ don't know ☐ other _____

Allergy Information

Do you have any allergies to medication? ☐ Yes ☐ No
If so please list below

1. _____ What allergic reaction did you have? _____
2. _____ What allergic reaction did you have? _____
3. _____ What allergic reaction did you have? _____
4. _____ What allergic reaction did you have? _____

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Medical Health Information

1. Medications

Please list all prescribed and over-the-counter medications that you are currently using:

Medication Name	Dose	Times per day	Year per day	Year Started	Purpose

2. Pharmacy Information

Name of pharmacy _____
Phone Number _____

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3. Surgical Information

Type of Surgery	Year

Have you or a family member ever have any trouble with anesthesia? ☐ Yes ☐ No
If yes, please explain what occurred _____

4. Medical History

Please indicate if any of the following conditions have ever been significant problems for you. Please specify the year diagnosed and the physician who currently manages the problem.

Cardiac:

Coronary Artery Disease ☐ Yes ☐ No Year diagnosed _____ Physician _____
MI (heart attack) ☐ Yes ☐ No Year diagnosed _____ Physician _____
If yes, treatment _____
High Cholesterol/Triglyceride ☐ Yes ☐ No Year diagnosed _____ Physician _____
Chest Pain ☐ Yes ☐ No Year diagnosed _____ Physician _____
Congestive Heart Failure ☐ Yes ☐ No Year diagnosed _____ Physician _____
Valvular Heart Disease (mitral valve prolapse, mitral valve regurgitation, etc.)
☐ Yes ☐ No Year diagnosed _____ Physician _____
Rheumatic Fever ☐ Yes ☐ No Year diagnosed _____ Physician _____

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Heart Murmur ☐ Yes ☐ No Year diagnosed _____ Physician _____
Irregular heart beat ☐ Yes ☐ No Year diagnosed _____ Physician _____
High blood Pressure ☐ Yes ☐ No Year diagnosed _____ Physician _____

Pulmonary:

Asthma ☐ Yes ☐ No Year diagnosed _____ Physician _____
Pneumonia ☐ Yes ☐ No Year diagnosed _____ Physician _____
Bronchitis ☐ Yes ☐ No Year diagnosed _____ Physician _____
COPD (Emphysema) ☐ Yes ☐ No Year diagnosed _____ Physician _____
Tuberculosis ☐ Yes ☐ No Year diagnosed _____ Physician _____
Diagnosed Sleep Apnea ☐ Yes ☐ No Year diagnosed _____ Physician _____
If yes, treatment _____
Stop breathing while sleeping ☐ Yes ☐ No
Loud Snoring ☐ Yes ☐ No Gasping for Breath at Night ☐ Yes ☐ No
Family History of Sleep Apnea ☐ Yes ☐ No Family Member _____

Endocrine:

Diabetes Mellitus ☐ Yes ☐ No Year diagnosed _____ Physician _____
Are you currently on Insulin? ☐ Yes ☐ No
Hyperthyroid ☐ Yes ☐ No Year diagnosed _____ Physician _____
Hypothyroid ☐ Yes ☐ No Year diagnosed _____ Physician _____
Adrenal (Cushing's) ☐ Yes ☐ No Year diagnosed _____ Physician _____
Other _____ ☐ Yes ☐ No Year diagnosed _____ Physician _____

Gastrointestinal:

Reflux Disease (Heartburn) ☐ Yes ☐ No Year diagnosed _____ Physician _____
Peptic Ulcer Disease ☐ Yes ☐ No Year diagnosed _____ Physician _____
Gallbladder Disease ☐ Yes ☐ No Year diagnosed _____ Physician _____
Liver Disease ☐ Yes ☐ No Year diagnosed _____ Physician _____
If yes, describe condition _____
Inflammatory Bowel Disease (ex. Crohn's, Ulcer Colitis, etc.)
☐ Yes ☐ No Year diagnosed _____ Physician _____
Hiatal Hernia ☐ Yes ☐ No Year diagnosed _____ Physician _____
If yes, describe condition _____
Other _____ ☐ Yes ☐ No Year diagnosed _____ Physician _____

Cancer:

Type/Organ(s) Affected: _____ Treatment _____
Do you have a history of breast cancer? ☐ Yes ☐ No Year diagnosed _____ Physician _____

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Peripheral Vascular Disease:

Arterial Vascular Disease	☐ Yes ☐ No	Year diagnosed _____	Physician _____
Pulmonary Embolism	☐ Yes ☐ No	Year diagnosed _____	Physician _____
DVT (Phlebitis)	☐ Yes ☐ No	Year diagnosed _____	Physician _____
Superficial Phlebitis	☐ Yes ☐ No	Year diagnosed _____	Physician _____
Swelling legs, ankles	☐ Yes ☐ No	Year diagnosed _____	Physician _____
Leg Ulcers	☐ Yes ☐ No	Year diagnosed _____	Physician _____
Do you have any Ulcers currently?	☐ Yes ☐ No		
Varicose Veins	☐ Yes ☐ No	Year diagnosed _____	Physician _____

Renal:

Kidney Disease	☐ Yes ☐ No	Year diagnosed _____	Physician _____
Urinary Stress Incontinence ☐ Yes	☐ No	Year diagnosed _____	Physician _____
Kidney Stones	☐ Yes ☐ No	Year diagnosed _____	Physician _____

Obstetric/Gynecologic:

Have you ever been pregnant? ☐ Yes ☐ No
Please indicate the number of pregnancies to term _____
Please indicate the number of deliveries _____
Please indicate whether you are ☐ Pre-menopausal ☐ Post-menopausal
Menstrual cycles ☐ None ☐ Irregular
Polycystic Ovarian Syndrome or History ☐ Yes ☐ No

Musculoskeletal:

Lower back pain ☐ Yes ☐ No Year diagnosed _____ Physician _____
Osteoarthritis/ Degenerative Joint Disease
☐ Yes ☐ No Year diagnosed _____ Physician _____
If yes, joints involved: ☐ Neck ☐ Shoulders ☐ Back ☐ Hips ☐ Hands/ Wrist
☐ Knees ☐ Ankles ☐ Feet ☐ Heels
Painful Joints (without osteoarthritis/ DJD)
☐ Neck ☐ Shoulders ☐ Back ☐ Hips ☐ Hands/ Wrist
☐ Knees ☐ Ankles ☐ Feet ☐ Heels

Central Nervous System:

☐ Seizures ☐ Migraines ☐ Frequent Headaches ☐ Visual disturbances
☐ Hearing Impairments ☐ Numbness of extremities
Autoimmune disease (ex. Lupus, Rheumatoid Arthritis, Connective Tissue, etc.)
☐ Yes ☐ No Year diagnosed _____ Physician _____
Gout ☐ Yes ☐ No Year diagnosed _____ Physician _____
If yes, lists joints involved _____
Have you ever had any broken bones of the face? _____

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Have you ever had any broken bones of the back/ neck? _____

Blood Disorders:

Anemia ☐ Yes ☐ No Year diagnosed _____ Physician _____
If yes, type if known _____
Do you have or have you had any abnormalities with bleeding or clotting? ☐ Yes ☐ No
If yes, explain _____

Psychiatric Disorders:

Depression ☐ Yes ☐ No
Bipolar Disorder ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No
Schizophrenia ☐ Yes ☐ No
Eating Disorder ☐ Yes ☐ No
Other _____
If yes to any of the above, please explain _____
Are you currently receiving therapy or medications? ☐ Yes ☐ No
Have you ever been hospitalized for the above conditions? ☐ Yes ☐ No

Other Medical Disorders:

_____
_____
_____
_____
_____

Social / Other History

Please complete the following questions regarding your social, personal and family history.

1. Personal Information

Occupation _____

☐ Full- Time ☐ Part Time ☐ Temporary ☐ Retired ☐ Disability- indicate cause _____

Highest grade or level of education

☐ 9 to 11 years ☐ High School Graduate ☐ Vocational/Technical Training ☐ Attending College
☐ College Graduate ☐ Graduate Degree

Religious affiliation (Optional)

☐ Atheist ☐ Catholic ☐ Jehovah Witness ☐ Jewish ☐ Methodist ☐ Presbyterian ☐ Other

Do you have any children? ☐ Yes ☐ No If yes, how many? _____ What are their ages? _____

2. Smoking/ Drug/ Alcohol History

Do you currently use tobacco? ☐ Yes ☐ No Have you ever used tobacco? ☐ Yes ☐ No

If you answered yes to the above questions:

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What type of tobacco did you use? ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chew/ Snuff
What age did you start tobacco use? _____
How many years have you used tobacco? _____
How much do/ did you usually smoke per day?
☐ ½ pack or less ☐ between 1 to 1 ½ packs ☐ between 1/1/2 to 2 packs ☐ 2 ½ packs +
If applicable, what age did you quit smoking? _____
Do you currently drink alcohol? ☐ Yes ☐ No
If you answered yes to the above question:
What type(s) of alcohol are you drinking ☐ Wine ☐ Beer ☐ Mixed Drinks ☐ Other _____
Please indicate how many drinks you currently drink.
☐ 1-2 month ☐ 3-4 month ☐ 5-6 month ☐ 7-9 month ☐ 10 month ☐ Other _____
Have you been treated for an alcohol problem? ☐ Yes ☐ No
Have you ever used any illicit drugs? (ex. Marijuana, Cocaine, Heroin, Amphetamine, etc.) ☐ Yes ☐ No
If yes, please indicate what _____
How long ago? ☐ 6 months or less ☐ 6 months – 1 year ☐ More than 1 year

3. Family History

In this section, please complete this chart to the best of your knowledge. If adopted and have no history of your biological family please place an X in the box ☐ Adopted

Family History	
Check the box if any blood relatives have had:	Medical information about your biological family (i.e., ages, medical conditions, types of cancer, etc.):
☐ Colon Cancer/ Polyps ☐ Crohns Disease, Ulcerative Colitis ☐ Liver Disease or Hepatitis ☐ Pancreatic Cancer ☐ Gall Bladder Disease ☐ Stomach or Esophagus Cancer ☐ Diabetes ☐ Coronary Artery Disease	Father: Mother: Siblings: Children: Paternal Grandparents:

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	Maternal Grandparents:

4. Previous Diagnostic Procedures

Please list any laboratory diagnostic procedures within the last year. Please indicate what month they were performed.

☐ EKG _____ ☐ Echocardiogram _____ ☐ Stress Test _____
☐ Heart Catheterization _____ ☐ Upper GI _____ ☐ Lower GI _____
☐ Upper Endoscopy_____ ☐ Abdominal Sonogram _____ ☐ Colonoscopy _____
☐ Sleep Study _____ ☐ Pulmonary Function Test _____ ☐ Chest X-ray _____
☐ CT Scan (body area) _____ ☐ Other _____

Please list any specific question(s) that you may have about your surgical procedures in order that our doctors may become aware of your concerns prior to your appointment with them.

_____
_____
_____
_____
_____
_____
_____
_____