

of University of Pittsburgh Medical Center

Division of Minimally Invasive Bariatric and General Surgery

Anita Courcoulas, MD Giselle Hamad, MD Carol McCloskey, MD Ramesh Ramanathan, MD

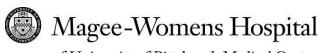
For Office Use Only
Date Received
BMI

in the interest of the control of th	INITIAL EVALUATION FORM	(Please answer ALL o	questions before	submitting
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Primary Care Physician Name \_\_\_\_\_

Name		Date	of Birth	Age	
Address					
City		State		Zip	
Home Phone		Wor	k Phone		
Preferred Number O Hom	ne O Work O	Other			
Social Security No		Email Addr	ess		
Employment Status: O Full	l-time O Part-time	O Unemployed	Place of Employ	ment	
	O Female O African-American	O Other			
Weight Hei	ght				
Insurance Type		Ins	urance ID#		
<ul><li>2) How did you receive this</li><li>O From attending an In</li><li>3) If you accessed this Initial</li></ul>	nformation Session	O From acces	ssing our officia		O Yes O No
Do you have a preference fo	or a Surgeon?	O Yes O No	If so, please	name?	
Surgery of interest to you:	O Gastric bypass	O Lap-band	O Other _		O Undecided
Have you had previous surg	gery for weight loss?	O Yes O No	If yes, what	type?	
In your opinion, what contr	ibutes to your excess	weight?			
O Portion sizes O Emotional eating O Medications	O Eating too muo O Compulsive ea O Nervous eating	ting	O Stress eatin O Lack of ex O Lack of kn	ercise	Ithful eating/exercis

Phone \_



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Name	 
Date of Birth	

Has your Primary Care Physician discusse	d weight loss options with you	? O Yes O No	
f yes, what treatment was recommended (	check all that apply): O Li	ifestyle O Surgery O Mo	edication
MEDICAL HISTORY			
O Heart disease O High blood pressure O High cholesterol O Sleep apnea O Thyroid disorder O Asthma O Anorexia and/or bulimia O Wheelchair/scooter dependent	O Diabetes O Reflux O Stomach ulcer O Arthritis O Osteoporosis O Urinary incontinence O Depression O Anxiety	O Heavy snoring O Polycystic ovarian syndrome O Clotting/bleeding disorder O Cancer (last treatment date)- O On dialysis O On transplant list O Oxygen-dependent at home O Other	
SURGICAL HISTORY (type of surgery and ap Procedure	oproximate date)  Date		
rocedure	Date		
Current prescription and over-the counter med	lications		
	Dose	How Often?	
If completing this form via our website, please Bariatric Surgical Coordinator B380 Blvd. of the Allies Pittsburgh, PA 15213 Phone: 412-641-3744 Fax: 412-641-3640  For Office Use Only – Please do not write belo			
Assessment: OS OHRM OHR		EV O BBMI	
<u>BMI</u> : O < 35 O 35-39 O >	> 70		
Patient Contacted Date	<u> </u>	Name	
Reviewed By	·	Date	

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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 considerir a surgical option and would like to be contacted to hear about voluntary participation in some or any of these studies, please answ "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?
O Yes O No