

# UPMC Jameson

## INITIAL EVALUATION FORM

(Please answer ALL questions before submitting)

Form XXX-XXXX-XXXX

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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 Jameson Minimally Invasive Bariatric Surgery 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

Surgery of interest to you:  Gastric bypass  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?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Portion sizes    | <input type="checkbox"/> Eating too much fat and sugar | <input type="checkbox"/> Stress eating                                     |
| <input type="checkbox"/> Emotional eating | <input type="checkbox"/> Compulsive eating             | <input type="checkbox"/> Lack of exercise                                  |
| <input type="checkbox"/> Medications      | <input type="checkbox"/> Nervous eating                | <input type="checkbox"/> 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:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Heart disease                | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Heavy snoring                       |
| <input type="checkbox"/> High blood pressure          | <input type="checkbox"/> Reflux             | <input type="checkbox"/> Polycystic ovarian syndrome         |
| <input type="checkbox"/> High cholesterol             | <input type="checkbox"/> High cholesterol   | <input type="checkbox"/> Clotting/bleeding disorder          |
| <input type="checkbox"/> Sleep apnea                  | <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Cancer (last treatment date): _____ |
| <input type="checkbox"/> Thyroid disorder             | <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> On dialysis                         |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Urinary            | <input type="checkbox"/> On transplant list                  |
| <input type="checkbox"/> Anorexia and/or bulimia      | <input type="checkbox"/> Incontinence       | <input type="checkbox"/> Oxygen-dependent at home            |
| <input type="checkbox"/> Wheelchair/scooter dependent | <input type="checkbox"/> Depression Anxiety | <input type="checkbox"/> 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 Jameson Minimally Invasive Bariatric Surgery Center  
26 Nesbitt Road, Suite 151  
New Castle, PA 16105  
Phone: 724-546-2502  
Fax: 724-588-8275

**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: \_\_\_\_\_