



PIONEER VALLEY SURGICAL ASSOCIATES, P.C.

BARIATRIC SURGERY PROGRAM

Intake Form

PLEASE NOTE:

TO AVOID RESCHEDULING OF YOUR APPOINTMENT, PLEASE COMPLETE THIS FORM PRIOR TO YOUR SCHEDULED APPOINTMENT DATE FOR REVIEW BY OUR SURGEON DURING YOUR FIRST CONSULTATION VISIT.

NAME: _____
FIRST MIDDLE LAST

DATE OF BIRTH: _____

DATE: _____

PLEASE LIST ANY ALLERGIES TO:

FOOD

MEDICATIONS



| PAST SURGERIES | |
|-----------------|------|
| TYPE OF SURGERY | DATE |
| | |
| | |
| | |
| | |
| | |

ADDITIONAL HEALTH HISTORY COMMENTS:

FAMILY HISTORY

*Do any of the following diseases run in your family (parents, sisters, brothers) *please indicate who is affected.*

| CHECK IF YES | PROBLEM | FAMILY MEMBER(S) AFFECTED |
|--------------------------|---|---------------------------|
| <input type="checkbox"/> | <i>Breast Cancer</i> | |
| <input type="checkbox"/> | <i>Diabetes</i> | |
| <input type="checkbox"/> | <i>Early heart attacks before the age of 60</i> | |
| <input type="checkbox"/> | <i>High Blood Pressure</i> | |
| <input type="checkbox"/> | <i>Obesity</i> | |
| <input type="checkbox"/> | <i>Thyroid Problems</i> | |
| <input type="checkbox"/> | <i>Other diseases that run in family</i> | |



WEIGHT HISTORY

HEIGHT: _____ CURRENT WEIGHT: _____

WEIGHT AT THE END OF HIGH SCHOOL: _____

LOWEST ADULT WEIGHT: _____ HIGHEST ADULT WEIGHT: _____

When did you begin to have problems with your weight?

Can you relate your weight gain to any particular factors in your life (ie: pregnancy, quitting smoking, life stress)?

Have you tried exercise to lose weight? YES NO
If yes, what type and when?



NAME: _____

DATE: _____

DATE OF BIRTH: _____

| DIETARY HISTORY | | | |
|---|-------------|---------------|----------------|
| TYPE OF DIET | WEIGHT LOST | WEIGHT GAINED | DATES/DURATION |
| <input type="checkbox"/> <i>Atkin's</i> | | | |
| <input type="checkbox"/> <i>Curves</i> | | | |
| <input type="checkbox"/> <i>Healthy Solutions</i> | | | |
| <input type="checkbox"/> <i>Jenny Craig</i> | | | |
| <input type="checkbox"/> <i>Medi-Fast</i> | | | |
| <input type="checkbox"/> <i>New Direction</i> | | | |
| <input type="checkbox"/> <i>Nutri System</i> | | | |
| <input type="checkbox"/> <i>Opti-Fast</i> | | | |
| <input type="checkbox"/> <i>Over Eaters Anonymous</i> | | | |
| <input type="checkbox"/> <i>Richard Simmons</i> | | | |
| <input type="checkbox"/> <i>Shape Up America</i> | | | |
| <input type="checkbox"/> <i>Slim Fast</i> | | | |
| <input type="checkbox"/> <i>The Solution</i> | | | |
| <input type="checkbox"/> <i>The Zone</i> | | | |
| <input type="checkbox"/> <i>Weight Watchers</i> | | | |
| <input type="checkbox"/> <i>Other</i> | | | |

| ANTI-OBESITY DRUGS | | |
|--|-------------|----------------|
| NAME | WEIGHT LOST | DATES/DURATION |
| <input type="checkbox"/> <i>Amphetamines (prescribed by physician)</i> | | |
| <input type="checkbox"/> <i>Anti-depressants used for weight loss</i> | | |
| <input type="checkbox"/> <i>Appetite suppressants (Dexatrim, Trim Spa)</i> | | |
| <input type="checkbox"/> <i>Meridia</i> | | |
| <input type="checkbox"/> <i>Phen-Fen</i> | | |
| <input type="checkbox"/> <i>Redux</i> | | |
| <input type="checkbox"/> <i>Xenical</i> | | |
| <input type="checkbox"/> <i>Other</i> | | |

**If you were on Phen-Fen or Redux, have you had an EKG done to check your heart valves?*

 YES

 NO



Do you drink alcohol? YES NO

If yes, how often? DAILY WEEKLY SELDOM NEVER

Have you ever had a problem with alcohol? YES NO

If yes, please explain.

Do you own a computer or have access to a computer? YES NO

E-MAIL ADDRESS: _____@_____

Do you have any family or friends that have had gastric by-pass/gastric lap-band surgery?

(PLEASE CIRCLE ONE)

YES

NO

Relationship to patient _____

Where the expectations of the gastric by-pass/gastric lap-band surgery met? YES NO

Please explain.

SIGNATURE

DATE: _____

BARIATRIC TEAM MEMBER SIGNATURE

DATE: _____