MERCYONE℠

Cedar Falls Weight Loss Center & Bariatric Surgery
515 College Street Suite 2800
Cedar Falls, IA 50613

New Patient Intake Form (Bariatrics)

Please provide your demographic information below:

Patient Name _____

Preferred Name _____

Social Security Number _____ Age _____

Date of Birth _____ Sex _____

Preferred Phone _____ Alt Phone _____

Patient Address _____

City _____ State _____ ZIP Code _____

Email Address _____

Reason for No Email Address _____

Primary Care Provider _____

Primary Insurance _____ Secondary Insurance _____

Primary Member # _____ Secondary Member # _____

Primary Group # _____ Secondary Group # _____

Primary Policy Holder _____ Secondary Policy Holder _____

Policy Holder DOB _____ Policy Holder DOB _____

Relationship to Policy Holder _____ Relationship to Policy Holder _____

Guarantor Name _____ Relationship _____ Guarantor DOB _____

Emergency Contact _____ Relationship _____

Home Phone _____ Cell _____ Work _____

Patient's Race _____ Patient's Ethnicity _____

Preferred Language _____ Patient's Religion _____

How did you hear about our program?

☐ Referral from Doctor ☐ Referral from Friend ☐ Facebook ☐ Billboard ☐ Other _____

New Patient Medical History (Bariatrics)

Patient Name _____ Date _____ Date of Birth _____

Please complete the questionnaire carefully and make your best guess when unsure of the answer. Please allow about 30 minutes to complete this questionnaire. Your answers will help us create your treatment plan. This information will become part of your medical record at MercyOne Northeast Iowa and may be shared with members of your treatment team. Thank you for taking the time to complete this questionnaire.

Referring Physician _____ Phone _____

Practice Name _____ Address _____

Primary Care Physician _____ Phone _____

Practice Name _____ Address _____

Other Providers _____ Phone _____

Practice Name _____ Address _____

Other Providers _____ Phone _____

Practice Name _____ Address _____

What is your current: Height (feet, inches) _____ Weight (lbs.) _____ Duration of Obesity _____ years

What has been your highest weight after age 21? ..... Weight _____ Age _____

What has been your lowest weight (not from illness) after age 21? ..... Weight _____ Age _____

If you have had any previous surgeries, please list below:

Surgery 1 _____ Date _____

Surgery 2 _____ Date _____

Surgery 3 _____ Date _____

Have you had any previous gastric surgery (i.e., gastric bypass)? ..... ☐ Yes ☐ No

If "Yes": 1) What was the procedure? _____

2) When was the procedure performed? _____

ALLERGIES

List any allergies and intolerances to medications, food or the environment.

Allergy:	Reaction:

☐ No Known Allergies

Patient Name _____ Date _____ Date of Birth_____

MEDICATIONS

List any medications you are taking, with the dose and how often. Use the back of form for additional medications.

Medication Name	Dose	How Often?	Reason for Taking?

☐ Not Taking Any Medications

List any Vitamins, Supplements and Over-the-Counter Medications

1.	4.
2.	5.
3.	6.

PERSONAL / SOCIAL HISTORY

Occupation _____ Gender Identity (optional) _____

Home many people live in your home? _____ Marital Status (married/single) _____

Number of Children _____ Children Overweight..... ☐ Yes ☐ No

Family Support for Weight Loss ... ☐ Yes ☐ No Assistance Needed with Transportation.. ☐ Yes ☐ No

Highest Year of School Completed:

Middle School			High School				College					
❑ 6	❑ 7	❑ 8	❑ 9	❑ 10	❑ 11	❑ 12	❑ 13	❑ 14	❑ 15	❑ 16	❑ Masters	❑ Docturate

Preferred Learning Method: ☐ Handouts ☐ Discussion ☐ Pictures ☐ Practice

Tobacco Use ☐ Yes ☐ No *If "yes," specify frequency* _____

E-Cigarette ☐ Yes ☐ No *If "yes," does it contain nicotine?* _____

Alcohol Use ☐ Yes ☐ No *If "yes," specify frequency* _____

Illegal Substances ☐ Yes ☐ No *If "yes," specify frequency* _____

Medical Marijuana ☐ Yes ☐ No *If "yes," specify frequency* _____

Patient Name _____ Date _____ Date of Birth_____

EXERCISE HISTORY

Exercise preferences (i.e., walking, running, tennis, swimming): _____

Average total minutes per day of exercise (physical activity listed above):

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun

Barriers to exercise (time, pain, fatigue, lack of interest: _____

How many hours of TV do you watch a day during the week? _____

How many hours of TV do you watch a day during the weekend? _____

How many hours of other screen time (computer, video games, phone) do you spend a day? _____

Have you had a weight related injury?..... ☐ Yes ☐ No

If yes, please describe _____

Can you walk unassisted?..... ☐ Yes ☐ No
If no, what do you use for assistance? _____

DIET HISTORY

Eating Habits *(Please fill in your typical intake including all food and beverages in a 24-hour period)*:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____ *Beverages* _____

How many meals do you eat a day? _____ How many snacks do you eat a day?_____

Who does the cooking in your home? _____ Who buys the groceries? _____

How many times do you get food from restaurants/fast/food/gas stations per week? _____

Do you feel you have any episodes of binge eating or emotional eating? ..... ☐ Yes ☐ No

Do you feel comfortable reading ingredient and/or nutrition labels? ..... ☐ Yes ☐ No

Patient Name _____ Date _____ Date of Birth_____

WEIGHT LOSS HISTORY

Please record your must successful weight loss attempts (diet, exercise, medication, etc.)

Method Used to Lose Weight	Age at Time of Effort	Weight at Start of Effort	# lbs. Lost
a.			
b.			
c.			
d.			
e.			

If you have tried to lose weight more than 5 times, please indicate what else you have tried below:

Self-directed	Group	Diets
☐ Reduced Portions and Snacks	☐ Weight Watchers	☐ Atkins
☐ Calorie Counting	☐ Overeaters	☐ Low Carbohydrate/Keto
☐ Decreasing Sweets	☐ Jenny Craig	☐ Intermittent Fasting
☐ Avoiding Certain Foods	☐ Other: _____	☐ Noom
☐ Exercise		☐ Whole 30
☐ Other _____		
Prescription Medication	**Surgery**	**Commercial Programs**
☐ Phen-fen	☐ Gastric Sleeve	☐ Beach Body
☐ Phentermine	☐ Roux-N-Y	☐ Slimfast
☐ Meridia	☐ Adjustable Gastric Band	☐ Optavia
☐ Xenical	☐ Vertical Banded Gastroplasty	☐ Nutrisystem
☐ Orlistat	☐ Doudenal Switch	☐ Profile by Sanford
☐ Contrave	☐ Other: _____	☐ Other: _____
☐ Wegovy		
☐ Other: _____		

Patient Name _____ Date _____ Date of Birth_____

PSYCHOLOGICAL FACTORS

How stressful has your life been during the past 6 months? (check one)

- ☐ Much Less Stressful than Usual
- ☐ Less Stressful than Usual
- ☐ Average Level of Stressed
- ☐ More Stressful than Usual
- ☐ Much More Stressful than Usual
- ☐ Unsure/Prefer Not to Answer

Please indicate if you are currently experiencing any greaterthan usual stress in your life related to:

a. Work ..... ☐ Yes ☐ No
b. Health ..... ☐ Yes ☐ No
c. Relationship with Significant Other ..... ☐ Yes ☐ No
d. Activities Related to Your Children..... ☐ Yes ☐ No
e. Activities Related to Your Parents..... ☐ Yes ☐ No
f. Legal/Financial Concerns ..... ☐ Yes ☐ No
g. School ..... ☐ Yes ☐ No
h. Moving ..... ☐ Yes ☐ No
i. Other: _____ ☐ Yes ☐ No

Please explain in a sentence any items to which you responded yes:

How stressful do you think that your life will be in the next 6 months excluding your efforts to lose weight?

Pick a number from 1-5, 1 = much less stressful than usual and 5 = much more stressful than usual._____

Have you ever had any problems with depression, anxiety, or an eating disorder?..... ☐ Yes ☐ No

Have you had an inpatient psychiatric admission in the past 2 years? ..... ☐ Yes ☐ No

If yes, where and when was your psychiatric admission? _____

Patient Name _____ Date _____ Date of Birth _____

MEDICAL HISTORY

Obesity-Related Diseases	YES	NO	Onset, Duration / Please Explain
Type II Diabetes	☐	☐	
Complications of Diabetes (kidney disease, retinal disease, peripheral neuropathy, etc.)	☐	☐	
Hypertension (high blood pressure)	☐	☐	
Joint Pain/Disability Level	☐	☐	
Heart Disease	☐	☐	
Stroke	☐	☐	
Asthma	☐	☐	
COPD	☐	☐	
Sleep Apnea (diagnosed by doctor)	☐	☐	
GERD (heartburn)	☐	☐	
Elevated Cholesterol/Triglycerides	☐	☐	
Menstrual Irregularity	☐	☐	
Depression/Anxiety (being treated)	☐	☐	
DVT/Pulmonary Embolism	☐	☐	
Fatty Liver Disease	☐	☐	
Polycystic Ovarian Syndrome	☐	☐	
Other	☐	☐	
Past Medical History			
Glaucoma	☐	☐	
Cancer	☐	☐	
Thyroid Disease	☐	☐	
Type I Diabetes	☐	☐	

Women:

When was your last mammogram? Date: _____

When was your last Pap smear? Date: _____

Have you ever had a colonoscopy? ☐ ☐ Date: _____

Have you ever had an endoscopy? ☐ ☐ Date: _____

Men:

Have you had a prostate exam? ☐ ☐ _____

Have you ever had a colonoscopy? ☐ ☐ Date: _____

Have you ever had an endoscopy? ☐ ☐ Date: _____

Family History – please explain whom (mom, dad, siblings)

Obesity ☐ ☐ _____

Hypertension ☐ ☐ _____

Type II Diabetes ☐ ☐ _____

Coronary Artery Disease ☐ ☐ _____

DVT/Pulmonary Embolism ☐ ☐ _____

Other: _____ ☐ ☐ _____

Patient Name _____ Date _____ Date of Birth_____

REVIEW OF SYSTEMS

In the last 30 days, have you experienced any of the following:

CONSTITUTIONAL	Yes	No
Chills	☐	☐
Fatigue/Weakness	☐	☐
Fever	☐	☐
Night Sweats	☐	☐
Weight Gain	☐	☐
Weight Loss	☐	☐
HEENT		
Headaches	☐	☐
Blurred/Double Vision	☐	☐
Eye Drainage	☐	☐
Eye Pain	☐	☐
Vision Loss/Changes	☐	☐
Ear Pain	☐	☐
Ear Drainage	☐	☐
Hearing Loss	☐	☐
Buzzing/Ringing in Ear	☐	☐
Sinus Problems	☐	☐
Nasal Drainage	☐	☐
Difficulty Swallowing	☐	☐
Sore Throat/Hoarse	☐	☐
RESPIRATORY		
COUGH	☐	☐
Shortness of Breath	☐	☐
TB Exposure	☐	☐
Wheezing	☐	☐
CARDIOVASCULAR		
Chest Pain	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Palpitations	☐	☐
Calf Pain When Walking	☐	☐
Leg Swelling	☐	☐
Feeling Cold or Numbness in Extremities	☐	☐
Pain in Arms	☐	☐
METABOLIC/ENDOCRINE		

	Yes	No
Cold Tolerance	☐	☐
Heat Tolerance	☐	☐
Excessive Hunger	☐	☐
Excessive Thirst	☐	☐
Hair Loss	☐	☐
Brittle Hair	☐	☐
Brittle Nails	☐	☐
GENITOURINARY		
Frequent Urination	☐	☐
Urinary Incontinence	☐	☐
Pain with Urination	☐	☐
Blood in Urine	☐	☐
Trouble Starting Urine	☐	☐
Trouble Stopping Urine	☐	☐
Female		
Heavy Periods	☐	☐
Painful Periods	☐	☐
Vaginal Discharge	☐	☐
Pain with Intercourse	☐	☐
Male		
Penile Discharge	☐	☐
Painful Erection	☐	☐
HEMATOLOGIC		
Bleeding Tendencies	☐	☐
Blood Clots	☐	☐
Easy Bruising	☐	☐
GASTROINTESTINAL		
Abdominal Pain	☐	☐
Black Tarry Stools	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Heartburn./GERD	☐	☐
Loss of Appetite	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Pain with Bowel Movement	☐	☐
NEUROLOGICAL		

	Yes	No
Difficulty Walking	☐	☐
Dizziness	☐	☐
Poor Coordination	☐	☐
Memory Loss	☐	☐
Seizures	☐	☐
Tremors	☐	☐
Falls	☐	☐
MUSCULOSKELETAL		
Back Pain	☐	☐
Neck Pain	☐	☐
Foot/Ankle Pain	☐	☐
Neuropathy of Feet	☐	☐
Knee Pain	☐	☐
Hip Pain	☐	☐
Joint Pain	☐	☐
Joint Swelling	☐	☐
Muscle Weakness	☐	☐
IMMUNOLOGICAL		
Environmental Allergies	☐	☐
Food Allergies	☐	☐
Seasonal Allergies	☐	☐
SKIN		
Contact Allergy	☐	☐
Itchy Skin	☐	☐
Poor Wound Healing	☐	☐
Rash	☐	☐
Skin Infections/Sores	☐	☐
PSYCHIATRIC		
Anxiety	☐	☐
Depression	☐	☐
Panic Attacks	☐	☐
Insomnia	☐	☐

Patient Name _____ Date _____ Date of Birth_____

EPWORTH SLEEPINESS SCALE

0 points = Would never fall asleep
1 point = Slight chance of falling asleep
2 points = Moderate chance of falling asleep
3 points = High change of falling asleep

SITUATION	0	1	2	3
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting, inactive in a public place (movie theater, meeting, etc.)	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting down and talking to someone	☐	☐	☐	☐
Sitting quietly after lunch	☐	☐	☐	☐
In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐
Totals:				
	TOTAL:			

Patient Name_____ Date _____ Date of Birth_____

EATING PATHOLOGY SYMPTOMS INVENTORY (EPSI)

Below is a list of experiences and problems that people sometimes have. Read each item to detrmine how well it describes your recent experiences. Then select the option that best describes how frequently each statement applied to you during the past four weeks including today. Your answers will be used to help create your weight loss plain. Use this scale when answering questions:

0	1	2	3	4
Never	Rarely	Sometimes	Often	Very Often

	0	1	2	3	4
1. I do not like how clothes fit the shape of my body	☐	☐	☐	☐	☐
2. I tried to exclude “unhealthy” foods from my diet	☐	☐	☐	☐	☐
3. I ate when I was not hungry	☐	☐	☐	☐	☐
4. People told me that I do not eat very much	☐	☐	☐	☐	☐
5. I felt that I needed to exercise nearly every day	☐	☐	☐	☐	☐
6. People would be surprised if they knew how little I ate	☐	☐	☐	☐	☐
7. I used muscle building supplements	☐	☐	☐	☐	☐
8. I pushed myself extremely hard when I exercised	☐	☐	☐	☐	☐
9. I snacked throughout the evening without realizing it	☐	☐	☐	☐	☐
10. I got full more easily than most people	☐	☐	☐	☐	☐
11. I considered taking diuretics to lose weight	☐	☐	☐	☐	☐
12. I tried on different outfits, because I did not like how I looked	☐	☐	☐	☐	☐
13. I thought laxatives are a good way to lose weight	☐	☐	☐	☐	☐
14. I thought that obese people lack self-control	☐	☐	☐	☐	☐
15. I thought about taking steroids as a way to get more muscular	☐	☐	☐	☐	☐
16. I used diet teas or cleansing teas to lose weight	☐	☐	☐	☐	☐
17. I used diet pills	☐	☐	☐	☐	☐
18. I did not like how my body looked	☐	☐	☐	☐	☐
19. I ate until I was uncomfortably full	☐	☐	☐	☐	☐
20. I felt that overweight people are lazy	☐	☐	☐	☐	☐
21. I counted the calories of foods I ate	☐	☐	☐	☐	☐
22. I planned my days around exercising	☐	☐	☐	☐	☐
23. I thought my butt was too big	☐	☐	☐	☐	☐
24. I did not like the size of my thighs	☐	☐	☐	☐	☐
25. I wished the shape of my body was different	☐	☐	☐	☐	☐

Patient Name_____ Date _____ Date of Birth_____

EATING PATHOLOGY SYMPTOMS INVENTORY (EPSI)
continued

26. I was disgusted by the sight of an overweight person wearing tight clothes	☐	☐	☐	☐	☐
27. I made myself vomit in order to lose weight	☐	☐	☐	☐	☐
28. I did not notice how much I ate until after I had finished eating	☐	☐	☐	☐	☐
29. I considered taking a muscle building supplement	☐	☐	☐	☐	☐
30. I felt that overweight people are unattractive	☐	☐	☐	☐	☐
31. I engaged in strenuous exercise at least five days per week	☐	☐	☐	☐	☐
32. I thought my muscles were too small	☐	☐	☐	☐	☐
33. I got full after eating what ost people would consider a small amount of food	☐	☐	☐	☐	☐
34. I was not satisfied with the size of my hips.	☐	☐	☐	☐	☐
35. I used protein supplements	☐	☐	☐	☐	☐
36. People encouraged me to eat more	☐	☐	☐	☐	☐
37. If someone offered me food, I felt that I could not resist eating it	☐	☐	☐	☐	☐
38. I was disgusted by the sight of obese people	☐	☐	☐	☐	☐
39. I stuffed myself with food to the point of feeling sick	☐	☐	☐	☐	☐
40. I tried to avoid foods with high calorie content	☐	☐	☐	☐	☐
41. I exercised to the point of exhaustion	☐	☐	☐	☐	☐
42. I used diuretics in order to lose weight	☐	☐	☐	☐	☐
43. I skipped two meals in a row	☐	☐	☐	☐	☐
44. I ate as if I was on auto-pilot	☐	☐	☐	☐	☐
45. I ate a very large amount of food in a short period of time (such as within 2 hours)	☐	☐	☐	☐	☐