GOOD SAMARITAN MEDICAL CENTER
PALM BEACH HEALTH NETWORK

Center for Bariatric and Weight Management

PATIENT INFORMATION - Please complete entire form

Name (Last, First, MI)_____ Height_____ Weight_____ BMI_____

DOB_____ Age _____ Occupation _____

Email_____Male _____ Female _____

Address_____City_____State _____Zip_____

Telephone# _____Cell#_____Work_____

Marital Status _____Spouse/significant other name _____

Emergency Contact Name _____Emergency phone_____

Relationship to Patient _____

Medical Weight Management? ☐ Yes ☐ No Past Bariatric Surgery? ☐ Yes ☐ No

Which procedure are you interested in? ☐ Gastric Bypass ☐ Gastric Sleeve ☐ Orbera ☐ Uncertain

Which surgeon? ☐ Dr. Follwell ☐ Dr. Lopes

How did you hear about us? ☐ Friend/Family ☐ Referring Physician _____

☐ Website/ Advertising ☐ Other _____

PATIENT'S ASSIGNED PROVIDERS - please provide your physician's phone number

Primary Physician_____ Phone _____

Cardiologist _____ Phone _____

Pulmonologist_____ Phone _____

Endocrinologist_____ Phone _____

Psychiatrist_____ Phone _____

INSURANCE INFORMATION

Bring your insurance cards & driver's license to the Orientation Appointment

Name of Insurance Company_____ Policy#_____

Policy Holders Name _____ Policy Holder's Date of Birth _____

Name of Secondary Insurance Company_____ Policy#_____

Policy Holders Name _____ Policy Holder's Date of Birth _____

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MEDICAL HISTORY

Please check boxes of any conditions you have been diagnosed with

	Heart disease		High Cholesterol
	Stent		Lymphedema
	High blood pressure		Brain Aneurysm
	Vascular disease		Stroke
	Hepatitis/Liver problems		Prior Vascular Surgery
	COPD		Joint Disease
	Depression		Gynecological Problems
	Sleep Apnea		Irritable Bowel Syndrome
	C-Pap		Acid Reflux/Heartburn/Stomach Ulcer
	Lung disease		DVT/PE
	Kidney disease		Fibromyalgia
	Bleeding problems		Arthritis
	Diabetes (Type I, or II)		Rheumatoid Arthritis
	Hiatal Hernia		Cancer
	Psychiatric Disorder (bipolar, schizophrenia, anxiety)		Gall Stones

PAST SURGICAL HISTORY- Please list all previous surgeries and dates

Surgery	Date

Have you ever had a problem with anesthesia _____If yes explain_____Vaccine_____

SOCIAL HISTORY

Do you use tobacco products/Vape?_____ What type?_____ How many years?_____

Do you drink alcohol?_____What type?_____ How often?_____

Do you use recreational drugs? _____ What type? _____ How often? _____

Do you use caffeine?_____How much? _____

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Please list all allergies and reactions

Allergy	Reaction

MEDICATIONS -
List all medications and vitamins you currently take

Medication	Dose	Frequency	Reason for taking

FAMILY HISTORY -
include parents, siblings and children

Relation	Alive?	Diabetes	Heart attack	High blood pressure	Cancer	Stroke	Obesity

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DIET HISTORY

Please list ALL diet programs you have done in the past 10 years

Diet Program	Approximate Year	Amount of weight lost
Atkins		
Body by Vi		
Exercise Routine		
Herbal Life		
Hypnosis		
HCG		
Jenny Craig		
Keto Diet		
LA Weight Loss		
LapBand		
Metabolife		
Nutra System		
Optifast/Medifast		
Overeaters Anonymous		
Phen-Fen (Redux)		
Phentermine		
Physician-Supervised		
Portion Control Diet		
Qsymia		
Quick Weight Loss		
Richard Simmons		
Slimfast		
Weight Watchers		
Worked with Dietitian		
Xenical		

At each age below, please check where you would describe your weight

Age	Obese	Overweight	Average	Below Average
Age 5				
Age15				
Age 20				
Age 30				
Age 40				
Age 50				
Age 60				
Age 70				

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WEIGHT HISTORY

Please list your weight

2022	2021	2020	2019	2018

What is your highest adult weight? _____ When? _____

What is the greatest factor in your life that prevents you from losing weight and keeping it off?

_____

_____

_____

What is the lowest weight you have maintained for greater than one year? _____

Have you lost weight recently? _____ How much? _____

Have you gained weight recently? _____ How much? _____

FOOD INTAKE - How many servings per day of the following?

	Poor food choices		Desserts/Sweets		Eating Too Little
	Inconsistent meals		Lack of Time		Skipping Meals
	Lack of food knowledge		Portion Control		Social Eating with friends
	Eating out frequently		Fast Food		Taking 2nd portions frequently
	Poor planning of meals		Lack of Vegetables		High fat intake
	Snacking		Lack of Fruits		Milk consumption
	Soft drinks/Soda		Use of White Refined flour products		Eating in the car while driving
	Sweetened Beverages/Fruit Juice		Lack of Exercise		TV/Computer Use

	Fruits		Low fat Dairy (milk)		Pork		Eggs
	Vegetables		Lean meat		Fish		Fruit Juice
	Whole grain		Poultry		Cheese		Water
	Desserts		Fats (butter/oil)		Soda		Other

ENERGY LEVELS -
How would you rate your energy levels today?

	Always Lacking Energy		Most of the day, LOWenergy levels		Most of the day, HIGHenergy levels		Always Energized!

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PLEASE DESCRIBE A TYPICAL DAY OF EATING FOR YOU:

MEAL	PORTION	FOOD ITEM
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

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RECREATIONAL ACTIVITIES, EXERCISE AND SPORTS

What types of recreational activities, exercises and sports are you currently participating in?

_____How many hours per week? _____

Are there any activities that you have always wanted to try but felt that you were too heavy?

What recreational activities do you intend to do after surgery?

What have we not asked that you feel is important for us to know?

What grade would you give yourself?					
BEHAVIOR	**A**	**B**	C	**D**	F
Exercise					
Screen Time					
Eating Fruit					
Whole Grains					
Sweet Drinks					
Portion Size					
Emotional Eating					
Eating Vegetables					
Taking Your Medication					