



PIONEER VALLEY WEIGHT LOSS CENTERS
2 Medical Center Drive Suite 202
Springfield, MA 01107
(413) 205-1200 Fax (413) 205-1220
www.pvweightloss.com

PIONEER VALLEY WEIGHT LOSS CENTERS was developed to give you the support, guidance and inspiration you need to help you achieve your desired weight loss. Our team of experts will work with you and guide you in the achievement of your goals. Most importantly, we recognize that everybody is an individual and therefore our team strives to create an individualized evaluation and treatment plan for each of our patients.

Our multidisciplinary team approach is modeled after the most successful programs in the country. Each specialist of our team is committed to your success.

Prior to your visit, you will need to fill out **ALL THE INFORMATION** included in this packet. Packets that are not completed may result in delays of appointments or curtailment of your initial visit. Completeness of this packet is essential because our staff will use this information to get a better understanding of your current health conditions and weight loss goals.

You will begin with a comprehensive medical evaluation by our board certified bariatrician. Once the initial visit has been completed, you will be scheduled to see one of our dieticians and one of our psychologists. Follow up visits with the bariatrician are often scheduled monthly. It is imperative that you keep these appointments since the appointments are reserved for you and you alone.

Cancellations of appointments without 24 hours notice will result in a fee determined by the program. This fee for a missed appointment will be \$50 for a missed initial appointment and \$25 for a missed follow-up appointment. Keeping your appointments are essential for your success in weight loss.

MEDICAL EVALUATION

During your appointment with the bariatrician (weight loss physician) your personal medical history will be reviewed, your current medical condition will be evaluated and recommendations regarding an appropriate and safe approach for your weight loss program will be made.

NUTRITIONAL EVALUATION

When you meet with the registered dietician, your current diet and food choices will be evaluated. Based on the results of that evaluation, a personalized meal plan and approach to meals will be developed. The goal of this experience is to find a meal plan that will result in weight loss as well as help you learn lifelong healthy habits.

PSYCHOLOGICAL EVALUATION

When you meet with the psychologist your medical and behavioral health histories will be evaluated. In addition, your current feelings and behaviors related to weight management issues

and surgery will be discussed. This mental health interview helps the team to better understand how to assist you with the progression of your weight loss goals and, if desired, preparation for possible surgery.

The focus of PIONEER VALLEY WEIGHT LOSS CENTERS is to be able to assist you with your weight loss goals in either medical or surgical approaches.

If surgical approaches are your choice for weight loss, our centers work with selected teams of bariatric surgeons in the area. You will be referred to one of these surgical teams for evaluation if you are appropriate and interested in that approach. While you are awaiting surgery, you will remain with the PIONEER VALLEY WEIGHT LOSS CENTERS, working on dietary components, activity components and behavioral changes in order to prepare you for the safest and best surgical experience possible. You will also follow up with us after surgery to receive the education and care necessary for the best possible outcomes in both the short term and the long term.

Because it is extremely important for your health and well being, you must meet certain criteria prior to the intervention of surgery. These will be discussed at your initial visit with us. Once you have completed these criteria, you will be scheduled for a pre-op evaluation which will include a comprehensive medical history and physical, baseline laboratory testing, an EKG and any other tests deemed necessary to prepare you for a safe surgical experience. In addition, you will meet with the surgeon of your choice on several occasions. He or she will also evaluate your health and preparedness for surgery.

If medical approaches are your choice for weight loss, our centers work with you diligently to help you understand the role of food, activity, and behavior in terms of successful weight loss. In addition, our bariatrician may choose certain medications that will assist you in your weight loss goals. Your current health and medications will be taken into consideration prior to prescribing any weight loss medications to assist you. Following the guidelines set up by our team of experts will best assist you in your weight loss goals.

*Thank you for choosing
PIONEER VALLEY WEIGHT LOSS CENTERS
to be your team for weight loss.*

**We hope your experience with us is all that you expect
and we look forward to assisting you in achieving your goals.**

*-The Staff at
PIONEER VALLEY WEIGHT LOSS CENTERS*



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NAME: _____

DOB ___/___/___ Age ___ Sex: M / F

Thank you for taking the time to complete this health history. Your information will assist us in providing you with an individualized plan for your health care needs. The information on this form is confidential and will be viewed only by our physicians and staff.

Please fill out ALL of this form out prior to your first visit.

ALLERGIES:

Primary Care Physician / Provider _____

Referring Physician / Provider (if different from above) _____

In regards to approaches to your weight loss

Please circle your interest in your approaches to weight loss:

1 I am interested only in medical approaches; I have no interest in surgery

2 I would like to learn about surgery BUT have no interest at this time

3 I would like to learn about surgery AND I am interested in having surgery

4 I am already educated in surgery AND I am interested in having surgery

5 I have ***already seen a surgeon*** about surgical approaches to weight loss

Referring Surgeon _____

PAST MEDICAL HISTORY: Please circle all that may apply to YOU:

- High Blood Pressure
- Type II Diabetes
 - HbA1C Level:
- High Cholesterol/Dyslipidemia

- Heart Disease
 - Type of Heart Disease:
- Stroke

- Obstructive Sleep Apnea
- Asthma
- Pulmonary Embolism
- Deep Venous Thrombosis (Blood clots)

- Cancer TYPE:

- Gastroesophageal Reflux Disease
- Fatty Liver
- Cholelithiasis/ Gallstones
- Hernias
- Urinary Stress Incontinence

- Hypothyroid Disease

- Polycystic Ovarian Syndrome
- Infertility

- Degenerative/Osteo Arthritis
- Low Back Pain
- Fatigue

OTHER MEDICAL CONDITIONS:

PAST SURGICAL HISTORY:

Please list any surgical procedures that you have had and the dates of the surgery

SURGICAL PROCEDURES

DATES OF SURGERY

FAMILY HISTORY: Please circle any that apply to members of YOUR FAMILY

Condition: Family Member:
 Obesity
 High Blood Pressure
 Type II Diabetes
 High Cholesterol/Dyslipidemia
 Heart Disease
 Coronary Artery Disease
 Congestive Heart Failure
 Stroke
 Cancer
 Type:

Condition: Family Member:
 Gastroesophageal Reflux Disease
 Hepatic Steatosis/ Fatty Liver
 Cholelithiasis/ Gallstones
 Hypothyroid Disease
 Polycystic Ovarian Syndrome
 Pulmonary Embolism
 Deep Venous Thrombosis/Blood clots
 Obstructive Sleep Apnea
 OTHER:

WEIGHT LOSS/ WEIGHT MANAGEMENT HISTORY

Current Height (inches): _____ **Current Weight (pounds):** _____

Desired Weight: _____ *When did you last weigh your desired weight listed?:* _____

Previous Weight Loss Programs and Weight Loss Medications: Use additional paper if needed:

PROGRAM or MEDICATION	DATES	WEIGHT LOSS

History of Weight Problems:

At what age were you first overweight by 10lbs or more? _____ Years old

Have you lost weight and gained it back? (Y / N) #of cycles _____ over _____ yrs

What has been your heaviest weight? _____ lbs

Social History:

Marital Status: Married Single Widow/Widower Divorced
Children (Y / N) AGES: _____

Who lives with you at home? _____

Smoking (Y / N) _____ Amount per day _____ Years smoking _____
Did you smoke in the past? (Y / N) When did you quit? _____

Alcohol (Y / N) When was your last drink? _____

Illicit Drug Use (Y / N) Present Drug Use: _____
Past Drug Use: _____

Occupation: _____

Hobbies: _____

Spirituality/Faith/Religion: _____

How do you describe your general mood and emotions?

DIETARY / EATING PATTERNS:

Who does the shopping at home? _____

Who does the cooking at home? _____

How many meals do you eat per day? _____

How many meals do you eat **per week** outside of the home? _____

Do you like Carbohydrate (Starches and Sweets) more than other foods? (Y / N)

ACTIVITY / EXERCISE:

To what extent do you enjoy activity: None Slightly Moderately Greatly
Area/ Methods Utilized: Health Club Home Outdoors Pool
Walking Jogging Sports: _____
OTHER: _____

How many hours of watching TV / Computer time per day: _____ hours/day

Method of Exercise:

Aerobic/ Endurance Training: Y / N Resistance Training: Y / N
Frequency per week _____ Duration per day _____

Activity/ Exercise in the Past (Y / N) What kinds of activity? _____

Present or Past History of Eating Disorders:

- (Y / N) Anorexia (fear of weight gain leading to malnutrition and usually excessive weight loss)
- (Y / N) Bulimia (overeating followed by vomiting, laxative/diuretic abuse and/or excessive exercise)
- (Y / N) Binge Eating Disorder (consuming a large quantity of food in a short period of time)
- (Y / N) Night Eating Disorder (eating very late at night / waking up at in the middle of the night to eat)

If you have answered YES to any of the above:

Have you been in treatment for the disorder: (Y / N)

Do you believe you still have problems with the disorder: (Y / N)

What type of medication or treatment plans related to eating disorders? :

Previous MEDICATION HISTORY (Psychiatric and Weight medications ONLY):

PREVIOUS PSYCHIATRIC OR WEIGHT LOSS MEDICATION	DOSE	FREQUENCY
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- Fen-phen
- Redux
- Phentermine
- Meridia
- Xenical
- Prozac
- Zoloft
- Paxil
- Wellbutrin

OTHERS:

REVIEW OF SYSTEMS: Circle any of the following you experience now or within the past 6 months

General

Fatigue, weakness, malaise
Fever, chills, sweats or night sweats

Skin

Skin disease (eczema, psoriasis)
Pigment or color change Rash
Excessive dryness Excessive bruising

Head

Frequent/ severe headache
History of head injury
Dizziness/Vertigo

Eyes

Difficulty with vision; eye pain; double vision
Redness, swelling, discharge
Wear glasses or contact lenses
History of cataract surgery/intraocular lens implant

Ears

Frequent ear infections; ringing; difficulty hearing

Nose and Sinuses

Frequent colds; sinus infections; nosebleeds
Seasonal allergies

Mouth and Throat

Bleeding gums, frequent sore throats
Difficulty swallowing; hoarseness; sour taste in mouth

Neck

Enlarged or tender lymph nodes; goiter

Lungs

Sleep apnea / CPAP Machine
Asthma; emphysema; bronchitis; pneumonia; tuberculosis
Chest pain with breathing
Wheezing or noisy breathing
Shortness of breath –
Cough; Sputum (color, amount)

Heart

History of heart attack; other heart problems
High blood pressure
High cholesterol
Chest pain
Use more than 2 pillows sleeping

Circulation

Swelling in legs
Coldness; numbness; tingling in hands or feet
Varicose veins
Pain in calf when walking
History of blood clot in leg
Ulcers on legs

Stomach and digestion

Difficulty swallowing; choking sensation
Heartburn; If yes, when does it occur?
Sour taste in mouth
Nausea; vomiting blood
Ulcer, liver or gallbladder disease
Jaundice
Appendicitis
Recent change in bowel habits
Blood in stool
Constipation; diarrhea
Rectal bleeding
Hemorrhoids; fistula

Urinary system

Urinary incontinence; stress incontinence
Kidney disease
Blood in urine

Males

Prostate problems
Penile or testicular pain
Genital sores or lesions
Penile discharge
Hernia

Females

Age at menarche (first period)
Premenstrual pain; severe cramps with period
Menopause Age of onset:
Last gynecological checkup/pap smear

Bones and Joints

Arthritis or gout
Joint pain; stiffness; swelling
Limitation of motion of joints
Back pain or disk disease

Nervous/Psychological System

History of seizure disorder; stroke
Memory problems
Nervousness; anxiety; tremors
Mood changes; depression
Bipolar disorder; schizophrenia

Hematological System

Bleeding tendencies of skin, mucus membranes
Excessive bruising
Blood transfusions

Endocrine System

History of diabetes
Excessive thirst, urination, appetite
History of thyroid disease
Intolerance to heat or cold

The Epworth Sleepiness Scale

Please rate your SLEEPINESS using the following number scale in the blanks below and to the left:

- 0 = Would never doze
- 1 = **Slight** chance of dozing
- 2 = **Moderate** chance of dozing
- 3 = **High** chance of dozing

For the following circumstances:

- ___ Sitting and Reading
- ___ Watching Television
- ___ Sitting inactive in a public place (i.e. 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 and talking to someone
- ___ Sitting quietly after a lunch without alcohol
- ___ In a car, while stopped for a few minutes in traffic

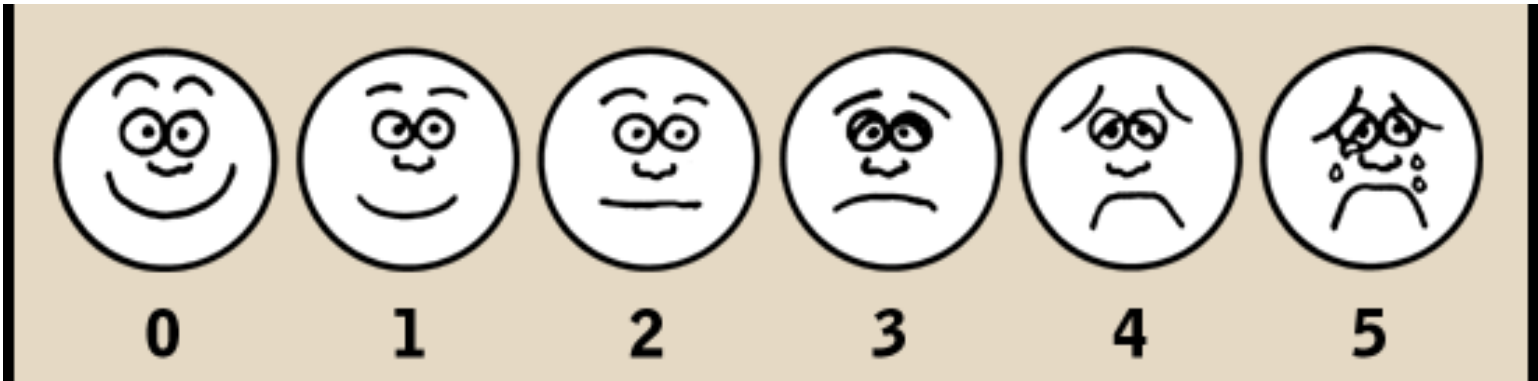
A total score of 10 or more suggests the need for further evaluation to determine the cause of excessive sleepiness. This is usually done with a SLEEP STUDY and will be discussed.

COMPREHENSIVE WEIGHT MANAGEMENT PROGRAM

QUALITY OF LIFE ASSESSMENT:

To what degree has your weight impaired the quality of your life?

Number: _____



Mild

Moderate

Severe