Dear Patient:

We would like to welcome you to The Bariatric Center. This Center was established to provide patients with a medical home for long term treatment and management of obesity. Our team, which includes a physician, dietitian, therapist, and exercise specialist, will help you learn about obesity and the tools you need to successfully manage it.

We have enclosed the paperwork for you to complete in the comfort of your own home. Please complete paperwork and provide it to our front office staff by mail, fax, or in person. Once we have received your paperwork, we will process it. After being processed, we will call you to set up your appointment. Do not attach a medication list PLEASE put any and all medications you are taking in the form provided to you in the new patient packet. Please have your primary doctor fax any labs done within the last three months and your most current EKG.

Please note that while we will be glad to bill your insurance company for our services, you will be responsible for any unmet deductible, non-covered services, co-payment or coinsurance. Should you have any questions regarding insurance coverage, please call your insurance company directly. The codes to check with your insurance company are diagnosis E66.01, procedure codes (Doctor 99205), (Dietician 97802), (Therapist 90837 & 90791). We will happy to work out a payment plan with you prior to your appointment as well.

In order to accommodate patients waiting for an appointment, we ask you to cancel or reschedule your appointment 48 hours in advance; otherwise you will be charged a $50.00 fee. Due to the length of our appointments, you would have to reschedule your appointment if you arrive more than 15 minutes late. If you have any questions feel free to contact our office. Thank you for your consideration and we look forward to meeting and working with you to help improve your health.

Respectfully,

Bariatric Center Administration
# PATIENT MEDICATION and SUPPLEMENT LIST

Name: ___________________________  DOB: ___________  Physician: ___________________________

Pharmacy: ___________________________

Medication Allergies: ___________________________

<table>
<thead>
<tr>
<th>Medication name</th>
<th>Dose</th>
<th>Taken by</th>
<th>Frequency (times per day)</th>
<th>Medication used for</th>
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Patient signature/date: ___________________________  /Date: ___________

Rev 10/2015
Bariatric
Tallahassee Memorial Bariatric Center
New Patient Questionnaire

Name: ___________________________ DOB: ___________________________

Are you interested in: Non-surgical treatment Gastric Band Gastric Sleeve
Gastric Bypass Liquid Meal Replacement Other

Household Income: 0-30,000 30,000-50,000 50,000-75,000 75,000-100,000 > 100,000
Education Level: Grade School High School College Post-Graduate

Dietary Content:
Problem foods:
Tough time of the day: Daytime Nighttime Other
Cravings: Sweet Salty Crunchy Other
Triggers: Emotion Habit Other
Are you hungry after a meal: No Yes Sometimes All the time
Is volume an issue: No Yes
Do you drink sugar sweetened beverages: No Yes

Dietary History:
Who grocery shops: ___________________________
How often do you eat out/week: ___________________________
Do you use a shopping list: ___________________________
Food Allergies: ___________________________
Food dislikes:
Typical Day: Breakfast time: ___________________________ Food/Drink: ___________________________
Lunch time: ___________________________ Food/Drink: ___________________________
Supper time: ___________________________ Food/Drink: ___________________________
Snacks time: ___________________________ Food/Drink: ___________________________

Weight History:
Weight gain: Gradual Rapid
Onset: Childhood Puberty Pregnancy Adult Menopausal
Associated with life changes: College Career Marriage Divorce Death Stress

Previous Attempts at weight loss:
What have you tried? ___________________________
What worked in the past? ___________________________
Why did it work? ___________________________
What did NOT work in the past? ___________________________
Why did it NOT work? ___________________________
What are your current expectations? ___________________________
Have you used weight loss medication in the past? □ Yes □ No
Which medication: ___________________________
When/how long: ___________________________
Effective: □ Yes □ No
Problems: ___________________________
Name: ___________________________  DOB: ___________________________

**Medical and Surgical History:** Please check any medical problems, current or past.

- Acid Reflux/Heartburn
- Diarrhea
- Kidney Disease
- Anemia
- DVT
- Liver Disease
- Anxiety
- Gout
- Lung Disease
- Asthma
- Glaucoma
- Osteoporosis
- Arthritis
- Gallbladder Disorder
- Polycystic Ovaries
- Cancer (Type _________)
- Heart Attack
- Pulmonary Embolism
- Carotid Disease
- Heart Disease
- Rheumatic/Scarlet Fever
- Chest Pain
- Heart Murmur
- Sleep Apnea
- Clotting Disorder
- High Blood Pressure
- Stroke
- COPD
- High Cholesterol
- Thyroid Disease
- Depression
- Irregular Menstrual Cycle
- Vascular Disease

Other:
- Surgery: ___________________________  Location: ___________________________  Date: ___________________________
- Surgery: ___________________________  Location: ___________________________  Date: ___________________________
- Surgery: ___________________________  Location: ___________________________  Date: ___________________________
- Surgery: ___________________________  Location: ___________________________  Date: ___________________________
- Surgery: ___________________________  Location: ___________________________  Date: ___________________________

**Psychiatric History:** Please check any problems current or past.

- Anxiety
- Alcoholism
- Anorexia
- Depression
- Drug Addiction
- Binge Eating
- Bipolar Disorder
- Schizophrenia
- Bulimia
- Panic Attacks
- Nervous Breakdown
- Stress

Have you ever been or are you currently under the care of a mental health provider?  Yes  No

If you answered “Yes” please explain the reason and who is the provider:

_________________________________________________________________________________________________________________________________________________________________________________________________________

What are your life stressors? (Please circle all that apply)

Work  School  Marriage  Family  Financial  Loss  Other

Do you have a history of? (Please circle one)

- Physical Abuse  Yes or No  If Yes from what age to what age: _________ - _________

- Emotional Abuse  Yes or No  If Yes from what age to what age: _________ - _________

- Sexual Abuse  Yes or No  If Yes from what age to what age: _________ - _________

If you chose any of the above please give a brief explanation:

________________________________________________________________________________________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________________________________________________________________________________________
Name: ___________________________  DOB: ___________________________

Family History:  Currently Living or Deceased  Age  General Health
Mother: ___________________________  ___________________________
Father: ___________________________  ___________________________
Brothers: ___________________________  ___________________________
Sisters: ___________________________  ___________________________

Have any blood relatives ever had any of the following:

- Obesity  No  Yes  Who: ___________________________
- Diabetes  No  Yes  Who: ___________________________
- Heart Disease/Stroke  No  Yes  Who: ___________________________
- High Blood Pressure  No  Yes  Who: ___________________________
- High Cholesterol  No  Yes  Who: ___________________________
- Depression  No  Yes  Who: ___________________________
- Eating Disorder  No  Yes  Who: ___________________________
- Substance Abuse  No  Yes  Who: ___________________________

Social History:
Single  Divorced  Married  Partner  Widow/Widower
Employment: ___________________________
Children/Ages: ___________________________
Who is in household: ___________________________  Relationship: ___________________________

- Tobacco  □ Yes  □ No  How Often? ___________________________
- Drugs  □ Yes  □ No  How Often? ___________________________
- Alcohol  □ Yes  □ No  How Often? ___________________________

Do you feel safe in your home?  □ Yes  □ No

Gynecologic History: (For women only)
Pregnancies:
Number  Vaginal Delivery/C-Section  Date  Weight Gain  Baby’s Weight
1. ___________________________  ___________________________  ___________________________  ___________________________  ___________________________
2. ___________________________  ___________________________  ___________________________  ___________________________  ___________________________
3. ___________________________  ___________________________  ___________________________  ___________________________  ___________________________
4. ___________________________  ___________________________  ___________________________  ___________________________  ___________________________
5. ___________________________  ___________________________  ___________________________  ___________________________  ___________________________

History of:  Gestational Diabetes  Pregnancy Induced Hypertension

Are you currently breastfeeding?  □ Yes  □ No
Are you currently pregnant or trying to become pregnant?  □ Yes  □ No

Menstrual Periods:  Age of Onset  □ Average Length  □ Regular  □ Y  □ N
Hysterectomy:  No  Yes  Why: ___________________________
Hormone replacement:  No  Yes
Method of Birth Control: ___________________________

Please use this section for additional information, if needed.

______________________________  ___________________________
Physician Signature and Date  Rev. April 2014
PAR-Q & YOU
(A Questionnaire for People Ages 15-69)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are not between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each honestly. Check YES or NO.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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**YES to one or more questions**

If

YOU

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions your answered YES.

- You may be able to do any activity you want as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.

**ANSWERED**

- Find out which community programs are safe and helpful for you.

**NO to all questions...**

If you answered NO honestly to all PAR-Q questions, you can be reasonably sure that you can:
- Start becoming much more physically active- begin slowly and build up gradually. This is the safest and easiest way to go.
- Take part in a fitness appraisal- this is an excellent way to determine your basic fitness so that you can plan the best way to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

**DELAY BECOMING MUCH MORE ACTIVE:**
- If you are not feeling well because of a temporary illness such as a cold or fever- wait until you feel better; or
- If you are or may be pregnant- talk to your doctor before you start becoming more active.

**PLEASE NOTE:** If your health changes so that you answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

Informed Use of the PAR-Q: The Canadian Society for Exercise Physiology, Health Canada, and their agents assume no liability for persons who undertake physical activity, and if in doubt after completing this questionnaire, consult your doctor prior to physical activity.

---

This PAR-Q form was adapted from the 2002 revised edition, courtesy of the Canadian Society for Exercise Physiology.

Note: If the PAR-Q is being given to a person before he or she participates in a physical activity program or a fitness appraisal, this section may be used for legal or administrative purposes.

"I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction."

Name: ___________________________ DOB: ___________________________
Signature: ___________________________ Date: ___________________________
Signature of Parent: ___________________________ Witness: ___________________________
Or Guardian (for participants under the age of majority): ___________________________
Exercise History and Attitude Questionnaire

Name: ________________________ DOB: ___________ Date: ______________

General Instructions: Please fill out this form as completely as possible. If you have any questions, ask the trainer at your first meeting.

1. Please rate your exercise level on a scale of 1 to 5 (1 = easy, 5 = very strenuous) at each age:
   Age: 15-20 _____ 21-30 _____ 31-40_____ 41-50____ 51-60____ 61+_____ 

2. Were you a high school and/or college athlete?
   □ Yes □ No If yes, please explain: ______________________________________

3. Rate yourself on a scale of 1 to 5 (1 = least and 5 = most).
   
<table>
<thead>
<tr>
<th>Athletic Ability</th>
<th>Competition</th>
<th>Cardiovascular Capacity</th>
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<tbody>
<tr>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Muscular Capacity</td>
<td>Flexibility Capacity</td>
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</tr>
<tr>
<td>1 2 3 4 5</td>
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</tbody>
</table>

4. When you start an exercise program
   □ I stick with it until I accomplish my goal.
   □ I stick with it most of the time.
   □ I'm good for a month and then miss a month and then back on again repeatedly.
   □ I usually don't stick with it very long and then quit.

5. How much time are you willing to devote to an exercise program?
   _____ minutes per day _____ days per week

6. Do you currently do cardiovascular exercise?
   Type(s): ___________________________ _____ minutes per day _____ days per week

7. Rate your perception of exertion during your cardiovascular exercise.
   □ Light □ Fairly Light □ Somewhat Hard □ Hard

8. How long have you been exercising regularly?
   _____ months _____ years

9. What other exercise, sport or active recreational activities have you participated in?
   In the past 6 months? ____________________________
   In the past 5 years? ____________________________

10. Can you exercise during your work day? □ Yes □ No

11. What types of exercise interest you?
   □ Walking □ Cycling □ Stair Climbing □ Jogging □ Group Exercise □ Yoga/Pilates □
   Elliptical □ Swimming □ Strength Training □ Racquet Sports □ Rock Climbing
   Other______________________
12. What do you want exercise to do for you?

13. Rate each goal separately:  
<table>
<thead>
<tr>
<th>Not Important</th>
<th>Somewhat Important</th>
<th>Extremely Important</th>
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<tbody>
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<td>1</td>
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<td>3</td>
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</tbody>
</table>
   a. Improve cardiovascular fitness
   b. Lose weight
   c. Lose body fat
   d. Reshape my body
   e. Improve performance for sports or other activity
   f. Improve my ability to cope with stress
   g. Improve flexibility
   h. Increase strength
   i. Improve balance
   j. Increase energy level
   k. Feel better
   l. Prevent/treat a medical condition

14. How many pounds would you like to lose? ________ pounds

15. What is your usual pace of walking?
   a. _______ casual or strolling (less than 2 mph)
   b. _______ average or normal (2-3 mph)
   c. _______ fairly brisk (3-4 mph)
   d. _______ brisk or striding (> 4 mph)

16. How many flights of stairs do you climb each day? ________ flights/day
17. How many hours do you spend watching TV per day? ________ hours/day
18. How many hours do you spend using your computer? ________ hours/day
19. How much of your work day is spent at a desk? ________ hours/day
20. How much of your work day is spent walking around? ________ hours/day
21. How much of your day is spent standing in one spot? ________ hours/day

22. At least once/week do you participate in regular activity like brisk walking, jogging, biking, swimming, etc. long enough to work up a sweat?
   □ No  □ Yes  How many times/week? ________ Activity ____________________

Signature: _______________________  DOB: __________  Date: ________________
Reviewed by Exercise Specialist: ___________________________________ Date: ____________
4/14; Rev 10/15
Thank you for completing this questionnaire. Please circle the appropriate response, or write in information where asked. You may skip any question you do not understand or do not wish to answer.

1. During the past 6 months, did you often eat within a two hour period what most people would regard as an unusually large amount of food?  
   Yes  
   No

2. During the times when you ate this way, did you often feel you couldn't stop eating or control what you how much you were eating?  
   Yes  
   No (If no, skip to question 5)

3. On average, during the past 6 months, how often did you have times when you ate this way— that is, large amounts of food, plus the feeling that your eating was out of control? (There may have been some weeks when it was not present—just average those in.)

   A. Less than one day a week.
   B. One day a week.
   C. Two or three days a week.
   D. Four or five days a week.
   E. Nearly every day.

4. Did you usually have any of the following experiences during these occasions?

   A. Eating much more rapidly than usual?  
      Yes  
      No
   B. Eating until you felt uncomfortably full?  
      Yes  
      No
   C. Eating large amounts of food when you didn't feel physically hungry?  
      Yes  
      No
   D. Eating alone because you were embarrassed by how much you were eating?  
      Yes  
      No
   E. Feeling disgusted with yourself, depressed, or feeling very guilty after overeating?  
      Yes  
      No

5. In general, during the past six months, how upset were you by overeating (eating more than you think is best for you)?

   A. Not at all
   B. Slightly
   C. Moderately
   D. Greatly
   E. Extremely

6. In general, during the past six months, how upset were you by the feeling that you couldn't stop eating or control what or how much you were eating?

   A. Not at all
   B. Slightly
   C. Moderately
   D. Greatly
   E. Extremely

7. During the past six months, how important has your weight or shape been in how you feel about or evaluate yourself as a person— as compared to other aspects of your life, such as how you do at work, as a parent, or how get along with other people?

   A. Weight and shape were not very important.
   B. Weight and shape played a part in how I felt about myself.
   C. Weight and shape were among the main things that affected how I felt about myself.
   D. Weight and shape were the most important things that affected how I felt about myself.

Name ____________________________ Date of Birth ____________________________
8. During the past six months, did you ever make yourself vomit in order to avoid gaining weight after binge eating?
   Yes  No
   If yes, How often, on average, was that?
   A. Less than once a week.
   B. Once a week.
   C. Two or three times a week.
   D. Four or five times a week.
   E. More than five times a week.

9. During the past three months, did you ever take more than twice the recommended dose of laxatives in order to avoid gaining weight after binge eating?
   Yes  No
   If yes, How often, on average, was that?
   A. Less than once a week.
   B. Once a week.
   C. Two or three times a week.
   D. Four or five times a week.
   E. More than five times a week.

10. During the past three months, did you ever take more than twice the recommended dose of diuretics (water pills) in order to avoid gaining weight after binge eating?
    Yes  No
    If yes, How often, on average, was that?
    A. Less than once a week.
    B. Once a week.
    C. Two or three times a week.
    D. Four or five times a week.
    E. More than five times a week.

11. During the past three months, did you ever fast- not eat anything at all for at least 24 hours- in order to avoid gaining weight after binge eating?
    Yes  No
    If yes, How often, on average, was that?
    A. Less than once a week.
    B. Once a week.
    C. Two or three times a week.
    D. Four or five times a week.
    E. More than five times a week.

12. During the past three months, did you ever exercise for more than an hour specifically in order to avoid gaining weight after binge eating?
    Yes  No
    If yes, How often, on average, was that?
    A. Less than once a week.
    B. Once a week.
    C. Two or three times a week.
    D. Four or five times a week.
    E. More than five times a week.

13. During the past three months, did you ever take more than twice the recommended dose of a diet pill in order to avoid gaining weight after binge eating?
    Yes  No
    If yes, How often, on average, was that?
    A. Less than once a week.
    B. Once a week.
    C. Two or three times a week.
    D. Four or five times a week.
    E. More than five times a week.

Name: ___________________________  Date of Birth: ___________________________