Johns Hopkins HealthCare LLC
Bariatric Medical Evaluation Form

Date: ____________

Patient Name: ______________________________ Patient DOB: ______________

Insurance Name ____________________ Insurance ID # ______________________

Physician Name ____

Physician Address ____

Telephone # ______________ Fax # ________________ Beeper # ______________

Patient Medical Information

List any specialists currently following patient:

Physician Name ____________________________ Specialty ________________
Physician Name ____________________________ Specialty ________________

List any medically managed weight reduction programs within the past 6 months within the previous 18 months. List weight reduction programs & medications tried in the past. List any self motivated programs, such as food diary or self-monitoring. Check one answer for each program. You may add any additional information on the back.

Program Name/ Date	Program Name/ Date	Program Name/Date
______________	______________	______________
☐ Successful	☐ Successful	☐ Successful
☐ Somewhat successful	☐ Somewhat successful	☐ Somewhat successful
☐ Not successful	☐ Not successful	☐ Not successful
Comments:	Comments:	Comment

The following is a list of thirteen evaluative steps that need to be completed as part of an agreement for both the Primary Care Physician and the patient.

1. Medical conditions contributing to obesity ______________________________

2. Evaluate need for treatment

   ____
   ____

3. Record reasons stated by patient as to readiness and motivation for treatment.

   ____
   ____

4. Physician and patient agree to the following diet therapy plan. List calorie intake per day. Assess for food label knowledge, and food measurement skills.

   ____
   ____
   ____

5. Physician and patient have discussed the diet medication listed below as adjunct to treatment plan. _____ Yes _____ No ______Does not apply
   Patient must be over 18, have a BMI over 40 kg/m2 or 35 kg/m2 and two co-morbidities.
   ____

6. Physician and patient have reviewed treatment goals. Patient has agreed to see a registered dietitian for nutritional counseling
   Name of Dietician ____
   Date of Appointment ____

7. Patient has been able to name the following as people who will support the treatment plan:
   Family Members: Physicians:
   Church Member: Social friends:

8. The patient and physician have agreed to the following exercise plan:
   ____
   ____

9. The patient and physician have agreed to record food intake and activity in the following way:
   ____
   ____

10. The patient and physician have agreed to try the following community weight loss programs, with weight loss goals of 1-2 lbs. per week or 10% weight loss in a 6-month period.
    ____
    ____

11. This patient has a BMI of _________ and ___________ co-morbidity's, therefore this patient and the physician have/ have not (circle one) discussed bariatric surgery.

12. The patient and the physician have discussed the following positive behavior modifications that will help sustain and maintain the patients weight loss.
    ____
    ____

13. All patients must agree to participate with mental health counseling as a support activity for weight loss.
    ____
    ____
    ____

Completed by ____________________________________ Job title ________________________

Physical Evaluation

Name ______ Date ______

HPI: ______

______

______

PMH Medical: ______

______

______

Surgery: ______

Allergies: ______

Medications/Dosage/Times a Day: ______ / ______ / ______ / ______

______

FH: Obesity? ______ Type II DM? ______

SH: Tobacco? ______ Alcohol? ______ Other Drugs? ______

Employed? ______ Family? ______

Exercise? ______

Diet History/Eating Disorder? ______

______

______

General Appearance:

NAD ____ Obese ____ Severely obese ____ Ambulation: Normal ____ Limited ____ B/P ____/____ P____

Skin/Scalp: ______ Height: ______ Weight: ______ BMI: ______

Eyes: PERRLA: ______ EOM: ______ Fundi: ______

Ears: TM's ______ Throat ______ Mucosa ______

Teeth: ______ Neck: ______

Thyroid: ______ Lymph Nodes: ______

Breast: (Male/Female) ______ Lungs: ______

C-V: ______ Pulses: ______

Abdomen: ______ Extremities: ______

Genitalia: ______ Back: ______

Neuro: ______

Diagnoses/Co-Morbidities:

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

Signature ______ Date ______

Updated 1/17/08/ss