Hillcrest
Plastic Surgery & Dermatology

Hillcrest Plastic Surgery - Metabolic Plastic Surgery Weight Loss Program

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Diplomate of the American Board of Plastic Surgery
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New Patient Welcome Letter

& Nutrition and Activity Baseline Intake Questions

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Welcome!

Congratulations on taking steps to achieve a healthy weight. Our program is highlighted by obesity medicine trained, physician-led comprehensive medical weight loss offerings with the latest anti-obesity medications as well as a key overview of the nutrition, activity and lifestyle changes needed to reach your weight loss goals. You will also have the added benefit of both non-surgical and surgical face, breast, body as well as skin care rejuvenation offerings led by board-certified plastic surgeons to help you address any existing or potential areas of aesthetic concern.

We realize that there are many ways to lose weight. You may have tried things before with or without success. To best help you at this time, we are asking for some information. Your answers to the questions on the enclosed questionnaire will help us find the best way to help you achieve a healthy weight. All people are not the same; what works for one person may not work for another.

You may find that some of the questions are very personal. You may read a question and think to yourself, "this has nothing to do with me!" This is OK. You may skip that question or ask our staff for more clarification. This intake survey is meant to help us find the best options for you. The survey may also help you learn more things about yourself. Together, we will work out a plan that will help you reach your goal.

Sincerely,

Dr. Ovalle and the Hillcrest Plastic Surgery Staff

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Confidential Patient Survey:
Weight Loss Appointment Intake Form

Please fill out this survey so we can best help you. All your answers will be kept private.

Date: _____

Name: _____

Personal Demographics

1. Age: _____

2. Sex: _____

3. Race/Ethnicity: _____

4. Current Height: _____

5. Current Weight: _____

6. What is the most you have ever weighed? (For women, don't include pregnancy weight)

_____ Lbs. at _____ years old

7. What is the lowest weight you have been (in adulthood) for at least one year?

_____ Lbs. at _____ years old

8. What is the weight you would ideally like to be at? (goal weight): _____ Lbs.

9. Please fill in the following as best you can. Most people have tried diets in the past. Please tell us your answers for the ones you have tried.

Type of Diet/Program	When did you try this program?	How long were you in this program?	How many pounds did you lose?	How long did you keep the weight off?
Low Calorie Diet				
Protein Diet				
Weight Watchers				
Overeaters Anonymous				
Obesity/Diet Center				
Diet Pills				
Herbal Diet Pills				
Physician supervised fast				
Slim-Fast				
Nutrisystem				
Other: _____				
Other: _____				

10. Besides certain diets, what other methods have you tried to lose weight?

_____
_____
_____

a. Why did these work or not work in the past?

_____
_____
_____

11. What do you think is the main cause of your weight problem?

_____
_____
_____

12. How do you think your life will change if you lose weight?

_____
_____
_____

Focused Medical History

13. Have you ever been diagnosed or are you currently receiving treatment for:

- High blood pressure: (circle) Yes No
- High cholesterol: (circle) Yes No
- Pre-diabetes: (circle) Yes No
- Diabetes, Type 1: (circle) Yes No
- Diabetes, Type 2: (circle) Yes No
    a. If yes, are you on insulin? (circle) Yes No
    b. If yes, what is your last Hemoglobin A1C? _____
- Thyroid disease: (circle) Yes No
    - If yes, what kind? _____
- Heart disease: (circle) Yes No
- Lung disease: (circle) Yes No
    - If yes, what kind? _____
- Kidney disease: (circle) Yes No
    - If yes, what kind? _____
- Liver, gallbladder, or pancreas disease: (circle) Yes No
    - If yes, what kind? _____
        a. Diagnosed with pancreatitis? (circle) Yes No
        b. Diagnosed with gallstones? (circle) Yes No
- Gastrointestinal (GI) disease: (circle) Yes No
        a. If yes, what kind? _____
        b. Diagnosed with gastroparesis? (circle) Yes No
- Cancers: (circle) Yes No
        a. If yes, what kind? _____
        b. Diagnosed with medullary thyroid carcinoma? (circle) Yes No

- Sleep apnea: (circle) Yes No
- For females: polycystic ovarian syndrome (PCOS): (circle) Yes No
- Genetic disorders: (circle) Yes No
    a. If yes, what kind? _____
    b. Diagnosed with Multiple endocrine neoplasia, type 2 (MEN 2)? (circle) Yes No
- Have you ever been diagnosed with an eating disorder in the past? (circle) Yes No
- Any other medical conditions that we should know about? _____

14. Do you smoke cigarettes or vape? (circle) Yes No

a. How many cigarettes (packs) or vape cartridges per day? _____

15. How often do you drink beer, wine or mixed drinks? Fill in ( ) one answer only.
( ) I never drink any alcohol.
( ) I seldom drink more than 8 drinks per week
( ) I often drink more than 8 drinks per week.
( ) I binged in the past three months. (Drank more than three drinks in three hours)

16. For female patients: Are you currently pregnant or do you plan on becoming pregnant within the next year? (circle) Yes No

Medications

17. Please list any current medications, vitamins or supplements that you are taking:
_____
_____
_____
_____

Family History

18. Are any of your family members obese? If yes, please circle those members that are obese.

Father Mother Sister(s) Brother(s)

Father's side: Grandmother Grandfather Aunts Uncles

Mother's side: Grandmother Grandfather Aunts Uncles

19. Does anyone in your family have a history of:

- High blood pressure: (circle) Yes No
- High cholesterol: (circle) Yes No
- Diabetes, Type 1: (circle) Yes No
- Diabetes, Type 2: (circle) Yes No
- Thyroid disease: (circle) Yes No
- Heart disease: (circle) Yes No
- Lung disease: (circle) Yes No
    a. If yes, what kind? _____
- Kidney disease: (circle) Yes No
- Liver, gallbladder, or pancreas disease: (circle) Yes No
- Gastrointestinal (GI) disease: (circle) Yes No
    a. If yes, what kind? _____
- Cancers: (circle) Yes No
    a. If yes, what kind? _____
    b. Diagnosed with medullary thyroid carcinoma? (circle) Yes No
- Genetic disorders: (circle) Yes No
    a. If yes, what kind? _____
    b. Diagnosed with Multiple endocrine neoplasia, type 2 (MEN 2)? (circle) Yes No

Focused Surgical History

20. Have you had bariatric (weight loss) surgery? (circle) Yes No
    c. If yes, what kind and when? _____

21. Please list any other surgeries (and when) you have had in the past:
_____
_____
_____
_____

22. Have you ever had any issues with anesthesia, bleeding, or clotting in general or around the time of surgery? (circle) Yes No

d. If yes, please explain: _____

Nutrition Questions / Eating Habits

23. How would you describe your current diet? Fill in ( ) one answer only.

( ) No specific diet, I eat pretty much everything.
( ) Vegetarian
( ) Vegan
( ) Other special diet/cultural restrictions: _____

24. Do you have any food allergies/intolerances?

25. Please think about the last 24 hours (i.e. from yesterday morning at 5am until today at 5am). To the best of your memory, please answer with the kinds and quantities of foods (meals & snacks) that you ate during this time period:

a. Describe what you ate for breakfast yesterday, and at what time:

_____

b. Describe any snacks you ate between breakfast and lunch yesterday:

_____

c. Describe what you ate for lunch yesterday, and at what time:

_____

d. Describe any snacks you ate between lunch and dinner yesterday:

_____

e. Describe what you ate for dinner yesterday, and at what time:

_____

f. Describe any snacks you ate after dinner yesterday:

_____

g. Were any of these meals/snacks from restaurants? Which ones?

_____

h. Are the above answers representative of a typical day for you? If not, what made that day different?

_____

26. After eating, have you ever forced yourself to vomit? (circle) Yes No

27. Have you ever had a problem with binge eating (eating large amounts of food in a short time and feeling you can't control what or how much you are eating)? (circle) Yes No

a. If so, do you binge eat regularly (at least once a week for 3 months)? (circle) Yes No

28. *Answer this question if you answered yes to question 26 or 27*
Do you recall the feelings that caused or accompanied these actions? If so, tell us what you were feeling. Also write down the last time you did vomit or binge.

a. Vomiting _____
_____

b. Binge eating _____
_____

29. Do you use diuretics or laxatives now to help control your weight? (circle) Yes No

Physical Activity

30. Do you get any regular physical activity now (This might be regular walking, jogging, swimming, housework, gardening, exercise classes)? (circle) Yes No

a. If yes, please write in below the activities you do. Also write down estimates for the number of minutes and the number of times each week for each one.

Type of Activity _____ # minutes _____ # times/wk _____

Type of Activity _____ # minutes _____ # times/wk _____

Type of Activity _____ # minutes _____ # times/wk _____

Type of Activity _____ # minutes _____ # times/wk _____

b. If you are not physically active on a regular basis, are you willing to start an exercise program? (circle) Yes No

31. What prevents you from exercising more? Fill in ( ) one answer:

( ) I think I do get enough exercise
( ) I have no time
( ) My health is not good (such as asthma, arthritis, etc.)
( ) The neighborhood is too unsafe to be outside
( ) I cannot afford gym memberships
( ) I do not have anyone to keep me encouraged
( ) I do not think that exercise is important
( ) Other: _____

32. Do you ever have chest pain or shortness of breath with physical activity? (circle) Yes No

Sleep/Other

33. At what time do you usually go to sleep? _____

34. How long do you sleep for each day? _____

35. Please use the space below to tell us anything else you think is important in understanding your weight problem or your successful participation in the program.

_____
_____
_____