



Mary Washington Weight Loss Center

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Initial Evaluation Form

Medical History *(Check All That Apply)*

- Elevated blood sugars
- Gestational diabetes
- Heart disease
- High cholesterol
- High blood pressure
- Ankle/leg swelling
- Asthma
- Shortness of breath
- Acid reflux/GERD
- Hiatal hernia
- Fatty Liver
- Urinary incontinence
- Kidney stones

- Thyroid problem
- Polycystic ovary syndrome
- Anemia
- Sleep apnea
- Depression/anxiety
- Arthritis
- Migraine/headaches
- Cancer
- Diabetes
- Other _____

Family History: *(Check All That Apply)*

- High blood pressure
- Heart disease
- Diabetes
- High cholesterol
- Sleep apnea

- Obesity
- Thyroid problems
- Asthma
- Other _____

Smoking Status:

- Current daily smoker
- Social smoker
- Former smoker
- Never smoked

Alcohol use:

- Yes No
- Type: _____
- Amount: _____
- Frequency: _____

Drug use:

- Yes No
- Type: _____
- Frequency: _____

Surgical History: *(Please list previous surgeries.)*

Have you or your relatives/spouse ever had bariatric surgery? Yes No

If yes, what type of procedure was performed? _____

Patient Name: _____ Date: _____