Bluepoint MEDICAL ASSOCIATES
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CENTREVILLE

2080 Old Bridge Road
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LAKERIDGE

Initial Evaluation Form

Patient Name: ______________________________ DOB: ______________________________

Medical History

☐ Elevated Blood Sugar	☐ Shortness of Breath	☐ Anemia
☐ Diabetes	☐ Acid Reflux/GERD	☐ Sleep Apnea
☐ Gestational Diabetes	☐ Hiatal Hernia	☐ Depression/Anxiety
☐ Heart Disease	☐ Fatty Liver	☐ Arthritis
☐ High Cholesterol	☐ Urinary Incontinence	☐ Migraine Headaches
☐ High Blood Pressure	☐ Kidney Stones	☐ Cancer
☐ Ankle/Leg swelling	☐ Thyroid Problem	☐ Other:
☐ Asthma	☐ Polycystic Ovary Syndrome	

Family History

☐ High Blood Pressure	☐ High Cholesterol	☐ Thyroid Problem
☐ Heart Disease	☐ Sleep Apnea	☐ Asthma
☐ Diabetes	☐ Obesity	☐ Other:

Surgical History *(Please list previous surgeries)*

***Have you or one of your relatives/spouse ever had Bariatric Surgery?** ☐ Yes ☐ No

If yes, what type of procedure was performed?

☐ Gastric Banding ☐ Roux-en-Y Gastric Bypass ☐ Sleeve Gastrectomy
☐ Other: ____________________

Social History

Smoking Status: ☐ Never Smoker ☐ Smoker ☐ Former Smoker

Alcohol Use: ☐ Yes ☐ No Type: ____________________

Drug Use: ☐ Yes ☐ No Type: ____________________

Medications:	

Known Allergies:	