

Weight Loss Surgery Screen Information: *(Please print in black ink only)*

PLEASE LIST YOUR FULL LEGAL NAME:

LAST: _____ FIRST: _____ MIDDLE: _____

STREET ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

E-MAIL ADDRESS: _____

SOCIAL SECURITY # _____ DATE OF BIRTH: _____ AGE _____ GENDER M F

MARITAL STATUS: Married__ Divorced__ Widowed__ Single

EMPLOYER: _____

EMPLOYER ADDRESS: _____

WORK PHONE: _____ PAGER/CELL PHONE _____

NAME OF SPOUSE/RESPONSIBLE PERSON: _____

RELATIONSHIP: _____ SOCIAL SECURITY # (if under their plan) _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

DAYTIME PHONE # _____

EMERGENCY CONTACT: _____

PHONE: _____ DOES EMERGENCY CONTACT SHARE YOUR ADDRESS? YES NO

EMERGENCY CONTACT MAY RECEIVE INFORMATION ABOUT YOUR MEDICAL CONDITION.

PRIMARY CARE PHYSICIAN/FAMILY CARE DOCTOR: _____

PHONE: _____ FAX: _____

HOW DID YOU HEAR ABOUT US? (Circle one)

Internet Seminar Referring Physician
Hospital referral line Friend Other: _____

INSURANCE INFORMATION: *Include a copy of the front and back of your insurance card*

PLEASE BE AS COMPLETE AS POSSIBLE – INCOMPLETE INFORMATION LEADS TO DELAYS IN PROCESSING

INSURANCE COMPANY: _____

ADDRESS: _____

ID# _____ GROUP # _____

PHONE # _____ PLAN: _____

NAME OF INSURED: _____ DATE OF BIRTH _____

SECONDARY INSURANCE: _____

ADDRESS: _____

ID# _____ GROUP # _____

PHONE # _____ PLAN: _____

NAME OF INSURED: _____ DATE OF BIRTH _____

I AUTHORIZE RELEASE OF MY MEDICAL RECORDS FOR USE IN PURSUING BENEFITS AND TO OTHER PHYSICIAN OFFICES AS DEEMED NECESSARY IN THE COURSE OF MY TREATMENT.

I HEREBY ASSIGN, TO THE PHYSICIAN, ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE. COPAYMENT AND DEDUCTIBLES ARE TO BE PAID AT THE TIME OF OFFICE VISIT.

PATIENT OR RESPONSIBLE PARTY

DATE

MEDICAL HISTORY

Patient Name: _____ Age: _____

Reason for Visit: _____

For Doctor's Notes: _____

Name

Address

Phone

Primary Care Physician: _____

Gynecologist: _____

Other: _____

PAST & CURRENT MEDICAL HISTORY

Please circle any of the following conditions/problems/disease that you either now have or have been diagnosed with in the past:

Abuse (Physical/Mental/Sexual/etc.)	Blood Clots	Glaucoma/Cataract	Lung disease
Abnormal PAP	Cancer/Tumor	Gout	Osteoporosis
Alcoholism/Drugs	Cholesterol (high)	Headaches/Migraine	Serious accident/Injury
Anemia	Chronic Pain	Heart disease	Sexual disease/VD
Anxiety/Nerves	Depression	Hepatitis (Any)	Stroke
Arthritis	Diabetes/Sugar	High Blood pressure	Thyroid Disease
Asthma/Allergies	Epilepsy/Seizures	HIV/AIDS	Tuberculosis
Bleeding disease	Genetic diseases	Kidney or Bladder problems	Ulcers/Stomach disease

Others: _____

PAST SURGICAL HISTORY : *List the year you had any of the following*

<i>Appendectomy</i> _____	<i>Gallbladder</i> _____
<i>Hernia</i> _____	<i>Tonsillectomy</i> _____
<i>Blood Transfusion</i> _____	<i>Heart / Cardiac</i> _____
<i>Hysterectomy</i> _____	<i>Tubal / Vasectomy</i> _____
<i>Stress Test/Cardiac Cath</i> _____	<i>Orthopedic</i> _____
<i>Other</i> _____	<i>Other</i> _____

CURRENT MEDICATIONS : *List all medications that you take routinely or that have been prescribed for you by a doctor (include vitamins, over-the-counter medications, eye drops, herbal medications, etc.)*

MEDS	DOSE	HOW OFTEN	MEDS	DOSE	HOW OFTEN
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

*Attach a medication list or ask for another sheet of paper if medications exceed the space given

ALLERGIES: (circle all allergies that apply and specify on lines given below)

NONE
Tape/Adhesive

Antibiotics (please specify)
Medications (please specify)

Latex
Other (please specify)

X-ray Contrast / Iodine

Specify: _____

PERSONAL & SOCIAL HISTORY:

Do you use (or have you used) any of the following:

Tobacco Never Now Quit (year) _____ Type Used: Cigarettes Cigars Pipe Smokeless
Amount used per day: _____ How many years: _____

Alcohol Never Now Quit (year) _____ Type Used: Beer Wine Liquor Other
Amount used per week: 12oz beer _____ 6oz wine _____ 2oz shots _____

Illegal Drugs Never Now Quit (year) _____ Type Used: Marijuana Cocaine IV Pain Pills Other
Amount used per day: _____ How many years: _____

Exercise None per week # of times/week: _____ Doing what? _____

Marital Status Married Divorced Single Widowed

Number of Children _____

Occupation _____

Are you disabled? YES NO

If Yes, reason for disability _____

FEMALES

Age at First Menstrual Cycle _____ Menstrual irregularities YES NO
Number of Pregnancies _____ Number of Live Births _____
Miscarriages / Abortions _____ Infertility YES NO
Date of last period _____ Date of Last Mammogram _____
Facility Done _____

FAMILY HISTORY:

Blood Relatives	Living?		Age	Obese?	Illness/Cause of death
Mother	YES	NO			
Grandmother	YES	NO			
Grandfather	YES	NO			
Father	YES	NO			
Grandmother	YES	NO			
Grandfather	YES	NO			
Sibling	YES	NO			
Child	YES	NO			

DIETARY HISTORY

List the approximate dates and diet programs you have tried:

PROGRAM	CHECK IF YES	START DATE	DURATION	PHYSICIAN SUPERVISED	MAX LOSS
Jenny Craig					
Nutri-System					
LA Weight Loss					
Weight Watchers					
Atkins Diet					
Sugar Busters					
T.O.P.S					
Metabolife					
Herbalife					
South Beach					
Overeaters Anonymous					
Grapefruit Diet					
Slimfast/Liquid Diet					

List any other weight loss attempts: _____

For female patients only:

Pregnancy #1	Year	Weight at Start	At delivery	Lost after 1 year
	_____	_____	_____	_____
Pregnancy #2	Year	Weight at Start	At delivery	Lost after 1 year
	_____	_____	_____	_____
Pregnancy #3	Year	Weight at Start	At delivery	Lost after 1 year
	_____	_____	_____	_____
Pregnancy #4	Year	Weight at Start	At delivery	Lost after 1 year
	_____	_____	_____	_____

EATING HABITS (Circle the patterns which best describe your eating habits on a regular basis)

3 meals/day

2 meals/day

Graze all day (5 or more meals/day)

Usually eat breakfast

Usually eat lunch

Usually eat dinner

Usually skip breakfast

Usually skip lunch

Usually skip dinner

Eat very little on some days & a lot on others

Other: _____

FOOD PREFERENCES (Circle the top 5 foods which you prefer – which foods most likely to give into temptation)

- | | | |
|------------------|--------------|-------------|
| Soda/soft drinks | French Fries | Fried Foods |
| Chips/Snacks | Steak/chops | Candy |
| Potatoes | Chocolate | Pasta |
| Cookies | Pizza | Cake/pies |
| Salad dressings | Milk | Juice |
| Beer | Wine | Cocktails |

MEDICATIONS (List the weight loss medications you have taken)

MEDICATION	CHECK IF YES	START DATE	DURATION	PHYSICIAN SUPERVISED	MAX LOSS
Amphetamines					
Phentermine					
Phen-Fen					
Dexfenfluramine (Redux)					
Xenical (Orlistat)					
Meridia					
Lindora					
Other Diet Medications					

PROGRAMS (List any alternative methods you have tried)

PROGRAM	CHECK IF YES	START DATE	DURATION	PHYSICIAN SUPERVISED	MAX LOSS
Acupuncture					
Hypnosis					
Biofeedback					
Behavior Modification					
Exercise					

List all exercise programs you have tried: _____

PREVIOUS WEIGHT LOSS SURGERIES

Surgery	Date	Location	Surgeon	Weight Loss

Is your family supportive of your having weight loss surgery? YES____NO____

PROGRAM EXPECTATIONS/PATIENT AGREEMENT:

NAME:_____ SEMINAR DATE:_____

1. I AM READY TO PURSUE SURGERY AS AN OPTION FOR TREATMENT OF MY OBESITY.
2. I AGREE TO FOLLOW THE PROGRAM AS PRESCRIBED, ACTIVELY PARTICIPATE IN MY AFTERCARE,ATTEND SUPPORT GROUP MEETINGS AS ABLE, AND UTILIZE THE ON-LINE GROUP WHEN UNABLE TO ATTEND GROUP MEETINGS.
3. I AGREE THAT I AM PRIMARILY RESPONSIBLE FOR OBTAINING INSURANCE APPROVAL FOR THIS PROCEDURE. I WILL FURNISH ALL RECORDS REQUESTED BY THE PROGRAM IN A TIMELY MANNER. I WILL FOLLOW UP AND INFORM THE PROGRAM OF ANY ADDITIONAL INFORMATION NEEDED TO OBTAIN APPROVAL.
4. I REALIZE THAT I AM RESPONSIBLE FOR CHARGES INCURRED FOR MY CARE SHOULD MY INSURER FAIL TO REIMBURSE IN AN ACCEPTABLE AND TIMELY MANNER.

SIGNATURE:_____