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 ABOUR YOUR MEDICAL CONDITION.

PRIMARY CARE PHYSICIAN/FAMILY CARE DOCTOR:_____

PHONE:_____FAX:_____

HOW DID YOU HERE 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*

Appendectomy	_____	*Gallbladder*	_____
Hernia	_____	*Tonsillectomy*	_____
Blood Transfusion	_____	*Heart / Cardic*	_____
Hysterectomy	_____	*Tubal / Vasectomy*	_____
Stress Test/Cardic Cath	_____	*Orthopedic*	_____
Other	_____	*Other*	_____

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 Antibiotics (please specify) Latex X-ray Contrast / Iodine
Tape/Adhesive Medications (please specify) Other (please specify)

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 Type Used: Marijuana Cocaine IV Pain Pills Other

Quit (year) _____

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			

PATIENT HISTORY QUESTIONAIRE

The information requested in this questionnaire is very important. To give you the best care, and to obtain your insurance approval, we must have complete answers.

WEIGHT HISTORY

Please estimate as closely as possible for all that apply

Birth Weight _____

Weight at start of school _____ Age:_____

Weight at high school graduation _____ Age: _____

Weight at marriage(s) _____ Age:_____

Current weight_____ Current height_____

Lowest weight in past 5 years _____

Highest weight in past 5 years_____

Using your own words, tell us how you believe your life will change by losing weight. What are your hopes, dreams, fears:

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					
Herbalfe					
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 (Oristat)					
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:_____