Doctor_______________________

OBESITY SURGERY SPECIALISTS

PATIENT INFORMATION

The information provided in this form is vitally important in the planning of your surgical care. Omission of complete and accurate information to the physician could result in the delay or cancellation of your surgery as well as jeopardize the ability of the physician to provide the best possible care.

PATIENT: ____
FIRST MIDDLE LAST

BIRTHDATE: ____________ AGE: ________MARITAL STATUS: S M W D Race__________

ADDRESS: ____
STREET APT# CITY STATE ZIP

HOME PHONE: _________________SOCIAL SECURTIY: _________________________

CELL PHONE: _________________________E-MAIL: ____________________________

EMPLOYER: ___________________________________PHONE: ____________________

ADDRESS: ______________________________________OCCUPATION: ______________
STREET CITY, STATE, ZIP

EMERGENCY CONTACT______________________________ PHONE #: ________________

ADDRESS:______________________________________RELATIONSHIP:______________

I

INSURED NAME (if other than patient): ______________________INSURANCE RENEWAL DATE________

ADDRESS: ____
STREET CITY STATE ZIP

BIRTHDATE: __________________SOCIAL SECURITY: _____________________________

EMPLOYER: ___________________________________PHONE: ____________________

ADDRESS: ______________________________________OCCUPATION: ______________
STREET CITY, STATE, ZIP

PRIMARY CARE PHYSICIAN _____________________________ PHONE #: ______________

ADDRESS____

May we send your PCP information about your case? ☐ Yes ☐ No

ARE YOU RECEIVING DISABILITY BENEFITS? ☐ No ☐ Yes REASON FOR DISABILITY?____________________

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS.
I AUTHORIZE PAYMENT OF INSURANCE BENEFITS TO_________________________ FOR HIS SERVICES.

______________________________ ____________________
SIGNATURE DATE

______________________________ ____________________
PARENT SIGNATURE (if patient under 18 yrs) DATE

How did you hear about Obesity Surgery Specialists?_________________________________

What is your current Weight?_____________ What is your current height? _________________

Are you interested in: (circle one) Gastric Bypass Surgery Lap-Band

List any medical problems you have for which you have seen a doctor or been hospitalized.

ILLNESS	DATE	TREATMENT	OUTCOME

Have you been diagnosed or treated for high blood pressure? ☐ No ☐ Yes
Have you been diagnosed or treated for diabetes? ☐ No ☐ Yes
Do you have high blood cholesterol? ☐ No ☐ Yes
Do you have high blood fats or triglycerides? ☐ No ☐ Yes
Have you ever been diagnosed with asthma? ☐ No ☐ Yes
Have you been diagnosed or treated for heartburn or
gastro-esophageal reflux (GERD)? ☐ No ☐ Yes
Have you ever had stomach ulcers? ☐ No ☐ Yes
Have you ever had blood clots in your leg veins? ☐ No ☐ Yes
Have you ever been anemic? ☐ No ☐ Yes
Have you ever had iron deficiency or taken iron? ☐ No ☐ Yes
Have you ever been diagnosed with hypothyroidism? ☐ No ☐ Yes
Have you ever had thyroid surgery? ☐ No ☐ Yes
Do you take thyroid replacement medication? ☐ No ☐ Yes

List all surgeries and specify if done open or laparoscopically.

SURGERY	DATE	REASON	OPEN or LAP

Have you had Weight loss surgery before? ☐ No ☐ Yes
If Yes when and what type of surgery____

Does your religion prohibit you from receiving blood products? ☐ No ☐ Yes
Have you had your gallbladder removed? ☐ No ☐ Yes
Have you had a hysterectomy? ☐ No ☐ Yes
Have you had a tubal ligation or had your “tubes tied”? ☐ No ☐ Yes

Pt. Name: _________________________

List all current medications, including prescriptions, vitamins, over-the-counter, and intermittently used drugs.

NAME	STRENGTH	HOW OFTEN TAKEN	PURPOSE	WHEN FIRST STARTED	REQUIRED DAILY	AS NEEDED

List any allergies to medication and explain reactions you experienced.

____

____

____

Do you take aspirin on a daily basis? ☐ No ☐ Yes
Do you take Plavix? ☐ No ☐ Yes
Do you take Coumadin? ☐ No ☐ Yes
Do you take Prednisone or Dexamethasone? ☐ No ☐ Yes

Have you ever smoked tobacco products? ☐ No ☐ Yes
If yes, how many years?_____________How many cigarettes per day?_______________________
Do you currently use tobacco products? ________________If yes, how many per day?________________

Do you get chest pain when exercising? ☐ No ☐ Yes
Do you get short of breath at rest? ☐ No ☐ Yes
Do you get short of breath when exercising? ☐ No ☐ Yes
Do you experience irregular or excessively strong heartbeats? ☐ No ☐ Yes
Do you sleep lying flat? ☐ No ☐ Yes
Do you wake up at night short of breath? ☐ No ☐ Yes
Have you had any blackouts? ☐ No ☐ Yes
Do you get swollen ankles? ☐ No ☐ Yes
Have you had easy or excessive bleeding from surgery
or minor injuries? ☐ No ☐ Yes
Have you had easy bruising? ☐ No ☐ Yes
Do you have heavy periods? ☐ No ☐ Yes
Are you still having periods? ☐ No ☐ Yes

Sleep Apnea Self Test

The quiz is designed to alert you to any problems resulting from poor sleep. Please answer the questions below. If you have had any symptoms in the past year, mark the box below and add up the total.

(20) _____ 1. I have been told that I snore or I know that I snore.
(-50) _____ 2. I definitely do not snore.
(0) _____ 3. I do not know if I snore.
(10) _____ 4. I have been told that I stop breathing when I sleep.
(10) _____ 5. I wake up choking.
(5) _____ 6. I sweat excessively at night.
(-5) _____ 7. (if female and above is true) I have hot flashes related to my cycle.
(2) _____ 8. I am tired and sleepy during the day even after 8 hours of sleep.
(2) _____ 9. I wake up tired and unrested.
(10) _____ 10. I suddenly wake up unable to breath.
(5) _____ 11. I have fallen asleep while driving.
(5) _____ 12. I am a restless sleeper (toss and turn a lot).
(20) _____ 13. My neck circumference is more than 17 inches.
(ask office staff to measure if unknown)
(5) _____ 14. I frequently have morning headaches.

_________Total (more than 30 points suggests that you have SLEEP APNEA.

Do you sleep with a C-Pap or Bi-Pap? (if yes circle one)

Have you ever received psychiatric treatment? ☐ No ☐ Yes

Diagnosis or reason for treatment: ____
Last treatment date: ______________________

Treated by : ☐ psychiatrists ☐ psychologists ☐ physician

Physicians Name: ____
Address: ____
Phone number: ____

Pt. Name:________________________
Last updated 7/15/2007

DIETARY HISTORY

PLEASE COMPLETE THIS FORM AS PRECISELY AS POSSIBLE

DIET PROGRAMS:	# Times Tried	Date(s) Tried	Length Of Time On Diet	# Lbs Lost	# Lbs Regained
Example:	3	1990/93/95	2-3 moth ea	5-24 lbs	All+
M.D. SUPERVISED					
☐ Medi-Fast………………………………………	______	__________	__________	_______	_______
☐ Opti-Fast………………………………………	______	__________	__________	_______	_______
☐ Mayo Clinic……………………………………	______	__________	__________	_______	_______
☐ Physician Diet Program……………………..	______	__________	__________	_______	_______
Shots: ☐ B-6……………………………………	______	__________	__________	_______	_______
☐ B-12…………………………………..	______	__________	__________	_______	_______
☐ Other________________………..	______	__________	__________	_______	_______
Pills: ☐ Lasix (diuretic)……………………..	______	__________	__________	_______	_______
☐ Xenical………………………………	______	__________	__________	_______	_______
☐ Meridia………………………………	______	__________	__________	_______	_______
☐ Other_________________………	______	__________	__________	_______	_______

M.D./Clinic Name____

NON M.D. SUPERVISED					
☐ Weight Watchers……………………………	______	__________	__________	_______	_______
☐ Nutri-Systems……………………………….	______	__________	__________	_______	_______
☐ Jenny Craig………………………………….	______	__________	__________	_______	_______
☐ Diet Center…………………………………..	______	__________	__________	_______	_______
☐ TOPS………………………………………...	______	__________	__________	_______	_______
☐ Overeaters Anonymous……………………	______	__________	__________	_______	_______
☐ Other:___________________…………….	______	__________	__________	_______	_______
LIQUID DIETS					
☐ Slimfast……………………………………..	______	__________	__________	_______	_______
☐ Sweet Success…………………………….	______	__________	__________	_______	_______
☐ Liquid Protein………………………………	______	__________	__________	_______	_______
☐ Other____________________………….	______	__________	__________	_______	_______

DIET PROGRAMS:

	# Times Tried	Date(s) Tried	Length Of Time On Diet	# Lbs Lost	# Lbs Regained
MISCELLANEOUS DIETS					
☐ Low Calorie Diet……					
☐ Low Fat Diet……					
☐ High Protein Diet……					
☐ Self-Imposed Fasts……					
☐ Richard Simmons……					
☐ Herbal Life……					
☐ Cambridge Diet……					
☐ Dr. Atkins Diet……					
☐ Other:________……					
DIET PILLS (over the counter)					
☐ Acutrim……					
☐ Dexatrim……					
☐ Metabolife……					
☐ Xenadrine……					
☐ Other:________……					
OTHER TYPES OF WEIGHT LOSS					
☐ Psychotherapy……					
☐ Acupuncture……					
☐ Hypnosis……					
☐ Subliminal Tapes……					
☐ Other:________……					
EXERCISE					
☐ Health Club……					
☐ VCR Tapes……					
☐ Other:________……					

How long have you been overweight?__________

Age began first diet?______________

Most weight you ever lost?______________lbs

How was weight loss obtained?______________

Are you a snacker? ☐Yes ☐No

Favorite foods____________________________

Do you eat a lot of sweets? ☐Yes ☐No

How often do you eat sweets?______________

Are you currently under a physicians care for weight loss? ☐Yes ☐No
If yes, name and address:____

I have provided complete and accurate information to the best of my knowledge.

Pt. Name:________________________

Last updated 7/15/2007