

## 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

ADDRESS: \_\_\_\_\_  
STREET APT# CITY STATE ZIP

HOME PHONE: \_\_\_\_\_ SOCIAL SECURITY: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
STREET CITY, STATE, ZIP

EMERGENCY CONTACT \_\_\_\_\_ PHONE #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

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 \_\_\_\_\_

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? \_\_\_\_\_

Pt. Name: \_\_\_\_\_ 1

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

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



### 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: \_\_\_\_\_

**DIETARY HISTORY**

**PLEASE COMPLETE THIS FORM AS PRECISELY AS POSSIBLE**

DIET PROGRAMS:	<u># Times Tried</u>	<u>Date(s) Tried</u>	<u>Length Of Time On Diet</u>	<u># Lbs Lost</u>	<u># Lbs Regained</u>
Example:	3	1990/93/95	2-3 moth ea	5-24 lbs	All+
<b><u>M.D. SUPERVISED</u></b>					
<input type="checkbox"/> Medi-Fast.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Opti-Fast.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Mayo Clinic.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Physician Diet Program.....	_____	_____	_____	_____	_____
<b>Shots:</b> <input type="checkbox"/> B-6.....	_____	_____	_____	_____	_____
<input type="checkbox"/> B-12.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Other.....	_____	_____	_____	_____	_____
<b>Pills:</b> <input type="checkbox"/> Lasix (diuretic).....	_____	_____	_____	_____	_____
<input type="checkbox"/> Xenical.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Meridia.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Other.....	_____	_____	_____	_____	_____

M.D./Clinic Name \_\_\_\_\_

**NON M.D. SUPERVISED**

<input type="checkbox"/> Weight Watchers.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Nutri-Systems.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Jenny Craig.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Diet Center.....	_____	_____	_____	_____	_____
<input type="checkbox"/> TOPS.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Overeaters Anonymous.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Other:.....	_____	_____	_____	_____	_____

**LIQUID DIETS**

<input type="checkbox"/> Slimfast.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Sweet Success.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Liquid Protein.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Other.....	_____	_____	_____	_____	_____

DIET PROGRAMS:	# Times Tried	Date(s) Tried	Length Of Time On Diet	# Lbs Lost	# Lbs Regained
<u>MISCELLANEOUS DIETS</u>					
<input type="checkbox"/> Low Calorie Diet.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Low Fat Diet.....	_____	_____	_____	_____	_____
<input type="checkbox"/> High Protein Diet.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Self-Imposed Fasts.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Richard Simmons.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Herbal Life.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Cambridge Diet.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Dr. Atkins Diet.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Other: _____	_____	_____	_____	_____	_____
<u>DIET PILLS (over the counter)</u>					
<input type="checkbox"/> Acutrim.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Dexatrim.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Metabolife.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Xenadrine.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Other: _____	_____	_____	_____	_____	_____
<u>OTHER TYPES OF WEIGHT LOSS</u>					
<input type="checkbox"/> Psychotherapy.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Acupuncture.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Hypnosis.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Subliminal Tapes.....	_____	_____	_____	_____	_____
<input type="checkbox"/> Other: _____	_____	_____	_____	_____	_____
<u>EXERCISE</u>					
<input type="checkbox"/> Health Club.....	_____	_____	_____	_____	_____
<input type="checkbox"/> VCR Tapes.....	_____	_____	_____	_____	_____
<input type="checkbox"/> 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.**

