WEIGHT LOSS SURGERY HEALTH QUESTIONNAIRE

Patient Name: _____Date of Birth: _____

The following information is very important to your health. Please take time to fully and completely fill out these forms. Important decisions are based on this information.

Weight Loss History:

Please check the appropriate boxes and add notes as needed (please be specific).
My obesity started: ☐ In childhood ☐ At puberty ☐ As an adult
☐ After pregnancy ☐ After a traumatic event
☐ _____

Additional notes regarding the onset of obesity: _____
_____
_____
_____
_____

Medical Problems: Have you been diagnosed with any of the following?

___ Diabetes ___ High Blood Pressure ___ Sleep Apnea ___Heart Disease

___ GERD ___ Hiatal Hernia ___ Joint Problems ___ Blood Clots

___ Asthma ___ Portal Hypertension ___ Stomach Ulcers ___ Autoimmune Disorder

___ Anorexia ___ Bulimia ___ Depression

Number of visits to your physician for medical problems (asthma, hypertension, heart problems, diabetes, arthritis, respiratory, circulation, etc) related to obesity:

Monthly _____ Estimated expense _____ Covered by Insurance? _____

Medically Supervised Weight Loss Attempts:

Drs who are following, or have followed, your weight problems: NAME	Diet programs your doctor has you trying, or has had you try:	**Weight Lost**	**Weight Regained**	**Length of Program**	**Est Cost**

Patient Name: _____Date of Birth: _____

Weight Loss Programs/Diets/Medications:

PROGRAM	**YEAR**	**WT LOSS**	**WT REGAINED**	**HOW MANY TIMES**	**LENGTH OF PROGRAM**	**EST. COST**
WEIGHT WATCHERS						
METABOLIFE						
OVEREATERS ANONYMOUS						
DIET CENTERS: Jenny Craig						
Nutra System						
Other:						
SLIM FAST						
OPTIFAST						
HYPNOSIS						
ACUPUNCTURE						
HERBAL LIFE						
RICHARD SIMMONS						
FAD DIETS:						
SELF IMPOSED DIET ATTEMPTS:						
OTHER:						
MEDICATIONS:						
FEN-PHEN						
REDUX (dexfenluramine)						
XENICAL (orlistat)						
MERIDIA (sibutramine)						
TENUATE (diethylpropion)						
ADIPEX (phentermine)						
AMPHETAMINES, STIMULANTS						
DEXATRIM						
OTHER:						

Patient Name: _____Date of Birth: _____

Eating Habits: (please check all that apply)

Do you consider yourself a:
☐ Grazer ☐ Snacker ☐Sweet Eater ☐Binge Eater ☐ Eat large portions

Do you eat for any of the following reasons:
☐ Stress ☐ Boredom ☐ Loneliness ☐ Other: _____

Physical Exercise:

PROGRAM	TIME SPENT	WT LOSS	WT REGAINED	LENGTH OF PROGRAM	EXPENSE
Bicycling					
Jogging					
Walking					
Swimming					
Spa Memberships					
Aerobic					
Video Tapes					
Health Rider					
Home Gym Equipment					

Describe the limitation (physical, emotional, employment) morbid obesity imposed on you in your daily activity: (If additional space is required, please use a separate sheet.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

The above is true and correct to the best of my belief.

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____

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PATIENT INFORMATION FORM

Please fill out completely

Name of Patient: _____ _____ _____ _____
First Middle Last Date of Birth Sex Marital Status

Address: _____City:_____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work Phone: _____

Social Security Number: _____ Driver's License#:_____ Email: _____

Employer: _____ Occupation: _____

Employment Address: _____ May we contact you at work? (Circle) Yes No

Emergency Contact: Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Who referred you to our office?

Name: _____ **Phone:** _____

Address: _____City:_____ State: _____ Zip: _____

Primary Care Physician:

Name: _____ **Phone:** _____

Address: _____City:_____ State: _____ Zip: _____

*****In order to avoid error or delay in the processing of your insurance claim, it is essential that the following section be filled out completely*****

PRIMARY INSURANCE COMPANY

Name: _____

Member ID Number: _____

Group Number: _____ Copay: _____

Name of Insured (employee):_____

Employer: _____

Employer Phone: _____

Insured's Social Security: _____

Insured's Date of Birth: _____

SECONDARY INSURANCE COMPANY

Name: _____

Member ID Number: _____

Group Number: _____ Copay: _____

Name of Insured (employee):_____

Employer: _____

Employer Phone: _____

Insured's Social Security: _____

Insured's Date of Birth: _____

It is my responsibility to pay any co-payment, deductible amount, co-insurance or any other balance not paid by my insurance. Finance charges (at an annual rate not to exceed 18%) on unpaid balances will be added to my account after 90 days. If it becomes necessary for my account to be turned over to a collection agency, I understand that collection fees will be added to my balance. I understand I will be responsible to pay all collections fees, attorney fees and court costs.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicaid, Private Insurance and other Health Plans to: **Center of Surgical Specialists, PC.** This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information, including medical history and medical records, to my insurance company.

_____ _____
PATIENT SIGNATURE **DATE**

Update: _____

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Patient History Form **DATE:** _____

Patient Name: _____ Age: _____ Date Of Birth: _____

The following information is very important to your health. Please take time to fully and completely fill out these forms. Important decisions are based on this information.

Height: _____ Weight: _____

ALLERGIES: Are you allergic to any medications (including over-the-counter drugs or iodine, tape or latex)?
Circle one: Yes No If yes, please complete the following:

Drug Allergy:	Reaction:	Other Allergy:	Reaction:
_____		_____	
_____		_____	
_____		_____	
_____		_____	

MEDICAL PROBLEMS: Please list **all** medical problems you have.

_____ _____
_____ _____
_____ _____
_____ _____

MEDICATIONS: Please list **all** medications (specify dosage and frequency) you are currently taking, including aspirin, over-the-counter medications, vitamins and herbal supplements.

_____ _____
_____ _____
_____ _____
_____ _____

Please list your PAST medications.

_____ _____
_____ _____
_____ _____

OPERATIONS: Please list **all** operations you have had.

Operation:	Date:	Operation:	Date:
_____		_____	
_____		_____	
_____		_____	
_____		_____	

SOCIAL HISTORY:
Do you use any type of tobacco product? Yes No If yes, how much per day _____
Have you EVER used any type of tobacco product? Yes No Date Quit _____
Do you drink alcohol? Yes No If yes, how often? _____
Do you use illicit drugs? Yes No If yes, please list: _____
For women: Last menstrual period: _____ Number of Pregnancies: _____ Number of Live Births: _____

Physician Signature: _____ **Date:** _____

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Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY: Have you been diagnosed with and/or are you currently having any of the following symptoms? Please check all that apply.

Neurologic/HEENT:
Have you had any neurological problems? Yes___ No___
___ Numbness/tingling
___ Loss of strength
___ Stroke (CVA/TIA)
___ Headaches-type _____
___ Seizures/epilepsy
___ Multiple Sclerosis
___ Ear problems
___ Eye problems
___ Nose/sinus problems
___ Throat problems

Musculoskeletal/Skin:
Have you had any muscle/bone problems? Yes___ No___
___ Back or neck problems/Joint pain
___ Loss of sensation
___ Rash/skin breakdown
___ Arthritis-type _____
___ Fractures-type _____
___ Osteoporosis

Endocrine:
Have you had any endocrine problems? Yes___ No___
___ Tired/Sluggish
___ Excessive thirst
___ Diabetes
___ Thyroid problems

Respiratory:
Have you had any breathing problems? Yes___ No___
___ Wheezing
___ Shortness of breath
___ Productive or bloody cough
___ Asthma
___ Emphysema/COPD
___ Bronchitis
___ Pneumonia
___ Sleep apnea
___ Pulmonary embolism

Cardiac:
Have you had any heart problems? Yes___ No___
___ Chest pain (Angina)
___ Palpitations/heart racing
___ Congestive heart failure
___ Heart attack
___ High blood pressure
___ Pacemaker
___ Heart valve
___ Rheumatic fever

Blood/Immune System:
Have you had any problems? Yes___ No___
___ Swollen glands
___ Anemia
___ Cirrhosis
___ DVT/phlebitis/blood clots
___ Jaundice
___ Lupus
___ Bleeding disorders
___ Scleroderma

Digestive (Stomach/Bowel):
Have you had any digestive problems Yes___ No___
___ Abdominal pain
___ Nausea/vomiting
___ Constipation
___ Diarrhea
___ Colitis
___ Diverticulitis
___ Hiatal hernia/reflux disease
___ Irritable bowel syndrome
___ Ulcers
___ Pancreatitis
___ Rectal Bleeding/rectal pain
___ Change in bowel habits
___ Hemorrhoids

Genitourinary/GYN:
Have you had any problems? Yes___ No___
___ Kidney problems/stones
___ Bladder infections
___ Kidney failure
___ Hernia

Men:
___ Prostate problems
___ Loss of sexual function

Women:
___ Uterine problems
___ Ovarian problems
___ Infertility
___ Bleeding between periods
___ Ever taken birth control pills? When: _____
___ Complications from childbirth

Constitutional:
Have you had any problems? Yes___ No___
___ Fever
___ Chills
___ Weight Loss
___ Night sweats

Communicable Diseases:
Have you had any problems? Yes___ No___
___ AIDS/HIV
___ Hepatitis A/B/C
___ Sexually transmitted disease
___ Tuberculosis

Psychological (Emotional):
Have you had any problems? Yes___ No___
___ Nervousness
___ Anxiety
___ Depression
___ Other _____

Physician Signature: _____

Date: _____

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Patient Name: _____ Date of Birth: _____

Cancer:

Have you ever been diagnosed with cancer? Yes___ No___

Type of Cancer:	Treatment:

Other:
Have you had any other medical problems not listed here?
Yes___ No___ Please list below:

_____

_____

_____

FAMILY HISTORY:

Please check which, if any, of your blood relatives had any of the following conditions:

Condition	**Parent**	**Siblings/ Children**	**Other Relatives** (Grandparents, Aunts, Uncles, Cousins, etc.)	**No Family History**	**Don't Know**
Diabetes					
Heart Disease					
Hypertension					
Gallstones					
Obesity					
Sleep Apnea					
Asthma					
Blood clots					
Cancer					
Stroke					
Kidney Disease					
Bleeding Problems					
Gout					
Allergies					
Dermatitis/Eczema					
High Cholesterol					
Osteoporosis					
Autoimmune Disease					
Psychiatric Illness					

Physician Signature: _____ **Date:** _____

******No changes to history******

Physician Signature: _____ **Date:** _____