SURGICAL WEIGHT MANAGEMENT ASSOCIATES

Restoring Health…Renewing Lives

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PATIENT INFORMATION

Date: _____ Patient Name: _____

Birth Date: _____/_____/_____ Age: _____ Gender: Male or Female

Social Security #: _____ Primary Language: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Native American ☐ Asian ☐ Other

Street Address, City, State, Zip: _____

Mailing Address (if different):_____

Primary Phone: (_____) _____ Secondary Phone: (_____) _____

Email Address: _____

Employer: _____

Occupation: _____ Status (Full-time, part-time, etc):_____

Emergency Contact Name: _____

Contact Phone: _____Relationship:_____

INSURANCE AND BILLING INFORMATION

Person Responsible for bill: _____

Birth Date: _____/_____/_____ Social Security: _____

Primary Insurance	Secondary Insurance
Name:	Name:
Phone #:	Phone #:
Policy/ Member #:	Policy/ Member #:
Group #:	Group #:
Subscriber Name:	Subscriber Name:
Relation to Patient: DOB:	Relation to Patient: DOB:
Subscriber SSN:	Subscriber SSN:
Subscriber Employer:	Subscriber Employer:

WEIGHT HISTORY

Height: _____ Weight: _____ BMI: _____

Which Surgery/ Procedure are you interested in? ☐ Gastric Sleeve
☐ Revision to previous bariatric surgery

Have you had prior surgery for weight loss? ☐ No ☐ Yes Type: _____ Date: _____

How long have you been overweight? _____

Have you been refereed to us? ☐ No ☐ Yes If yes, person name: _____

How did you hear about us? ☐ Physician ☐ Facebook
☐ Friend/Family ☐ Billboard
☐ Website ☐ Other: _____

Primary Care Physician or Internist: _____

List all physicians who have treated you for weight management:

Physician: _____ Phone#:_____

Years Treated: _____ ☐ Prescribed Diet ☐ Prescribed Medication: _____

Physician: _____ Phone#:_____

Years Treated: _____ ☐ Prescribed Diet ☐ Prescribed Medication: _____

List ant other diet or exercise programs, dates and weight lost:

_____

_____

_____

MEDICAL AND SURGICAL HISTORY

Please list all prescribed over-the-counter medications, vitamins, minerals:

Medication/Dose	Purpose

ALLERGIES: Please list all allergies including any known medication allergies and reactions

_____

_____

SURGICAL HISTORY: Check all surgeries you have had and note year surgery was performed

☐Appendectomy	☐ CABG	☐ Knee replacement
☐ Anti-reflux procedure	☐ Cesarean section	☐ Laminectomy
☐Bowel Resection	☐ Discectomy	☐ Past Gastric Surgery
☐Breast cancer, biopsy	☐ Gallbladder removal	☐ Peripheral Vascular procedure
☐Breast cancer, mastectomy	☐ Hip Replacement	☐ Tubal Ligation
☐Breast cancer, radiation	☐ Hysterectomy	☐ Vasectomy

Additional surgeries & approximate dates:

_____

_____

_____

FAMILY HISTORY: Please check if you have family history of any of the following

☐ Obesity ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke ☐ Cancer

☐ Bleeding Disorder ☐ Early Death (Cause: _____)

SOCIAL HISTORY:

Alcohol Use: ☐ None ☐ Rare ☐ Occasional ☐ Frequent Drinks/day/week: _____

Substance Abuse: ☐ None ☐Rare ☐ Occasional ☐ Frequent

Tobacco Use: ☐ None ☐ Rare ☐ Occasional ☐ Frequent Hoe much per day? _____

☐ Past Tobacco User Number Years: _____ Year Quit: _____

MEDICAL HISTORY: Please mark any of the following conditions you have.

☐ Hypertension Treatment: ☐ One Medication ☐ Multiple Medications

☐ Congestive Heart Failure (CHF) ☐ Class 1 ☐ Class 2 ☐ Class 3 ☐ Class 4 ☐ Class 5

☐ Heart Attack ☐ Heart Stent(s) or CABG

☐ Angina (chest pain): _____

☐ Peripheral Vascular Disease: _____

☐ Lower Extremity Edema (swelling) ☐ Intermittent ☐ Treatment ☐ Stasis ulcers ☐ Disability

☐ DVT/PE (blood clots)

☐ Pre-Diabetes/ Diabetes Treatment: ☐ None ☐ 1 pill ☐ Multiple pills ☐ Insulin

☐ High Cholesterol Treatment: ☐ None ☐ Diet ☐ 1 pill ☐ Multiple pills

☐ Gout

☐ Sleep Apnea Treatment: ☐ None ☐ CPAP machine

☐ Severe Obesity-Related Lung Disease

☐ Pulmonary Hypertension

☐ Asthma Treatment: ☐ None ☐ Meds without steroid ☐ Steroid ☐ Hospitalized in last 2yrs

☐ GERD (reflux) Treatment: _____

☐ Gallstones

☐ Liver Disease: _____

☐ Back Pain: _____

☐ Joint Pain: _____

☐ Fibromyalgia Treatment: ☐ Non-narcotic meds ☐ Narcotics

☐ PCOS Treatment: ☐ None ☐ Medication ☐ Diet

☐ Menstrual Cycle Issues: ☐ Irregular ☐ Heavy ☐ No cycle

☐ Mental Health Diagnosis Type: _____ Physician: _____

☐ Depression Treatment: _____

☐ Urinary Incontinence

☐ Pseudo-tumor Cerebri

☐ Abdominal Hernia

☐ Functional Impairment Treatment: ☐ Cane, walker, crutch ☐ Wheelchair

☐ Other Diagnosis: _____

_____

SLEEP HISTORY

	Frequently	Sometimes	Never
Do you wake up gasping for breath?			
Do you awaken with headaches?			
Do you fall asleep while reading?			
Do you have heartburn or "reflux" while sleeping?			
Do you have difficulty falling asleep or staying asleep?			
Do you wake up with a dry mouth, sore throat, or headache in the morning?			
Have you ever been to a sleep lab for treatment or evaluation?	Circle: YES NO		
Do you use a CPAP or BiPAP?	Circle: YES NO		

REVIEW OF SYSTEMS

Please circle any of the following symptoms or conditions you are currently experiencing or those with which you have had significant problems in the past.

GENERAL	Weakness, Fatigue, Fever, Chills, Sweats, Weight Gain, Weight Loss, Anemia
NEUROLOGICAL	Headache, Dizziness, Weakness, Numbness, Seizures, Tremors, Memory Changes, Fainting, Unsteady Gait, Speech Problems, Nervousness, Disorientation, Behavioral Changes
PSYCHIATRIC	Anxiety, Depression, Mood Swings, Hallucinations, Difficulty Sleeping, Alcohol Abuse
EYES	Blurred Vision, Double Vision, Blindness, Pain, Retina Problems, Cataracts, Glaucoma
EARS	Ringing, Pain, Frequent Discharge, Drainage
NOSE	Bleeding, Sinus Problems, Pain, Frequent Infection
THROAT	Pain, Hoarseness, Ulcers, Difficulty Swallowing, Tooth Pain, Frequent Infections, Bleeding Gums
ENDOCRINE	Hypothyroidism, Hyperthyroidism, Heat or Cold Intolerance, Constant Thirst, Hypoglycemia, Cirrhosis, Portal Hypertension, Hepatic Insufficiency, Severe Liver Damage

LUNGS	Chronic Cough, Wheezing, Shortness of Breath, Congestion, Coughing up Blood, Sputum
CARDIOVASCULAR	Chest Pain, Chest Tightness, High Blood Pressure, High Triglycerides, Palpitations, Mitral Valve Prolapse, Murmur, Heart Attack, Blood Clots, Shortness of Breath, Shortness of Breath while Lying Flat, Ankle Swelling, Lower Extremity Edema, Venous Stasis (Leg) Ulcers, Coagulopathy
GASTROINTESTINAL	Abdominal Pain, Nausea, Vomiting, Diarrhea, Heartburn, Constipation, Ulcers, Blood in Stool, Difficulty Swallowing, Rectal Pain, Loss of Appetite, Gallstones, H. Pylori, Changes in Bowl Pattern, Rectal Bleeding, Hemmoroids, Excessive Thirst, Colitis, Hiatal Hernia, Diverticulosis/itis, Stricture, Stenosis, IBS, Gastric Motility, GI Bleed, Achalasia, Inflammatory Disease, GI Track Disorder
URINARY	Frequency, Urgency, Discharge, Pain with Urination, Menstrual Problems, Blood in Urine, Prostrate Problems, Frequent UTI's, Chronic Renal Disease
MUSCULOSKELETAL	Back Pain, Joint Pain, Joint Swelling, Muscle Pain, Decreased Range of Motion, Plantar Fasciitis
SKIN	Rashes, Burning, Itching, Swelling, Moles, Bruise Easily, Change in Hair/Nails

Please list any specific questions or concerns that you may have, so that your surgeon can address them at your consultation:

_____
_____
_____
_____
_____

The above information is true and accurate to the best of my knowledge. (This questionnaire will become a part of your medical chart and will be reviewed by a medical professional during your initial appointment.)

Patient Signature: _____ Date: _____

Note:

(1) Medical clearance from your primary care physician (PCP) or cardiologist is required prior to surgery.

(2) A letter of medical necessity from your primary care physician (PCP) or cardiologist is also required by your insurance company before surgery can be approved. This letter must include how long you have been treated by your physician and how long you have been obese, list any obesity-related co-morbidities, and state that bariatric surgery is medically necessary for the patient.

** Please fax completed form to 985-868-2232 or bring it by our office.

**If you have not received a phone call from our office within 3 days of submitting this form, please call us at 985-868-2206. Our goal is to assist you timely. Thank you again for choosing our practice.