

New Patient Information

(Please complete all items in ink)

Name		Date of Birth	Age	Gender (circle) Male Female
Address/City/State/Zip				
Home Phone (include area code)		Cell Phone (include area code)	Work Phone (include area code)	
Marital Status (circle) Single Married Divorced Widow	Race/Ethnicity (circle) Caucasian African American Hispanic Native American Asian Other: _____	E-Mail Address*		Social Security Number
Employer Name		Occupation		
Emergency Contact		Emergency Contact Phone Number (include area code)		
Referral Source: Family/Friend Patient _____ Doctor _____ Billboard Internet T.V. Magazine Newspaper Radio Other: _____				
I have attended a seminar given by Surgical Specialists of LA <input type="checkbox"/> Yes <input type="checkbox"/> No City: _____				

Primary Insurance Information (Please complete even if you have supplied us with a copy of your insurance card)

Insurance Company				
Claims Mailing Address/City/State/Zip				
Policy Holder Name (if insurance is through a spouse please list spouses' information here)			Date of Birth	Social Security Number
Member ID/Policy Number	Group Number		Phone Number for Customer Service	

Secondary Insurance Information

Insurance Company				
Claims Mailing Address/City/State/Zip				
Policy Holder Name (if insurance is through a spouse please list spouses' information here)			Date of Birth	Social Security Number
Member ID/Policy Number	Group Number		Phone Number for Customer Service	

I authorize my insurance company to pay directly any and all claims submitted by Surgical Specialists of LA. I accept responsibility for any unpaid balance following reimbursement or should insurance deny coverage for services for any reason and will pay the balance in a timely manner.

Signature _____ Date _____

* My Signature on this document authorizes Surgical Specialists of LA to communicate via e-mail address. **Initial:** _____

** My Signature on this document authorizes Surgical Specialists of LA to request copies of any and all medical records from any source pertinent to my medical care. **Initial:** _____

Name: _____ DOB: _____

Please list all physicians whose care you are under. Please place a next to the doctor's if they know you are interested in Bariatric Surgery. Please complete this section in full.

	First, Last Name	Address/City/State/Zip	Phone Number (include area code)
Primary Care Physician			
Internist			
Cardiologist			
Endocrinologist			
Gastroenterologist			
Gynecologist			
Orthopedist			
Psychiatrist			
Therapist/ Psychologist			
Pulmonologist			
Other			

Please check if you have had any of the following surgeries and list details below

- Previous obesity surgery
 Appendectomy Tonsillectomy Gallbladder removal Splenectomy Hysterectomy Both ovaries removed
 Still with ovaries Hernia Surgery Liposuction Tummy Tuck C-Section

Please list all major surgeries you have experienced in adulthood.

Surgery Type	Date

- Which surgery are you interested in? Roux-en Y Gastric Bypass Adjustable Band (LAP-BAND)
 Gastric Sleeve Duodenal Switch Revision to a previous Bariatric Surgery POSE other _____
 Undecided

Name: _____ DOB: _____

- I Have had a sleep study date: _____ Results: Negative Positive
- Diagnosed with Sleep Apnea Syndrome
- CPAP/BI PAP used Setting: _____

Please check if you have any of the following symptoms.

- Morning headaches Daytime drowsiness/fatigue Snoring Witnessed apnea (stop breathing in sleep) Restless sleep

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

- 0= Would never doze off
- 1= Slight chance of dozing
- 2= Moderate chance of dozing
- 3= High chance of dozing

Score: _____

<u>Situation</u>	<u>Chance of Dozing</u>			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting inactive in a Public Place	0	1	2	3
Sitting quietly after a lunch (i.e. movies, meeting) without alcohol	0	1	2	3
In a car, while stopping for a few minutes in traffic	0	1	2	3

Name: _____ DOB: _____

Nutritional Assessment

Use this chart to choose an answer that best fits your daily eating patterns:

- 1- Less than one time a week OR Never
- 2- 1-2 times a day
- 3- 3-4 times a day
- 4- 5-6 times a day
- 5- 7 or more times a day.

I prefer not to answer these questions.

Pattern		Less than once a week OR Never	1-2 times a day	3-4 times a day	5-6 times a day	7 or more times a day
Starch Group	bread, cereal, biscuits, potatoes, corn, green peas, pasta, and rice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-Starch Group	broccoli, cauliflower, carrots, lettuce, green leafy vegetables, and green beans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fruit Group	apple, banana, berries, melons, grapes, strawberries, fruit juices, and dried fruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Protein Group	beef, chicken, fish, pork, turkey, eggs, and cheese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fat Group	butter, gravies, sauces, peanut butter, salad dressings, and mayonnaise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Milk Group	milk, yogurt, cream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beverages	regular soda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beverages	diet soda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beverages	wine/beer/other alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dessert	Ice cream, frozen yogurt, cookies, pie, and cake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list any food allergies or intolerances _____

Do you drink more than 8oz of liquid with each of your meals? Y N

How long does it take for you to finish a meal? 5-10 mins. 15-20 mins. 30 mins or longer

Do you usually have a second helping? Y N

Do you use vitamins, minerals, dietary supplements, fiber tablets, herbal medications, DHEA, or garlic pills? Y N
If so, please list _____

How often do you eat at a restaurant or fast food place? _____/week

Do you binge eat? Y N Do you routinely skip any meals? If so, which one(s) _____

Do you routinely snack after 8pm? Y N

Please check if you have had any of the following medical conditions:

HEART

- Chest pain
- Coronary Heart Disease
- Blockage
- Treated with:
 - Meds Stent Bypass
- Heart Attack date: _____
- Stress test date: _____
- Angiogram/plasty date: _____
- Congestive Heart Failure (fluid around heart)
- Atrial fibrillation
- PVC
- Other arrhythmias
- Pacemaker date: _____
- Cardiomegaly (enlarged heart)
- Cardiomyopathy (weakened heart)
- Abnormal EKG
- Murmur
- Mitral valve prolapse
- Peripheral vascular disease (poor circulation)
- Lower extremity edema (swelling in legs)
- Thrombophlebitis
- DVT (bloodclot) or PE (pulmonary embolism)
- CVA (stroke/TIA/min-stroke)
- Hypertension (high blood pressure)
Year diagnosed: _____
- High cholesterol
- High triglycerides

ENDOCRINE

- Diabetes Year diagnosed: _____
 - With pregnancy
 - With neuropathy (numbness or pain to feet)
 - With retinopathy (vision impairment)
- Glucose intolerance
- Hypothyroidism
- Hyperthyroidism (graves disease)
- Goiter
- PCOS (polycystic ovary disease)
- Infertility
- Cushings Disease
- Menstrual Irregularity
- Fibroids
- Menorrhagia (heavy periods)

PULMONARY

- Asthma
- COPD
- Emphysema
- Pulmonary hypertension
- Pneumonia date of last episode: _____
- PE (pulmonary embolism)
- Shortness of breath on exertion
- Oxygen dependent
- Obstructive Sleep Apnea
Year diagnosed: _____
- CPAP/BiPAP setting: _____

Please check if you have had any of the following medical conditions:

GASTROINTESTINAL

- Abdominal pain
- Hiatal hernia
- Peptic Ulcer
- Esophageal Stricture
- GERD (belching acid)
- Have had a upper GI Xray
- Normal Abnormal
- Have had an Endoscopy
- Normal Abnormal
- Barrett's esophagus
- Ulcerative Colitis
- Crohn's Disease
- Irritable Bowel Syndrome
(colitis/spastic colon)
- Pancreatitis
- Hepatitis C
- Fatty Liver
- Cholelithiasis (gallstones)

HEMATOLOGIC

- Anemia
- Bleeding disorder
- History of abnormal white blood
cell or platelet count
- HIV/AIDS

MUSCULOSKELETAL

- Arthritis
- DJD (osteoarthritis)
- Rheumatoid Arthritis
- Herniated disk
- Chronic back pain
- Hip Pain
- Ankle/foot pain
- Knee pain
- Plantar fasciitis
- Fibromyalgia
- Gout
- Lupus
- Stasis Ulcers

UROLOGIC

- Urinary stress incontinence (leakage
of urine with cough or sneeze)
- Interstitial Cystitis
- Kidney Stones
- BPH (enlarged prostate)
- Chronic renal failure (on dialysis)
- Kidney Disease

Please check if you have had any of the following medical conditions:

PSYCHOLOGICAL

- Depression
- Mild Moderate Major
- Bipolar Disorder
- Suicidal Attempts
- Schizophrenia
- Anxiety/Panic attacks
- Panic Attacks
- Mild Moderate Major
- Psychiatric Hospitalization
date: _____
- ADHD/ ADD
- Substance abuse/chemical
dependency(drugs or alcohol)
- Recovery program completed
date: _____
- How long drug/alcohol free? _____
- Previous sexual/physical abuse
- Anorexia
- Bulimia
- Binge eating
- OTHER: _____

OTHER

Cancer:

- Breast
- Colon
- Lung
- Uterine
- Prostrate
- Other _____

- Cellulitis (skin infection)
- MRSA (resistant staph infection)
- Multiple Sclerosis
- Epilepsy
- Migraine headaches
- Pseudotumor Cerebri
- Rashes in skin folds
- Excessive Abdominal skin

Please list previous diet attempts:

DIET: _____ DATES: _____
Ex: Weight watchers 3/09-10/11

Weight history:

Were you overweight as a child? N Y

At what age were you overweight? _____

How many years have you been obese?

Over the past 5 years, what was your lowest
weight? _____

Over the past 5 years, what was your
highest weight? _____

What is the most weight you have ever lost
on a diet, with medication, and/or exercise?
