

Patient Information

(Please complete all items in ink)

Name		Date of Birth	Age	Gender (circle) Male Female	
Address		City		State	Zip Code
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. Newspaper Radio Other: _____					
I have attended a seminar given by Surgical Specialists of Louisiana <input type="checkbox"/> No <input type="checkbox"/> Yes 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 Louisiana. 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 Louisiana to communicate via e-mail address. **Initial:** _____

** My Signature on this document authorizes Surgical Specialists of Louisiana 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

- Appendectomy
 Tonsillectomy
 Gallbladder removal
 Splenectomy
 Previous obesity surgery date: _____
 Hysterectomy
 Both ovaries removed
 1 ovary 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?**
 Laparoscopic Roux-en Y Gastric Bypass
 Laparoscopic Adjustable Band
 Laparoscopic Duodenal Switch
 Revision to a previous Bariatric Surgery
 Undecided
 Laparoscopic Gastric Sleeve

Name: _____ DOB: _____

Please check if you have any of the following conditions:

<ul style="list-style-type: none"> <input type="checkbox"/> Heart Disease <ul style="list-style-type: none"> <input type="checkbox"/> Blockage Treated with: <input type="checkbox"/> Meds <input type="checkbox"/> Stents <input type="checkbox"/> Bypass <input type="checkbox"/> Heart Attack Date: _____ <input type="checkbox"/> Congestive Heart Failure (fluid around heart) <input type="checkbox"/> A-Fib or other arrhythmias <input type="checkbox"/> Enlarged Heart/Cardiomegaly <input type="checkbox"/> Weakened Heart/ Cardiomyopathy <input type="checkbox"/> Stress test date: _____ <input type="checkbox"/> Angiogram/plasty date: _____ <input type="checkbox"/> Abnormal EKG <input type="checkbox"/> Murmur <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Vascular Disease / poor circulation <input type="checkbox"/> Stroke/TIA/Mini Stroke <input type="checkbox"/> Carotid Blockage <input type="checkbox"/> High Blood Pressure/ Hypertension Year diagnosed: _____ <input type="checkbox"/> Diabetes Year diagnosed: _____ <ul style="list-style-type: none"> <input type="checkbox"/> with pregnancy <input type="checkbox"/> with neuropathy (numbness to feet) <input type="checkbox"/> with retinopathy (vision impaired) <input type="checkbox"/> controlled with <input type="checkbox"/> diet <input type="checkbox"/> insulin <input type="checkbox"/> pills <input type="checkbox"/> High Cholesterol/ <input type="checkbox"/> High Triglycerides <input type="checkbox"/> Asthma <input type="checkbox"/> COPD/ Emphysema <input type="checkbox"/> Heartburn <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> Ulcer <input type="checkbox"/> Esophageal Stricture <input type="checkbox"/> Belching acid or sour fluid in back of throat/GERD <input type="checkbox"/> Have had an Upper GI series <input type="checkbox"/> NL <input type="checkbox"/> Abnl <input type="checkbox"/> Have had an Endoscopy <input type="checkbox"/> NL <input type="checkbox"/> Abnl <input type="checkbox"/> Barrett's Esophagitis <input type="checkbox"/> PCOS (Polycystic ovary disease) <input type="checkbox"/> Infertility <input type="checkbox"/> Leakage of urine with laughing/coughing/sneezing/ Stress Incont <input type="checkbox"/> Sleep Apnea CPAP/BIPAP setting: _____ <input type="checkbox"/> OTHER: _____ 	<ul style="list-style-type: none"> <input type="checkbox"/> Arthritis on x-ray/DJD/Osteoarthritis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Low back pain <input type="checkbox"/> Hip pain <input type="checkbox"/> Ankle/foot pain <input type="checkbox"/> Knee pain <input type="checkbox"/> Plantar Fasciitis <input type="checkbox"/> Edema/ swelling in legs/feet <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Hyperthyroidism/Graves Disease <input type="checkbox"/> Goiter <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding disorders <input type="checkbox"/> History of abnormal white blood cell count or platelet count <input type="checkbox"/> Cancer <input type="checkbox"/> Cellulitis (skin infection) <input type="checkbox"/> MRSA <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Cushings Disease <input type="checkbox"/> DVT/Blood clot <input type="checkbox"/> Enlarged prostate/ BPH <input type="checkbox"/> Fatty Liver <input type="checkbox"/> Gallstones <input type="checkbox"/> Gout <input type="checkbox"/> Hepatitis C <input type="checkbox"/> HIV/ AIDS <input type="checkbox"/> Interstitial Cystitis <input type="checkbox"/> Irritable Bowel Syndrome/Colitis/ Spastic colon <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Lupus <input type="checkbox"/> Migraines <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Pancreatitis <input type="checkbox"/> PE (Pulmonary Embolus) <input type="checkbox"/> Renal Disease (kidney) <input type="checkbox"/> Shortness of Breath on Exertion <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Fibromyalgia
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Name: _____ DOB: _____

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

<ul style="list-style-type: none"> <input type="checkbox"/> Wheezing <input type="checkbox"/> Chest Pain <input type="checkbox"/> Frequent vomiting (not related to a virus) <input type="checkbox"/> Frequent diarrhea <input type="checkbox"/> Frequent pains in stomach <input type="checkbox"/> Frequent nausea <input type="checkbox"/> Frequent constipation <input type="checkbox"/> Blood in urine <input type="checkbox"/> Thyroid nodules <input type="checkbox"/> Seizures <input type="checkbox"/> Frequent skin infections Where: _____ 	<ul style="list-style-type: none"> <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Trouble swallowing/ Pain with swallowing <input type="checkbox"/> Food sticking in chest or throat/lump in throat <input type="checkbox"/> Blood in sputum <input type="checkbox"/> Palpitations <input type="checkbox"/> Irregular heartbeat/skipping <input type="checkbox"/> Blood in stools <input type="checkbox"/> Frequent urinary tract infections <input type="checkbox"/> Herniated/ bulging disc <input type="checkbox"/> Weakness in any muscles <input type="checkbox"/> Numbness/ tingling Where: _____
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Please check if there is a family history of:

- High Blood Pressure Obesity High Cholesterol Diabetes Heart Disease Sleep Apnea
- Colon Cancer Breast Cancer Eating Disorders Premature Heart Disease (heart attack before the age of 50)

Please check if you have experienced any of the following.

- Depression Mild Moderate Major
- Panic attacks Mild Moderate Major
- Suicide attempts
- Psychiatric in-patient hospitalization date: _____
- Mental Disorder
- ADD/ADHD/ or learning disability
- Binge eating
- Bulimia
- Anorexia
- Substance abuse/Chemical dependency (drugs or alcohol)
 - Successful Recovery Program Completed Date: _____
 - How long drug/alcohol free: _____
- Previous sexual/physical abuse

Name: _____ DOB: _____

Please complete the following weight history. Please estimate as closely as possible for all that applies.

Approx. weight at: Start of high school _____ High school graduation _____ Adulthood (age 30) _____
 What is the most weight you have ever lost on a diet, with medication, and/or exercise? _____ How long over 200 pounds? _____

Below, check the diet programs you have tried.

- Jenny Craig Nutri-systems Weight Watchers FenPhen/Redux other: _____
 Accupuncture Dietician/ Nutritionist Sugar Busters Atkin's Rx Medications for weight loss: _____

List the type of exercise and frequency you participate in currently. _____

Nutritional Assessment

Use the chart below 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

<u>Starch Group:</u> bread, cereal, biscuits, potatoes, corn, green peas, pasta, and rice	1	2	3	4	5
<u>Non-Starch Group:</u> broccoli, cauliflower, carrots, lettuce, green leafy vegetables, and green beans	1	2	3	4	5
<u>Fruit Group:</u> apple, banana, berries, melons, grapes, strawberries, fruit juices, and dried fruit	1	2	3	4	5
<u>Protein Group:</u> beef, chicken, fish, pork, turkey, eggs, and cheese	1	2	3	4	5
<u>Fat Group:</u> butter, gravies, sauces, peanut butter, salad dressings, and mayonnaise	1	2	3	4	5
<u>Milk Group:</u> milk, yogurt, cream	1	2	3	4	5
<u>Beverages:</u> regular soda	1	2	3	4	5
diet soda	1	2	3	4	5
wine/beer/other alcohol	1	2	3	4	5
<u>Dessert:</u> Ice cream, frozen yogurt, cookies, pie, and cake	1	2	3	4	5

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

Patient Name: _____ DOB: _____ Sex: _____

Please check if you have any of the following symptoms.

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

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Answer each question from the point of view of your normal lifestyle and normal activities.

Use the following scale to choose the most appropriate number of each situation:

- 0= would never
- 1= slight chance of dozing
- 2= moderate chance of dozing
- 3= high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g. an airport or a theater)	
A passenger riding in a car for an hour without stopping	
Lying down to rest in the afternoon	
Sitting and speaking with someone	
Sitting quietly after a lunch without alcohol	
Driving a car, while stopped, for a few minutes in traffic	

Total _____

Medical assistant's Initials: _____