



PATIENT REGISTRATION AND PROTECTED HEALTH INFORMATION PREFERENCES

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

May we send mail to your home? Yes No

Employer: _____

Employer Address: _____

Employer Phone: _____

Occupation: _____

City: _____ State: _____ Zip: _____

Social Security #: _____

Age: _____ Birth Date: _____

Marital Status: S M D W Sex: M F

Race/Ethnicity: _____

Home Phone: _____

May we call you at home? Yes No

May we leave a message at home? Yes No

Mobile Phone: _____

May we call you at this number? Yes No

May we leave a message here? Yes No

Work Phone: _____

May we call you at work? Yes No

May we leave a message at work? Yes No

Email: _____

May we send you email? Yes No

Other: _____

Emergency Contact: _____

Emergency Phone: _____

I HAVE ATTENDED A LIVE OR ON-LINE GASTRIC BAND SEMINAR

Other than you, your insurance company and healthcare providers involved in your care, whom can we talk with about your healthcare information?

Name: _____ Relationship: _____ Phone: _____

Primary Insurance: _____

Subscriber Name: _____

Subscriber Address: _____

City: _____ State: _____ Zip: _____

Subscriber Birth Date: _____

Subscriber Social Security #: _____

Subscriber Employer: _____

ID #: _____ Group # _____

Claims Mailing Address: _____

Insurer Website Address: _____

Relationship to Patient: Self Spouse Child

Secondary Insurance: _____

Subscriber Name: _____

Subscriber Address: _____

City: _____ State: _____ Zip: _____

Subscriber Birth Date: _____

Subscriber Social Security #: _____

Subscriber Employer: _____

ID #: _____ Group # _____

Claims Mailing Address: _____

Insurer Website Address: _____

Relationship to Patient: Self Spouse Child

PLEASE READ CAREFULLY: I hereby authorize release of any information obtained in the course of my registration, interview, examination and treatment necessary to file a claim with my insurance carrier. If my insurance company does not offer bariatric benefits, I understand that Weight Loss Surgical Center may attempt to bill to my insurance company. I authorize payment directly to the provider for services provided. I understand I am financially responsible for charges not covered by my insurance including but not limited to medical services deemed routine, elective, or not medically necessary by my insurance company and/or any co-pays, deductibles, co-insurance amounts or non-covered items specified by my insurance company. In the event that my account is placed in the hands of a collection agency or attorney for collection, I agree to pay all costs and expenses related to the collection thereof. A copy of this signature is valid as the original.

DATE: _____ PATIENT SIGNATURE: _____ INSURED'S SIGNATURE: _____



PATIENT HISTORY

Page 1

Name: _____ Birth date: _____ AGE: _____

Referred by (Physician/Patient/Other): _____

How long have you had a weight problem? _____

PRIMARY CARE DOCTOR _____

(Please fill in all blanks.)

Name: _____ Specialty: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

SPECIALIST LIST _____

(Please list all doctors who have assisted you with weight loss or are involved in your medical care.)

Doctor: _____ Specialty: _____ Phone: _____

Reason Seen: _____

Address: _____ City: _____ State: _____ Zip: _____

Doctor: _____ Specialty: _____ Phone: _____

Reason Seen: _____

Address: _____ City: _____ State: _____ Zip: _____

Doctor: _____ Specialty: _____ Phone: _____

Reason Seen: _____

Address: _____ City: _____ State: _____ Zip: _____

Doctor: _____ Specialty: _____ Phone: _____

Reason Seen: _____

Address: _____ City: _____ State: _____ Zip: _____

DIETING HISTORY

(Please check the ones you have tried.)

Diets/Programs

- | | | |
|---|---|--|
| <input type="checkbox"/> Advocare | <input type="checkbox"/> High Protein | <input type="checkbox"/> Rapid Slim |
| <input type="checkbox"/> American Diabetic Association Diet | <input type="checkbox"/> HMR (Wichita) | <input type="checkbox"/> Release the Fat |
| <input type="checkbox"/> American Heart Association Diet | <input type="checkbox"/> Hollywood Liquid | <input type="checkbox"/> Richard Simmons |
| <input type="checkbox"/> Atkins | <input type="checkbox"/> Jenny Craig | <input type="checkbox"/> Scarsdale |
| <input type="checkbox"/> Blood Type | <input type="checkbox"/> LA Weight Loss | <input type="checkbox"/> Six Week Body Make Over |
| <input type="checkbox"/> Body for Life | <input type="checkbox"/> Low Calorie | <input type="checkbox"/> Slim-4-Life |
| <input type="checkbox"/> Cabbage Soup | <input type="checkbox"/> Low Carbohydrate | <input type="checkbox"/> Slimfast |
| <input type="checkbox"/> Diet Center | <input type="checkbox"/> Low Fat | <input type="checkbox"/> South Beach Diet |
| <input type="checkbox"/> E-Diet | <input type="checkbox"/> Metabolic Type | <input type="checkbox"/> Starvation |
| <input type="checkbox"/> Fit for Life | <input type="checkbox"/> Michael Thurman | <input type="checkbox"/> Suzanne Summers |
| <input type="checkbox"/> Flush the Fat | <input type="checkbox"/> Nutrisystem | <input type="checkbox"/> Tops |
| <input type="checkbox"/> Grapefruit Diet | <input type="checkbox"/> Omni-Trim | <input type="checkbox"/> Weight Watcher's |
| <input type="checkbox"/> Health Strategies | <input type="checkbox"/> Out-of Eden | <input type="checkbox"/> Zone |
| | <input type="checkbox"/> Physicians Weight Loss | |
| | <input type="checkbox"/> Rachel Ray Diet | |

Over-the-Counter Meds

- | | |
|---|---|
| <input type="checkbox"/> AB-B-Gone | <input type="checkbox"/> Hoodia |
| <input type="checkbox"/> Cortislim | <input type="checkbox"/> Hydroxycut |
| <input type="checkbox"/> Dexatrim | <input type="checkbox"/> Leptopril |
| <input type="checkbox"/> Envy | <input type="checkbox"/> Lipozene |
| <input type="checkbox"/> Ephedra | <input type="checkbox"/> Medifast |
| <input type="checkbox"/> Fahrenheit | <input type="checkbox"/> Metabolife |
| <input type="checkbox"/> Fastin | <input type="checkbox"/> Relacore |
| <input type="checkbox"/> Flush the Fat | <input type="checkbox"/> Sleep Away Fat |
| <input type="checkbox"/> Ginko Biloba | <input type="checkbox"/> Slim Quick |
| <input type="checkbox"/> Ginseng | <input type="checkbox"/> Stacker-2 |
| <input type="checkbox"/> Grapefruit pills | <input type="checkbox"/> Trimspa |
| <input type="checkbox"/> Green Tea pills | <input type="checkbox"/> Xenidrine |
| <input type="checkbox"/> Herbal Life | <input type="checkbox"/> Zantrex-3 |

Prescription Meds

- Adipex
- Didrex
- Fhen-Phen
- Ionamin
- Meridia
- Phentermine
- Tenuate
- Xenical

Exercise

- Bali
- Curves
- YMCA

Other: _____

MEDICAL HISTORY

Obesity Co-Morbidities or Signs & Symptoms

(The medical conditions listed below are associated with obesity, check the ones you have.)

- | | | |
|---|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Polycystic Ovary Syndrome |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heartburn/Reflux | <input type="checkbox"/> Portal Hypertension |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath with Exertion |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> High Triglycerides | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chronic Pancreatitis | <input type="checkbox"/> Hip, Knee, Ankle, Foot Problems | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Infertility | <input type="checkbox"/> Urinary Stress Incontinence |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Uterine Cancer |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Lupus | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Myasthenis Gravis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis | |
| <input type="checkbox"/> Esophageal Dysmotility | | |
| <input type="checkbox"/> Gallbladder Disease | | |

Additional Medical History

(Please check all medical conditions you have or have had in the past.)

- | | | |
|---|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Goiter | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Gout | <input type="checkbox"/> Reaction to Anesthesia |
| <input type="checkbox"/> Breast Mass | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scleroderma |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Herpes | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Cancer (Type)
_____ | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Sexually Transmitted Infections |
| <input type="checkbox"/> Chemical/Drug Dependency | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sinus Infections |
| <input type="checkbox"/> Clotting Problems | <input type="checkbox"/> Immune System Disorders | <input type="checkbox"/> Sjogrens Syndrome |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Deep Vein Thrombosis (DVT) | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Elevated Blood Pressure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lupus | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraines/Headaches | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Pacemaker | |
| | <input type="checkbox"/> Pneumonia | |

SURGICAL HISTORY

(Please list all surgical procedures you have had done in the past.)

Surgery	Year	Surgeon

Any surgical complications/infections? _____

FAMILY MEDICAL HISTORY

(Please check all medical conditions your blood relatives have, indicate relationship.)

- | | | |
|---|---|--|
| <input type="checkbox"/> AIDS _____ | <input type="checkbox"/> Clotting Disorders _____ | <input type="checkbox"/> Hepatitis _____ |
| <input type="checkbox"/> Alcoholism _____ | <input type="checkbox"/> Colitis _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Anxiety _____ | <input type="checkbox"/> Crohn's Disease _____ | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Liver Disease _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Lupus _____ |
| <input type="checkbox"/> Bleeding Disorders _____ | <input type="checkbox"/> Emphysema _____ | <input type="checkbox"/> Obesity _____ |
| <input type="checkbox"/> Breast Disease _____ | <input type="checkbox"/> Heart Attack _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Thyroid Disease _____ |

SOCIAL HISTORY

(Please answer all the questions below.)

Occupation: _____ Marital Status: Single Married Widowed Divorced

Number of Pregnancies: _____ Live Birth/s: _____ Miscarriage/Abortion/s: _____

Do you or did you smoke? Y N If yes, have you quit? Y N

Do you or did you drink excessive alcohol? Y N If yes, have you quit? Y N

Do you use or have you used recreational drugs? Y N If yes, have you quit? Y N

CURRENT MEDICATIONS

(Please list all current medications with dosages, or provide a list.)

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

DRUG ALLERGIES/REACTIONS: _____

REVIEW OF SYSTEMS

(Please check symptoms that you have had or may be experiencing.)

General/Constitution

- Fever
- Fatigue
- Weakness
- Weight Gain/Loss
- Decreased Appetite

Skin/Breast

- Hives
- Rashes
- Breast Mass
- Breast Pain
- Nipple Discharge

Ear, Nose & Throat

- Loss of Hearing
- Ringing in Ears
- Nosebleeds
- Bleeding Gums
- Mouth Sores
- Frequent Sore Throat
- Hoarseness
- Constant Throat Clearing
- Difficulty Swallowing
- Nasal Congestion

Eyes

- Pain
- Loss of Vision
- Double Vision
- Blurred Vision
- Flashing spots/light
- Glasses

Cardiovascular

- Chest Pain with Activity
- Shortness of breath at rest
- Shortness of breath with activity
- Chest pain at rest
- Leg Swelling
- Irregular heart Beat
- Heart Palpitations

Respiratory

- Chronic Cough
- Coughing up Blood
- Wheezing
- Night Sweats

Hematologic

- Anemia
- Bleeding Tendency
- Clotting Tendency

Gastrointestinal

- Nausea
- Vomiting
- Vomiting Blood
- Heartburn
- Regurgitation
- Difficulty Swallowing
- Pain with Swallowing
- Diarrhea
- Constipation
- Stomach Pain
- Blood in Stools
- Black Tarry Stools
- Hemorrhoids
- Frequent Laxative/enema use

Genitourinary

- Difficult Urination
- Painful Urination
- Blood in Urine
- Frequent Urination
- Urgency
- Kidney Stones
- Frequent Night Urination
- Discharge from penis/vagina
- Erection difficulties
- Prostate troubles

Neurological

- Headaches
- Dizziness
- Fainting
- Convulsions
- Arm/Leg weakness
- Memory Loss
- Sensitivity of hands/feet

Endocrine

- Heat/cold intolerance
- Flushing
- Increased Thirst
- Increased Salt Intake
- Finger Nail Changes

Psychiatric

- Depression
- Suicide attempt
- Psych. Counseling
- Panic Attacks

Prior Bariatric

- R-N-Y
- BPD
- VBG

I have completed this form to the best of my ability. I understand that I will be required to meet with a Physician's Assistant or Nurse Practitioner, and a surgeon prior to surgery. This information will be used to determine if I am a surgical candidate and to assist in the pre-determination of my surgery through my insurance company.

SIGNATURE: _____ DATE: _____