



Date: ____/____/____

HEALTH QUESTIONNAIRE

Are you interested in:
 Bariatric (Weight Loss) Surgery
 Medical Weight Loss

SELF		
LAST NAME	FIRST	MAIDEN
ADDRESS		
CITY	STATE	ZIP
SOCIAL SECURITY NUMBER		DATE OF BIRTH
PREFERRED PHARMACY:		PHARMACY #:
MALE	FEMALE	MARRIED DIVORCED WIDOWED SEPARATED NEVER MARRIED
PLEASE CHECK PREFERRED METHOD OF CONTACT:		
<input type="checkbox"/> HOME PHONE _____	CAN BE REACHED AT HOME PHONE # DURING THE DAY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<input type="checkbox"/> WORK PHONE _____	CAN BE REACHED AT WORK PHONE # DURING THE DAY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<input type="checkbox"/> CELL PHONE _____	CAN BE REACHED AT CELL PHONE # DURING THE DAY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
MAY WE LEAVE A VOICE MAIL? YES <input type="checkbox"/> NO <input type="checkbox"/> EMAIL ADDRESS: _____		
OTHER PERSONS WE ARE ALLOWED TO SPEAK WITH REGARDING YOUR CARE (IF APPLICABLE):		
(1) NAME: _____	(PHONE): _____	
(2) NAME: _____	(PHONE): _____	
EMPLOYER	OCCUPATION	
SPOUSE OR SIGNIFICANT OTHER		
LAST NAME	FIRST	
SOCIAL SECURITY NUMBER		DATE OF BIRTH
EMPLOYER		
YOUR PRIMARY CARE PHYSICIAN		
FAMILY PHYSICIAN		
ADDRESS		
PHONE	FAX	
PHYSICIAN WHO REFERRED YOU TO US		
REFERRING PHYSICIAN		
ADDRESS		
PHONE	FAX	
<input type="checkbox"/> CHECK IF YOU ARE SELF-REFERRED		
HOW DID YOU HEAR ABOUT THE CENTER: <input type="checkbox"/> INTERNET: <input type="checkbox"/> Ethicon <input type="checkbox"/> Obesity Help <input type="checkbox"/> Center for Weight Management and Wellness		
<input type="checkbox"/> Television <input type="checkbox"/> Radio <input type="checkbox"/> Physician <input type="checkbox"/> Another Patient <input type="checkbox"/> Other _____		

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the physicians and outpatient staff in attendance on this case to release medical information to the pertinent insurance company (s) or third party carriers and request payment to be made directly to the billing entity. I understand that I am financially responsible for any balance not covered by the insurance carrier (s). I also request that payment of benefits from my policy _____ be paid directly to the billing entity until otherwise notified.

Signature

Signature of parent (if minor)



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INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY		
INSURANCE COMPANY NAME		
INSURANCE COMPANY ADDRESS		
CITY	STATE	ZIP
POLICYHOLDER'S NAME		
RELATIONSHIP TO PATIENT		
POLICY NUMBER	GROUP/PLAN NUMBER	
CUSTOMER SERVICE PHONE NUMBER		
PROVIDER INQUIRY/PRE CERTIFICATION PHONE NUMBER		
CONTACT PERSON		
IS GASTRIC BYPASS FOR 'MORBID OBESITY' A COVERED BENEFIT?		
YES <input type="checkbox"/> NO <input type="checkbox"/>		

SECONDARY INSURANCE COMPANY		
INSURANCE COMPANY NAME		
INSURANCE COMPANY ADDRESS		
CITY	STATE	ZIP
POLICYHOLDER'S NAME		
RELATIONSHIP TO PATIENT		
POLICY NUMBER	GROUP/PLAN NUMBER	
CUSTOMER SERVICE PHONE NUMBER		
PROVIDER INQUIRY PRE CERTIFICATION PHONE NUMBER		
CONTACT PERSON		
IS GASTRIC BYPASS FOR 'MORBID OBESITY' A COVERED BENEFIT?		
YES <input type="checkbox"/> NO <input type="checkbox"/>		

SELF-PAY OPTION
<p>IF Weight Loss Surgery is not a “covered benefit” or “exclusion” under your insurance plan, the insurance company will not pay for this procedure. Please be certain that your policy covers this surgery before returning this application. If your policy does not cover weight loss surgery, any costs will be your responsibility.</p>
<p>IF YOUR INSURANCE DOES NOT COVER THIS PROCEDURE, WOULD YOU LIKE INFORMATION ABOUT THE SELF-PAY OPTION?</p> <p>Please send me self -pay information YES <input type="checkbox"/> NO <input type="checkbox"/></p>



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MEDICAL INFORMATION

Do you have - or have you ever been treated for - any of the following:			
YES <input type="checkbox"/> NO <input type="checkbox"/>	Diabetes/Gestational Diabetes	YES <input type="checkbox"/> NO <input type="checkbox"/>	GERD / Heartburn
YES <input type="checkbox"/> NO <input type="checkbox"/>	High Cholesterol	YES <input type="checkbox"/> NO <input type="checkbox"/>	Ulcer s
YES <input type="checkbox"/> NO <input type="checkbox"/>	High Blood Pressure	YES <input type="checkbox"/> NO <input type="checkbox"/>	Liver Disease/Hepatitis
YES <input type="checkbox"/> NO <input type="checkbox"/>	Chest Pain/Angina	YES <input type="checkbox"/> NO <input type="checkbox"/>	Frequent Diarrhea
YES <input type="checkbox"/> NO <input type="checkbox"/>	Heart Attack	YES <input type="checkbox"/> NO <input type="checkbox"/>	Crohn's Disease/Colitis
YES <input type="checkbox"/> NO <input type="checkbox"/>	Heart Failure	YES <input type="checkbox"/> NO <input type="checkbox"/>	Infertility
YES <input type="checkbox"/> NO <input type="checkbox"/>	Stroke	YES <input type="checkbox"/> NO <input type="checkbox"/>	Bladder Incontinence
YES <input type="checkbox"/> NO <input type="checkbox"/>	Asthma/Emphysema/COPD	YES <input type="checkbox"/> NO <input type="checkbox"/>	Cancer
YES <input type="checkbox"/> NO <input type="checkbox"/>	Sleep Apnea	YES <input type="checkbox"/> NO <input type="checkbox"/>	Lupus
YES <input type="checkbox"/> NO <input type="checkbox"/>	Arthritis	YES <input type="checkbox"/> NO <input type="checkbox"/>	HIV
YES <input type="checkbox"/> NO <input type="checkbox"/>	Joint Pain/Back Pain		

OTHER HEALTH PROBLEMS	

OPERATIONS (Please include prior weight loss surgery if applicable)			
DATE	SURGERY	DATE	SURGERY

Allergies: Are you allergic to any drug, food, or substance? YES <input type="checkbox"/> NO <input type="checkbox"/>	
If yes, please list and explain what the reaction is (swelling, hives, rash, etc)	

Would you accept a blood transfusion is necessary? YES <input type="checkbox"/> NO <input type="checkbox"/>	
If not, what is your reason?	



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SOCIAL HISTORY		
Tobacco products: Do you ever use any tobacco products? YES <input type="checkbox"/> NO <input type="checkbox"/>		
If yes, What kind?		
How often?		
What year did you start?		
When did you quit?		
Alcohol: How much of the following do you drink per week?		
Mixed drinks	Beer	Wine
Street Drugs: Have you ever used any street drugs? YES <input type="checkbox"/> NO <input type="checkbox"/>		
If yes, What kind?		
When was the last time?		

EDUCATION
What is your highest level of education? <input type="checkbox"/> Some High School <input type="checkbox"/> High School/GED <input type="checkbox"/> College <input type="checkbox"/> Post-graduate

SUPPORT
Does your family support your efforts to lose weight? YES <input type="checkbox"/> NO <input type="checkbox"/>
Does your spouse/significant other support your efforts to lose weight? YES <input type="checkbox"/> NO <input type="checkbox"/> <div style="text-align: center; padding-left: 100px;">Are they overweight or obese? YES <input type="checkbox"/> NO <input type="checkbox"/></div>
Do your children support your efforts to lose weight? YES <input type="checkbox"/> NO <input type="checkbox"/> <div style="text-align: center; padding-left: 100px;">Are they overweight or obese? YES <input type="checkbox"/> NO <input type="checkbox"/></div>



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HEALTH QUESTIONNAIRE

FAMILY HISTORY

	Age	Alive			Other Health Problems
Mother		YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer <input type="checkbox"/> Blood Clots <input type="checkbox"/> Overweight/Obesity	
Father		YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer <input type="checkbox"/> Blood Clots <input type="checkbox"/> Overweight/Obesity	
		YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer <input type="checkbox"/> Blood Clots <input type="checkbox"/> Overweight/Obesity	
		YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer <input type="checkbox"/> Blood Clots <input type="checkbox"/> Overweight/Obesity	
		YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer <input type="checkbox"/> Blood Clots <input type="checkbox"/> Overweight/Obesity	
		YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer <input type="checkbox"/> Blood Clots <input type="checkbox"/> Overweight/Obesity	

WEIGHT HISTORY

Current weight:	Weight at 18 years of age:
Height:	Lowest Adult Weight:
Goal (desired) weight:	Weight 1 year ago:
	Weight 2 years ago:
	Weight 3 years ago:
	Weight 4 years ago:
	Weight 5 years ago:



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EXAMPLES OF WEIGHT LOSS METHODS

1. SUPERVISED DIET

- Diet Counters
- Medifast
- Supervised calorie counting diet (Dietician or Nutritionist)
- Overeaters Anonymous
- Optifast
- New Direction

- Weight Watchers
- Health Management Resources
- Nutri-Systems
- T.O.P.S.
- Jenny Craig
- National Weight Loss

2. NON- SUPERVISED DIETS

- Body for Life
- Calorie counting
- Atkins Diet
- Gloria Marshall
- Health Spas
- High Protein
- Hypnosis
- Low carbohydrates

- Low fat
- Pritikin
- Richard Simmons
- Scarsdale
- Stillman Diet
- Sugar Busters
- Slim-Fast
- Mayo Clinic

3. WEIGHT LOSS MEDICATIONS

- Acutrim
- Adipex-P
- Amphetamines
- Anorex
- Benzphetamine
- Bontril
- Dexatrim
- Dexfenfluramine
- Didrex
- Fastin
- Fenfluramine
- Fen-Phen

- Ionamin
- Mazanor
- Meridia
- Obalan
- Orlistat
- Phendiet

- Phentermine
- Pentrol
- Plegine
- Pondimin
- Prelu-2
- Redux

- Sanorex
- Tenuate
- Tepranol
- Wehless
- Xenical
- X-Troazine