



Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## HEALTH QUESTIONNAIRE

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

<b>SELF</b>						
LAST NAME		FIRST		MAIDEN		
ADDRESS						
CITY		STATE		ZIP		
SOCIAL SECURITY NUMBER						
DATE OF BIRTH						
MALE	FEMALE	MARRIED	DIVORCED	WIDOWED	SEPARATED	NEVER MARRIED
PLEASE CHECK PREFERRED METHOD OF CONTACT:						
<input type="checkbox"/> HOME PHONE _____		CAN BE REACHED AT <b>HOME</b> PHONE # DURING THE DAY?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	
<input type="checkbox"/> WORK PHONE _____		CAN BE REACHED AT <b>WORK</b> PHONE # DURING THE DAY?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	
<input type="checkbox"/> CELL PHONE _____		CAN BE REACHED AT <b>CELL</b> 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						
EMPLOYER				OCCUPATION		
<b>SPOUSE OR SIGNIFICANT OTHER</b>						
LAST NAME		FIRST				
SOCIAL SECURITY NUMBER				DATE OF BIRTH		
EMPLOYER						
<b>YOUR PRIMARY CARE PHYSICIAN</b>						
FAMILY PHYSICIAN						
ADDRESS						
PHONE			FAX			
<b>PHYSICIAN WHO REFERRED YOU TO US</b>						
REFERRING PHYSICIAN						
ADDRESS						
PHONE			FAX			
<input type="checkbox"/> <b>CHECK IF YOU ARE SELF-REFERRED</b>						
HOW DID YOU HEAR ABOUT THE CENTER:						
<input type="checkbox"/> TELEVISION	<input type="checkbox"/> RADIO	<input type="checkbox"/> INTERNET	<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)



Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

# HEALTH QUESTIONNAIRE

## INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY		
NAME		
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		
<b>IS GASTRIC BYPASS FOR 'MORBID OBESITY' A COVERED BENEFIT?</b>		
YES <input type="checkbox"/> NO <input type="checkbox"/>		

SECONDARY INSURANCE COMPANY		
NAME		
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		
<b>IS GASTRIC BYPASS FOR 'MORBID OBESITY' A COVERED BENEFIT?</b>		
YES <input type="checkbox"/> NO <input type="checkbox"/>		

SELF-PAY OPTION
<p><b>IF</b> Weight Loss Surgery is not a “covered benefit” or is an “exclusion” under your insurance plan, the insurance company will not pay for this procedure. Please be certain that your policy covers this surgery <b>before</b> 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><b>Please send me self-pay information</b> YES <input type="checkbox"/> NO <input type="checkbox"/></p>



Name: \_\_\_\_\_

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## HEALTH QUESTIONNAIRE

### 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"/> Joint Pain/Back Pain
YES <input type="checkbox"/>	NO <input type="checkbox"/>	High Cholesterol	YES <input type="checkbox"/> NO <input type="checkbox"/> Infertility
YES <input type="checkbox"/>	NO <input type="checkbox"/>	High Blood Pressure	YES <input type="checkbox"/> NO <input type="checkbox"/> Bladder Incontinence
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Chest Pain/Angina	YES <input type="checkbox"/> NO <input type="checkbox"/> Ulcers
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Heart Attack	YES <input type="checkbox"/> NO <input type="checkbox"/> Liver Disease/Hepatitis
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Heart Failure	YES <input type="checkbox"/> NO <input type="checkbox"/> Frequent Diarrhea
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Stroke	YES <input type="checkbox"/> NO <input type="checkbox"/> Crohn's Disease/Colitis
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

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)	





Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## HEALTH QUESTIONNAIRE



Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## HEALTH QUESTIONNAIRE

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"/> Are they overweight or obese? YES <input type="checkbox"/> NO <input type="checkbox"/>
Do your children support your efforts to lose weight? YES <input type="checkbox"/> NO <input type="checkbox"/> Are they overweight or obese? YES <input type="checkbox"/> NO <input type="checkbox"/>



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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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# HEALTH QUESTIONNAIRE

## 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