

INITIAL PATIENT QUESTIONNAIRE

NAME: _____
ADDRESS: _____
CITY: _____ STATE _____ ZIP _____
HOME PHONE (____) _____
CELL PHONE (____) _____
DATE OF BIRTH: ____/____/____ AGE ____ SEX ____
SOCIAL SECURITY # _____
EMAIL ADDRESS _____

PRIMARY INSURANCE _____
INSURANCE ADDRESS _____
CITY _____ STATE _____ ZIP _____
INSURANCE PHONE: (____) _____
POLICY HOLDER: _____
POLICY # _____ GROUP# _____

OCCUPATION _____
EMPLOYER _____
EMPLOYER ADDRESS _____
CITY _____ STATE _____ ZIP _____
EMPLOYER'S PHONE (____) _____

SECONDARY INSURANCE _____
INSURANCE ADDRESS _____
CITY _____ STATE _____ ZIP _____
INSURANCE PHONE (____) _____
POLICY HOLDER _____
POLICY# _____ GROUP# _____

SPOUSE'S NAME _____
DATE OF BIRTH ____/____/____ AGE ____
SOCIAL SECURITY # _____
SPOUSE'S EMPLOYER _____
EMPLOYER'S PHONE _____

RACE:
CAUCASION ____ AFRICIAN AMERICAN ____
HISPANIC OR LATINO ____ OTHER _____

SINGLE ____ MARRIED ____ DIVORCED ____
WIDOWED ____ SEPARATED ____ OTHER ____

DRIVER'S LICENSE# _____
STATE _____ EXPIRATION _____

(PRIMARY CARE PHYSICIAN) _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHONE (____) _____

REFERRING PHYSICIAN _____
PHYSICIAN ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHONE (____) _____

WHY ARE WE SEEING YOU TODAY? _____

WHO IS THE CLOSEST RELATIVE NOT LIVING WITH YOU? _____
RELATIONSHIP? _____ PHONE _____

MEDICARE SIGNATURE AUTHORIZATION

I authorize any holder of medical or other information about me to be released to the social security administration and health care financing administration or its intermediaries or carriers or to the billing agent of this physician or supplier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that this signature is a lifetime signature.

Signature Date

AUTHORIZATION AND ASSIGNMENT

I assign to the undersigned Physician all payments for services rendered and authorize payment made directly to him. I also authorize the Physician to furnish information to insurance carriers concerning my illnesses and my treatments.

Signature Date

PRESENT MEDICAL HISTORY

NAME: _____ DATE _____
PRIMARY CARE PHYSICIAN _____ PHONE _____
HOW LONG HAVE YOU BEEN OVER-WEIGHT? _____

PERSONAL AND FAMILY HISTORY

PATIENT	FAMILY HISTORY (CHECK IF APPLICABLE)		
	MOTHER	FATHER	SIBLING
1. HEART DISEASE, ANGINA, CHEST PAIN	YES ___ NO ___ DATE _____	_____	_____
2. HYPERTENSION	YES ___ NO ___ DATE _____	_____	_____
3. STROKE	YES ___ NO ___ DATE _____	_____	_____
4. DIABETES	YES ___ NO ___ DATE _____	_____	_____
5. CANCER _____	YES ___ NO ___ DATE _____	_____	_____
6. KIDNEY DISEASE	YES ___ NO ___ DATE _____	_____	_____
7. LIVER DISEASE (HEPATITIS)	YES ___ NO ___ DATE _____	_____	_____
8. STOMACH OR BOWEL DISORDER	YES ___ NO ___ DATE _____	_____	_____
9. HERNIA _____	YES ___ NO ___ DATE _____	_____	_____
10. VARICOSE VEINS	YES ___ NO ___ DATE _____	_____	_____
11. GALLBLADDER DISEASE	YES ___ NO ___ DATE _____	_____	_____
12. ARTHRITIS _____	YES ___ NO ___ DATE _____	_____	_____
13. VASCULAR DISEASE	YES ___ NO ___ DATE _____	_____	_____
14. BACK PROBLEMS	YES ___ NO ___ DATE _____	_____	_____
15. ASTHMA	YES ___ NO ___ DATE _____	_____	_____
16. EMPHYSEMA	YES ___ NO ___ DATE _____	_____	_____
17. ANEMIA: IRON DEFICENCY OR B12	YES ___ NO ___ DATE _____	_____	_____
18. SEIZURE DISORDER	YES ___ NO ___ DATE _____	_____	_____

PLEASE EXPLAIN ALL YES CHECKS: _____

LIST ALL MEDICATIONS YOU ARE NOW TAKEN AND IN WHAT DOSES:

LIST MONTH AND YEAR OF ALL HOSPITAL STAYS AND SURGERIES:

ARE YOU ALLERGIC TO ANY MEDICATIONS? _____ YES _____ NO

IF YES, PLEASE LIST _____

DO YOU CURRENTLY SMOKE? ___ YES ___ NO # CIGARETTES/ DAY? _____ # YEARS? _____

DID YOU USED TO BE A SMOKER? _____ YES _____ NO # CIGARETTES/DAY? _____ # YEARS? _____

WHEN DID YOU QUIT SMOKING? _____

DO YOU DRINK BEER/WINE/ALCOHOL? _____ YES _____ NO AMOUNT PER DAY? _____

IS YOUR CONDITION DUE TO A JOB RELATED ACCIDENT? _____ YES _____ NO

IS YOUR VISIT THE RESULT OF AN AUTO ACCIDENT? _____ YES _____ NO

DATE OF ACCIDENT? _____

SIGNATURE

DATE

(FOR WOMEN ONLY)

IF YOU ARE STILL MENSTRUATING:

DATE OF LAST MENSTRUAL PERIOD? _____ ARE YOUR PERIODS REGULAR? _____Y _____N
 FLOW: LIGHT___ MEDIUM___ HEAVY___ CURRENT BIRTH CONTROL METHOD? _____
 ARE YOU CURRENTLY TRYING TO CONCEIVE? ___Y ___N POLYCYSTIC OVARIAN SYNDROME ___Y ___N
 BREAST DISEASE _____Y _____N IF YES, PLEASE EXPLAIN _____

WEIGHT HISTORY

PLEASE STATE YOUR WEIGHT AT THE FOLLOWING AGES. INDICATE WHETHER ANYTHING SIGNIFICANT HAPPENED WHICH MAY CONTRIBUTE TO A WEIGHT GAIN OR A WEIGHT LOSS. (Milestone: Birth of a child, quit smoking, moved, loss of a loved one, marriage, divorce, change of job, etc.)

How long have you been 70-100 pounds overweight? _____
 Were you overweight as a child? _____

AGE	WEIGHT	MILESTONE	AGE	WEIGHT	MILESTONE
PRESCHOOL			40		
20			45		
25			50		
30			55		
35			60		

DIET HISTORY

Identify weight loss programs or methods you have utilized in the past. Check methods used and appropriate dates. **Also include pounds lost and regained.**

<u>DIET</u>	<u>DATE & RESULTS</u>	<u>DIET</u>	<u>DATE&RESULT</u>
1. Diet Pills/over the counter _____		10. Susan Powter _____	
2. Diet Pills/prescription _____		11. Atkins/ South Beach _____	
3. Diet Shots (HCG, B-12, Diuretics) _____		12. Anti-depressants (Prozac, Paxil, Wellbutrin) _____	
4. Weight Watchers _____		13. Acupuncture _____	
5. Overeaters Anonymous _____		14. Gastric Surgery _____	
6. Nutri-Systems, Jenny Craig, Metabolic Research _____		15. Therapy/Counseling _____	
7. Opti-Fast, Medi-Fast, Liquid Protein _____		16. Nutritionist _____	
8. Hypnosis _____		17. In-patient/ Out-patient treatment _____	
9. Richard Simmons _____		18. Other (Jaw wired shut, etc.) _____	

LIST ALL PHYSICIANS THAT PRESCRIBED MEDICATION AND/OR DIET AND MONITORED YOUR WEIGHT LOSS:

DR. _____	MEDS/DIET _____	DATE _____
DR. _____	MEDS/DIET _____	DATE _____
DR. _____	MEDS/DIET _____	DATE _____
DR. _____	MEDS/DIET _____	DATE _____

PLEASE FEEL FREE TO INCLUDE YOUR OWN LISTING OF ALL ATTEMPTS TO LOSE WEIGHT BUT IT IS VERY IMPORTANT TO INCLUDE DETAILS OF ANY MEDICALLY SUPERVISED WEIGHT LOSS EFFORT AND INCLUDE THE DOCUMENTATION (PROGRESS NOTES).

Signature _____ Date _____

12 REASONS

“Why I want to reach my ideal body size”

NAME _____ DATE _____

Before writing these reasons out, give some thought to them. It is of the utmost importance that these 12 reasons be true goals and desires that are very personal to you. They should not be generalizations or what you think would please US because they will be used as your “PERSONAL MOTIVATOR”. Each day before you go to sleep, slowly read through this list. This is what is called mental programming. Besides making a copy for the Doctor, also transfer this list onto a 3x5 card that is to be carried with you at ALL TIMES! When confronted with a difficult food situation, make the following commitment to yourself NOW. Regardless of whether you finally eat the food or not, you will read the entire card BEFORE doing so. Unlike your previous promises of “I’m not going to eat this,” which never worked anyway, this will be a positive resolution. It involves doing something rather than avoidance of eating a specific food.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

11. _____

12. _____

Signature _____ Date _____

Review Of Symptoms			
ARE YOU CURRENTLY OR HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING PLEASE CHECK YES OR NO AND USE THE NOTES AREA TO ADD ANY ADDITIONAL INFORMATION			
Cardiovascular Disease	Yes	No	Notes
Hypertension (High BP)			
Congestive Heart Failure (CHF)			
Ischemic Heart Disease (Heart Disease)			
Angina (Chest Pain)			
Peripheral Vascular Disease (Poor Circulation)			
Lower Extremity Edema (Leg Swelling)			
DVT \ Pulmonary Emboli (Blood Clots)			
Heart Attack			
Valvular Disease (Heart Murmur)			
Arrhythmias (Irregular Heart Beat)			
Varicose Veins			
Cellulitis \ Phlebitis			
Metabolic Disease	Yes	No	Notes
Glucose Metabolism Disease (Diabetes)			
Hyperlipidemia (High Cholesterol)			
Hyperuricemia (Gout)			
Thyroid Disease			
Respiratory Disease	Yes	No	Notes
Obstructive Sleep Apnea			
Obesity Hypoventilation Syndrome			
Pulmonary Hypertension			
Asthma			
COPD			
Emphysema			
Chronic Bronchitis			
Shortness of Breath on Exertion			
Sarcoidosis			
Gastro-Intestinal Disease	Yes	No	Notes
Gastro-Esophageal Reflux (GERD)			
Cholelithiasis (Gallbladder Disease)			
Liver Disease			
Ulcers			
H-Pylori			
Diverticulosis			
Irritable Bowel Disease			
Crohn's Disease			
Constipation			
Hemorrhoids			
Musculoskeletal Disease	Yes	No	Notes
Back Pain			
Musculoskeletal Disease			
Fibromyalgia			
Arthritis			
Reproductive Disease	Yes	No	Notes
PCOS (Polycystic Ovarian Syndrome)			
Menstrual Irregularities			

Review Of Symptoms

ARE YOU CURRENTLY OR HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING
PLEASE CHECK YES OR NO AND USE THE NOTES AREA TO ADD ANY ADDITIONAL INFORMATION

Psychosocial	Yes	No	Notes
Psychosocial Impairment (Need daily assistance)			
Depression			
Anxiety \ Bipolar \ Psychosis \ Personality Disorder			
Suicidal Thoughts			
Bulimia \ Anorexia			
Alcohol Use (How much \ often)			
Substance Abuse (Illegal \ Street Drugs)			
Tabacco Use (How much \ how long)			

Genitourinary Disease	Yes	No	Notes
Stress Urinary Incontinence			
Kidney Stones or Kidney Disease			
Frequent Urinary Tract Infections			
Urinary Retention			

Neurologic Disease	Yes	No	Notes
Pseudotumor Cerebri			
Frequent Headaches \ Dizziness			
Stroke \ TIA			
Neuropathy \ Numbness (Affecting what on body?)			

General / Other	Yes	No	Notes
Abdominal Hernia \ Past Hernia (Where?)			
Functional Status (Use Cane or Wheel Chair?)			
Abdominal Skin \ Pannus (Large Hanging Skin)			
Other Skin Disorders \ Problems (Please Specify)			
Autoimmune Disease (Lupus \ Multiple Sclerosis)			
Bleeding \ Clotting Disorders (Please Specify)			
Cancers (Please Specify)			
Infectious Disease (Hepatitis \ HIV \ Tuberculosis)			
Anemia (Iron Deficiency \ B-12 Deficiency)			

PLEASE GIVE US DETAILS OF ANY MAJOR ILLNESS OR MEDICAL PROBLEMS: _____

DATE: _____

PLEASE DO NOT WRITE BELOW THIS LINE (CHECK IF NORMAL X FOR ABNORMAL WITH DESCRIPTION)

Physical Assessment

OBESITY: _____

GENERAL: _____

HEENT: _____

CARDIAC: _____

PULMONARY _____

ABDOMINAL: _____

MUSC.-SKELETAL _____

SKIN _____

NEURO _____

OTHER: _____

DATE: _____

PHYSICIAN SIGNATURE: _____



Bariatric & Laparoscopy Center of Ocala
Patient – Contact Information

I wish to be contacted in the following manner (initial all that apply):

Home Telephone: _____

_____ O.K. to leave a message with detailed information
_____ Leave message with call back number only

Work Telephone _____

_____ O.K. to leave a message with detailed information
_____ Leave message with call back number only

Cell Telephone _____

_____ O.K. to leave a message with detailed information
_____ Leave message with call back number only

Written Communication

_____ O.K. to mail to my home address
_____ O.K. to mail to my work/office address
_____ O.K. to fax to this number _____

Personal Contacts

O.K to release Protected Health Information (PHI) to the following:

Name: _____ Relationship _____
Name: _____ Relationship _____
Name: _____ Relationship _____

I understand it is my responsibility to change this information should my circumstances change. I will notify Bariatric & Laparoscopy Center of Ocala in writing of any changes to the above.

_____ I have received and understood the Notice Of Privacy Practices

Signature

Date



Directions to our Offices

Ocala Office

**2820 SE 3rd Court, Suite 100
Ocala, FL 34471**

(If you GPS or use Mapquest, make sure to put COURT)

- From I-75 (North or South bound), get off on Exit #350 to SR 200 / College Rd.
- Head East on SR 200 to Ocala.
- Your next turn will be at the intersection of 441/301/Pine St., there make a right, heading south on 441/301.
- Go to second traffic light (CR 475), Pizza Hut will be on your left and a BP gas station will be on the right.
- Make a right turn onto CR 475, go down to 3-way stop; at 3-way stop go straight.
- On the left you will see South Pine Medical Park, turn in there, go to stop sign, and at stop sign make a left turn. We are the third office bldg. on the left.
- left.



Orlando Office
1601 Park Center Drive, Unit 8
Orlando, FL 32835

- From Florida's Turnpike take Exit 265 onto FL-408 E Towards Orlando/Titusville (toll Road)
- Take exit 4 toward Hiwassee Rd (toll road) South
- Keep right at the fork on Hiwassee Rd
- Turn left at Currin Dr
- Park Center Plaza will be straight ahead (you will see a sign that says 1601 Dentist)

***If you need further assistance with directions to our office, please contact us @ 352-351-5770.**