Bariatric Surgery Patient Information Sheet

Name: ______________________________________ **Date of Birth/Age:**_________________

Address: ____

Phone Number: _______________________ **Height:** _______ **Weight:** ________

Insurance Type & Employer: ____

Procedure Desired: Gastric Bypass ______ Sleeve ______ Gastric Band _____ Uncertain ______
Surgeon preference: Dr. Fernandez ____ Dr. McNatt ____ Dr. Powell ____ **Either**_________

Please list ***weight loss attempts/diets*** over the past 5 years: ___________________________
____

5 year weight history: 2014 _________ 2013 ________ 2012 _________

2011 _________ 2010 ________

Current Medical History: *(please include year diagnosed)*

- ○ **YES** ○ **NO** Heart disease
- ○ **YES** ○ **NO** High blood pressure
- ○ **YES** ○ **NO** Vascular disease
- ○ **YES** ○ **NO** Hepatitis
- ○ **YES** ○ **NO** COPD
- ○ **YES** ○ **NO** Depression
- ○ **YES** ○ **NO** Sleep Apnea
- ○ **YES** ○ **NO** Stress Incontinence
- ○ **YES** ○ **NO** Lung disease
- ○ **YES** ○ **NO** Kidney disease
- ○ **YES** ○ **NO** Bleeding problems
- ○ **YES** ○ **NO** Diabetes
- ○ **YES** ○ **NO** Other Medical Problems:(list) ___________________________________
____
- ○ **YES** ○ **NO** High Cholesterol
- ○ **YES** ○ **NO** Aneurysm disease
- ○ **YES** ○ **NO** Stroke
- ○ **YES** ○ **NO** Prior Vascular Surgery
- ○ **YES** ○ **NO** Joint Disease/Arthritis
- ○ **YES** ○ **NO** Gynecological Problems
- ○ **YES** ○ **NO** Irritable Bowel Syndrome
- ○ **YES** ○ **NO** Acid Reflux/Heartburn
- ○ **YES** ○ **NO** Possible DVT/PE

Surgical History (type & date): ____
____

Medication List: ____
____

- Do you have Sleep Apnea? _______ Using CPAP or BiPAP? _________
- Have you been hospitalized for depression, anxiety, or other related problems? _____

If yes, please give the date(s) and reason(s): ____

- Do you currently smoke? __________ If yes, how much and what product? _______________

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PATIENT INFORMATION

Name (Last, First, Middle):____ AKA:_______________________________________

Maiden Name:________________________ Mother's First Name:____

DOB:_______________________ Email Address:____

Address:____

Telephone#__________________________Cell#__________________________Work#_____________________________________

Sex: Male____ Female_____ Race:____________________________ Marital Status:________________________________

GUARANTOR INFORMATION

Relationship to Patient:__________________

Insurance Card Holder's Name:______________________________________ DOB:______________________________________

Address Line:____ City, St, Zip:__________________________________

Race:____________________________ Sex: Male____ Female___

Telephone#________________________________ Effective Date of Insurance:___________________________________

NEAREST RELATIVE INFORMATION

Emergency Contact Name:______________________________Emergency Phone#_______________________________________

Nearest Relative's Name:_______________________________Relationship to Patient:____

Address Line:____

City,State:_______________________________Zip:____

Telephone#:_________________________________

EMPLOYMENT HISTORY

Employer:____

Address:___________________________________ City, State:_________________________ Zip Code:_________________

Telephone#:____ Effective Date of Employment:___________________________

PATIENT'S ASSIGNED PROVIDER

Family Medical Doctor:____

INSURANCE INFORMATION

Name of Ins. Company:____ Ins Comp tele# __________________________________

Insurance Comp. Address:____

ID Number:____ Group Number:____

Patient's Relationship to Card Holder:____________________________Card Holder's Name:____________________________________

Card Holder's DOB:________________________________

Card Holder's Sex:___________________________Card Holder's Employer:____