Northwest Weight Loss Surgery

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Patient Registration

Name: ______________________________ Preferred Name: ______________
Last *First* *Middle*

Social Security Number: ______________ Sex: ❐ Female ❐ Male

Date of birth: __________ Age: ______ Marital Status: ______ Race: ________

Address: ______________________________

City/State/Zip ______________________________

Home phone: ( ) ______________ Work phone: ( ) ______________

Cell phone: ( ) ______________ E-mail: ______________

Occupation: ______________________________

Employer: ______________ Phone: ( ) ______________

❐ Full Time ❐ Part Time ❐ Self Employed ❐ Homemaker ❐ Student

❐ Disabled ❐ Unemployed

How did you hear about us? ______________________________

INSURANCE INFORMATION

Primary Insurance: ______________________________
Name *Group* *Number*

Co-pay: YES NO Referral needed: YES NO

Secondary Insurance: ______________________________
Name *Group* *Number*

Co-pay: YES NO Referral needed: YES NO

Responsible party: ______________________________

Primary Care Provider ______________________________

PCP Phone Number: ( ) __________ PCP Email: ______________

PCP Address: ______________________________

EMERGENCY INFORMATION

In case of emergency, we would appreciate the name of a contact, NOT living with you at the same address.

Name: ______________________________
Last *First* *Middle*

Home Phone: ( ) ______________ Work Phone: ( ) ______________

Please read the following statement carefully before signing:

I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize the clinic to receive all benefits to which my dependents or I are entitled under my health insurance plan. In addition, I will not withhold or delay payment if my insurance company denies payment on any of the charges. I have been informed of the $35.00 fee (per RCW 62A.3-515 & 520) on checks returned from my bank for insufficient funds. The undersigned agrees that whether s/he signs as an agent, that s/he is obligated to pay for the account. Should the balance of the account exceed an amount the undersigned agrees to pay in full, a payment plan can be established with 1% per month interest (per RCW 19.52) on the unpaid balance.

Signature: ______________________ Date: ______________

Please give the receptionist your insurance card.

Medical History

Date: ______

Name: ______ Social Security ______

DOB: ______ Age: ______ Height ______ Weight ______ BMI: ______

Primary Care Doctor: ______

FOR OFFICE USE ONLY											
Height		Weight		BMI		Neck		Goal		Ideal	
BMI>45		Age>38		Apnea		HbA1c		Insulin		Male	
Temp		HR		BP	/						

PAST MEDICAL HISTORY

Please circle the appropriate response

Bleeding	YES	NO	Blood clots in the legs	YES	NO
Rheumatic fever	YES	NO	Blood clots to the lungs	YES	NO
Thyroid problems	YES	NO	Diabetes currently	YES	NO
Tuberculosis	YES	NO	Diabetes while pregnant	YES	NO
Urinary tract infections	YES	NO	Age at onset of diabetes		
Kidney disease	YES	NO	Diabetes control	GOOD	POOR
Hepatitis	YES	NO	Problems with anesthesia	YES	NO
Antibiotics for dental work?	YES	NO	Polycystic ovarian syndrome (PCOS)	YES	NO
AIDS/HIV	YES	NO	Hypertension/high BP	YES	NO
			High cholesterol or triglycerides	YES	NO

PAST SURGICAL HISTORY		PAST HOSPITALIZATIONS	
Please list all surgeries	Approx. date	Please list all hospitalizations	Approx. date

FOR OFFICE USE ONLY – PATIENT MEDICAL SUMMARY

Review of Symptoms

Please circle the appropriate response

GENERAL		
Fevers	YES	NO
Sweats	YES	NO
Fatigue	YES	NO
Loss of appetite	YES	NO
Bloody sputum	YES	NO
Persistent cough	YES	NO
SKIN		
Rash	YES	NO
Acanthosis nigricans	YES	NO
Hirsute (excess body hair)	YES	NO
Acne	YES	NO
Skin cancer	YES	NO
SENSES		
Visual problems	YES	NO
Hearing problems	YES	NO
Ear ringing	YES	NO
NEUROLOGICAL		
Dizziness	YES	NO
Migraines	YES	NO
Frequent headaches	YES	NO
Seizures	YES	NO
Strokes	YES	NO
Memory loss	YES	NO
Shaking	YES	NO
Numbness	YES	NO
Uncoordination	YES	NO
GENITO-URINARY		
Blood in urine	YES	NO
Vaginal infections	YES	NO
Stress urinary incontinence	YES	NO
Bladder/kidney infections	YES	NO
Prostate infections	YES	NO
SLEEP APNEA		
Snoring	YES	NO
Require C-PAP	YES	NO
Daytime drowsiness	YES	NO
Frequent waking at night	YES	NO
Choking at night	YES	NO
Number of pillows used: ______________		
PULMONARY DISEASE		
Short of breath on exertion	YES	NO
Hay fever	YES	NO
Emphysema/COPD	YES	NO
Pneumonia	YES	NO
Asthma/choking	YES	NO
Aspiration/choking	YES	NO

INFECTION		
HIV	YES	NO
AIDS contact	YES	NO
TB exposure	YES	NO
Swollen glands	YES	NO
Recurring infections	YES	NO
Skin infections	YES	NO
EXERCISE LIMITATIONS		
Mild	YES	NO
Moderate	YES	NO
Severe	YES	NO
PAIN IN JOINTS		
Back	YES	NO
Hips	YES	NO
Knees	YES	NO
Feet	YES	NO
Arthritis	YES	NO
Where?______________________________		
GASTROINTESTINAL		
Heartburn/acid reflux	YES	NO
Stomach pains	YES	NO
Stomach ulcers	YES	NO
Gastritis	YES	NO
H. pylori infection	YES	NO
Rectal bleeding	YES	NO
Liver disease	YES	NO
Hepatitis or cirrhosis	YES	NO
Colitis or enteritis	YES	NO
Frequent diarrhea	YES	NO
Frequent constipation	YES	NO
Crohn's disease	YES	NO
Intestinal telangectasia	YES	NO
Stomach surgery	YES	NO
PHYSICAL LIMITATIONS		
Climbing stairs	YES	NO
Unusual fatigue	YES	NO
Airline travel	YES	NO
Lifting from floor	YES	NO
Use of public seating	YES	NO
Personal care	YES	NO
Tying shoelaces	YES	NO
Playing with children	YES	NO

Review of Symptoms *(continued)*

GYNECOLOGICAL (females only)		
Last menstrual period:______________________		
Pregnancies:______________________________		
Current contraception:______________________		
Currently pregnant?	YES	NO
Intend pregnancy next 2 yrs?	YES	NO

CARDIOVASCULAR		
Heart attack	YES	NO
Congestive heart failure	YES	NO
Thrombophlebitis	YES	NO
Swelling of ankles	YES	NO
Chest pain	YES	NO
Coronary heart disease	YES	NO
Varicose veins	YES	NO
Heart murmur	YES	NO
Pulmonary embolism	YES	NO
Stroke	YES	NO
Ever taken Fen-Phen	YES	NO

PSYCHOLOGICAL		
Depression	YES	NO
Feeling down	YES	NO
Suicidal episodes	YES	NO
Mood swings for days at a time	YES	NO
Hospitalized/psych. reasons	YES	NO
Use alcohol or drugs to cope	YES	NO
Hospitalized/substance abuse	YES	NO
Eating disorder	YES	NO
Vomiting to lose weight	YES	NO
Fasting to lose weight	YES	NO
Laxatives to lose weight	YES	NO
Life more stable than 1 yr. ago	YES	NO
If <18 years old, history of frequent school absence	YES	NO
History of sexual abuse	YES	NO
Psychiatric medications in past or present	YES	NO
Overeat in reaction to feelings	YES	NO
Intend other weight loss surgery in the next year	YES	NO

Age you first become overweight: ____________

Epworth Sleepiness Scale

NOTE: *The Epworth Sleepiness scale refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.*

SCALE:

0=	Would never doze
1 =	Slight chance of dozing
2 =	Moderate chance of dozing
3 =	High chance of dozing

SITUATION	LIKELIHOOD
Sitting and reading	____________
Watching TV	____________
Sitting, inactive in a public place	____________
A passenger in a car for 1 hour, no break	____________
Sitting and talking to someone	____________
Sitting quietly after lunch without alcohol	____________
In a car, stopped in traffic	____________
Lying down to rest in the afternoon when circumstances permit	____________

TOTAL SCORE: ____________

Medications

List all daily medications including over-the-counter medications and vitamins, herbs or supplements, and contraceptives. Please include dosage and frequency if known.

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

Aspirin	YES	NO	NSAIDS	YES	NO
Ibuprofen	YES	NO	Insulin	YES	NO
Aleve	YES	NO	Steroids	YES	NO

ALLERGIES		
	To what?	What kind of reaction?
Medication		
Other allergies:		

Sensitive/allergic to:						
	Latex	YES	NO	Iodine	YES	NO
	Dye	YES	NO	Tape	YES	NO

Social History

Marital status: ❐ Single ❐ Married/partnered ❐ Divorced/separated ❐ Widowed

Religious preference: ______________________

Ethnic background: ______________________

Education: ______________________

Number of people living in your home: ________ Who? ______________________

What type of work or hobbies do you do? ______________________

What type of sports do you do? ______________________

Do you smoke? YES NO How many per day? ________ How often? ________

Do you drink? YES NO How many per day? ________ How often? ________

Do you use controlled substances? YES NO

How does your spouse/partner/family/friends/significant other feel about your weight loss surgery?

____

____

For adolescents only

Highest grade in school: ______________________

School performance: ❐ Excellent ❐ Very good ❐ Good ❐ Fair ❐ Poor

School name: ______________________

Are you sexually active? ______________________

Do you smoke marijuana? ______________________

Family History

DISEASE	WHICH FAMILY MEMBER HAD IT?	WHEN?	WAS IT FATAL?
Cancer (what type)			
Diabetes			
Heart attack			
Severe obesity			
Other			

Weight Loss History

NON-SUPERVISED ATTEMPTS					
Body For Life/Bill Phillips	YES	NO	Atkins Diet	YES	NO
Gloria Marshall	YES	NO	AYDS	YES	NO
Health spa	YES	NO	Mayo Clinic Diet	YES	NO
High protein	YES	NO	Pritikin	YES	NO
Hypnosis	YES	NO	Richard Simmons	YES	NO
Low carbohydrate	YES	NO	Scarsdale Diet	YES	NO
Low fat	YES	NO	Stillman Diet	YES	NO
Calorie counting on my own	YES	NO	Sugar Busters	YES	NO
Gym membership	YES	NO	Slim Fast	YES	NO
Home gym equipment	YES	NO	South Beach Diet	YES	NO
			Other Diet	YES	NO

SUPERVISED WEIGHT LOSS ATTEMPTS					
Diet Pills From MD	YES	NO	Supervised calorie counting	YES	NO
Diet Shots From MD	YES	NO	Acupuncture	YES	NO
Diet Center	YES	NO	Psychological counseling	YES	NO
Overeaters Anonymous	YES	NO	Weigh Of Life	YES	NO
Optifast	YES	NO	Weight Loss Center	YES	NO
Weight Watchers	YES	NO	Exercise counseling	YES	NO
Health Management Resources	YES	NO	Medifast	YES	NO
Nutri-System	YES	NO	Metrical	YES	NO
T.O.P.S.	YES	NO	Nutritional counseling	YES	NO
Jenny Craig	YES	NO	Personal trainer	YES	NO
New Direction	YES	NO	National Weight Loss	YES	NO

WEIGHT LOSS MEDICATIONS					
Acutrim	YES	NO	Obalan	YES	NO
Adipex-P	YES	NO	Orlistat	YES	NO
Amphetamines	YES	NO	Phendiet	YES	NO
Anorex	YES	NO	Phentermine	YES	NO
Benzphetamine	YES	NO	Phentrol	YES	NO
Dexatrim	YES	NO	Plegine	YES	NO
Didrex	YES	NO	Pondimin	YES	NO
Fastin	YES	NO	Redux	YES	NO
Fenfluramine	YES	NO	Sanorex	YES	NO
Herbal Remedies	YES	NO	Tepanol	YES	NO
Ionamin	YES	NO	Tenuate	YES	NO
Mazanor	YES	NO	Wehless	YES	NO
Meridia	YES	NO	Xenical	YES	NO
Metabolife	YES	NO	Other	YES	NO

PREVIOUS WEIGHT LOSS SURGERY					
Gastric bypass (RNY or other)	YES	NO	Gastric band	YES	NO
Stomach stapling	YES	NO	Other	YES	NO
Vertical banded gastroplasty	YES	NO			

Nutrition History

How many meals do you eat daily? ______________________________

Do you snack between meals?	YES	NO	How many daily?	__________
Do you drink soda?	YES	NO	How many daily?	__________
Diet	YES	NO		
Regular	YES	NO		

FOOD PREFERENCES

Candy	YES	NO	Fast food	YES	NO
Cookies	YES	NO	Seafood	YES	NO
Fried food	YES	NO	Cakes or pies	YES	NO
Pizza	YES	NO	Vegetables	YES	NO
Chocolate	YES	NO	Steak/red meat	YES	NO
Chips/snacks	YES	NO	Dairy products	YES	NO

Food allergies: ______________________________

FOOD PATTERNS

Please record the type of food and the amount you have eaten over the past two days.

	ALL FOODS EATEN YESTERDAY	ALL FOODS EATEN THE DAY BEFORE YESTERDAY
Before breakfast		
Breakfast		
Morning break		
Lunch		
Afternoon break		
Dinner		
After dinner		
Before bed		
Other		