# PATIENT INFORMATION

Please fill in all the information on the following pages. Print clearly using a pen, not pencil.

Please be as complete as possible. We know this is a lot of paperwork, but it is necessary for us to help you. This form will be used to help us evaluate your health and medical history. It will also be used to provide the necessary information to get approval from your insurance company for your surgery.

Name: ________________________________________ Age:__________
First Middle Last

Date of birth: ______/_______/_______

Address: ______________________________

______________________________

Phone #: ___________________

Insurance: __________________

Body Mass Index (BMI): ________

## Weight Loss Attempts

| | **Weight Loss** | | **Weight Loss** | | **Weight Loss** |
|---|---|---|---|---|---|
| □ Atkins | | □ Jenny Craig | | □ Pritikin | |
| □ Acupuncture | | □ LA Diet | | □ Richard Simmons | |
| □ Calorie Counting | | □ Low Carb | | □ Scarsdale | |
| □ Diet Center | | □ Low Fat | | □ Self Diet | |
| □ Fad Diet | | □ Metabolite | | □ Slim Fast | |
| □ Herbal Diet | | □ Medifast | | □ Start Fresh | |
| □ Health Spa | | □ Nutrisystem | | □ South Beach | |
| □ High Protein | | □ Nutritionist | | □ Weight Watchers | |
| □ Hypnosis | | □ Optifast | | □ Zone | |
| □ Jaw Wiring | | □ Overeaters Anonymous | | □ Others | |

Inpatient Rehab Programs:
___________________________________________________________________

Has a physician ever supervised your attempts to lose weights? Yes ______ No ______

If yes please list:
____________________________________________________________________________
______________________________________________________________________________
____________

**FYI- Most insurance companies require 6 month physician supervised diet and exercise program.**

How long have you been obese? Since age __________ (OR) for ______________ years
Within a 20-pound weight gain or loss, how many months/years have you been at your current
weight? _________________________________

COMORBID FACTORS – Obesity related medical problems.
Please read carefully and make sure you write an X on each line.

| MEDICAL PROBLEM | | | | I TAKE MEDICINE FOR THIS | |
|---|---|---|---|---|---|
| | YES | NO | NOT SURE | YES | NO |
| High Blood Pressure | | | | | |
| Heart Problems | | | | | |
| Stroke | | | | | |
| High Cholesterol | | | | | |
| High Triglycerides | | | | | |
| Asthma (Seasonal) | | | | | |
| Asthma (Year-Round) | | | | | |
| Sleep Apnea (documented) | | | | | |
| Use CPAP? | | | | | |
| Sleep Apnea (un-documented) | | | | | |
| Reflux (GERD, frequent heartburn) | | | | | |
| Peptic Ulcer | | | | | |
| Liver Disease | | | | | |
| Diabetes | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Thyroid Problems | | | | | |
| Degenerative Joint diseases (DJD) | | | | | |
| Back Pain | | | | | |
| Infertility (if not from hysterectomy) | | | | | |
| Irregular periods | | | | | |
| Incontinence of urine | | | | | |
| (Use pads for this) | | | | | |
| Depression | | | | | |
| Varicose Veins | | | | | |
| Arthritis | | | | | |
| Rashes due to skin folds | | | | | |

How did you learn about us?

Your doctor ____________________________________________

Another patient __________________________________________

Internet/Website__________________________________________

**Missed appointment policy:** If you do not call to cancel a scheduled appointment in advance you will be charged a **$25.00** fee that is not covered by your insurance company. We are a General Surgery Office that provides emergent care and if you cannot keep an appointment there are always last minute urgent appointment spots needed. **Please be courteous.**

I have given complete information in all parts of this medical history form to the best of my knowledge and have not knowingly omitted any information relating to my present or past health

Your name (print) __________________________________________

Your Signature ____________________________________________

Date you completed this form _________________________

**Please send your completed forms to:**

**Surgical Associates of Ithaca**
**1301 Trumansburg Rd, Suite E**
**Ithaca, NY 14850**