

La Jolla Weight Management

**9850 Genesee Ave. #730
La Jolla, CA 92037
Email: ljsurgical.com**

**Phone: (858) 457-4917
Fax: (858) 457-3287**

Requested Surgeon: _____

Requested Procedure: _____

Last name, First, Middle	Date of Birth	Sex	Marital Status M D S W
Street Address	Home Phone		Cell Phone
City State Zip code	Social Security #		FAX Number
Employer's Name	Email Address		
Employer's Street Address	Work Phone		Drivers License# & State
City State Zip code	Occupation	<u>Race/Ethnicity</u> (for study purposes)	
Emergency Contact:	Relationship	Cell Phone	Religious Preference
Street Address, City, State, ZIP	Home Phone		Work Phone
Referring Physician	Address, City, Sate, ZIP		Work Phone
Primary Care Physician	Address, City, State, ZIP		Work Phone
Primary Insurance	Secondary Insurance		
Address	Address		
Customer Service Phone Number	Customer Service Phone Number		
Policy or ID number	Policy or ID number		
Subscribers Name	Subscribers Name		
Relationship to Patient	Relationship to Patient		
Subscriber's Employer, Address, Telephone Number	Subscriber's Employer, Address, Telephone Number		

How did you hear about us? Former patient TV ad Newspaper ad Internet Reader/Magazine

website: www. _____ Friend **Physician's Name:** _____

Date attended Seminar (if applicable) _____

I consent to any medical treatment or physical examination required for myself or the minor named above for whom I am legally responsible. I authorize release of medical information necessary to process claims for health insurance and disability benefits, and request that payment be made directly to my physician for services rendered. A copy of this authorization will be accepted to be as valid as the original. I have received a copy of the HIPPA Notice of Privacy Practices Pamphlet. ____ (Initials)

Signature: _____ Date: _____

For Office Use only:

La Jolla Weight Management

PATIENT HISTORY QUESTIONNAIRE

The information requested in this questionnaire is very important. To give you the best quality care, please try to complete all the answers to the best of your ability.

Name:	Date:	Age:
Occupation: (If retired or disabled, what <i>did</i> you do or what is your disability?)		
Weight	Height	BMI
		Body Frame – Circle One Small Medium Large

WEIGHT HISTORY

How long have you been suffering from Morbid Obesity? _____

In your own words, please describe what you hope to accomplish and how you believe your life will change by losing weight:

DIETARY HISTORY Approximate age when you first seriously dieted: _____

List the diets and diet programs you have tried:

Program	Yes	No	Dates	Duration	MD Supervised?	Max Loss
Jenny Craig:	Yes	No	_____	_____	_____	_____
Nutri-Systems	Yes	No	_____	_____	_____	_____
Weight Watchers	Yes	No	_____	_____	_____	_____
OptiFast	Yes	No	_____	_____	_____	_____
Medi Fast	Yes	No	_____	_____	_____	_____
Fen/Phen/Redux	Yes	No	_____	_____	_____	_____
Meridia	Yes	No	_____	_____	_____	_____
Lindora	Yes	No	_____	_____	_____	_____
T.O.P.S.	Yes	No	_____	_____	_____	_____
O.A.	Yes	No	_____	_____	_____	_____
Acupuncture	Yes	No	_____	_____	_____	_____

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Metabolife	Yes	No	_____
Atkins Diet	Yes	No	_____
Pritikin Diet	Yes	No	_____
Other:	Yes	No	_____

List any physician-supervised and documented weight loss attempt: _____

List any other diets and/or weight loss methods you've tried: _____

For female patients only:

Pregnancy #1	Year _____	Weight at start _____	at delivery _____
Pregnancy #2	Year _____	Weight at start _____	at delivery _____
Pregnancy #3	Year _____	Weight at start _____	at delivery _____
Pregnancy #4	Year _____	Weight at start _____	at delivery _____

Food and Exercise History

What are your dietary pitfalls? (circle answers)

Snacking	stress eating	grazing all day	love sweets	eating large meals	fast foods
Love salty	love crunchy	skipping meals	restaurants	boredom	love carbs
Other _____	_____				

What do you typically eat for the following:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

Do you ever eat until you are uncomfortably full? Y/N

What do you do for exercise:

What is the number of times you exercise per week? _____

Difficulty with exercise is due to (circle answers): shortness of breath joint discomfort
back pain lack of motivation lack of time embarrassment time
scheduling family other: _____

WEIGHT RELATED ILLNESSES

Have you had, or do you have, any of the following illnesses or symptoms?

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1. Heart Disease Yes No

If Yes: ♦ Year Diagnosed _____

Do you have, or have you had:

- Angina (date _____)
- M.I. (myocardial infarction, "heart attack") (date _____)
- CABG (coronary artery bypass graft)
- Abnormal EKG (date: _____)
- Stress test to rule out cardiac problems (if yes, date performed? _____)
- Palpitations

2. High Cholesterol Yes No High Triglycerides Yes No

If Yes: ♦ Year diagnosed _____

♦ List medications _____

3. High Blood Pressure Yes No

If Yes: ♦ Year diagnosed _____

♦ List medications _____

4. Diabetes Yes No

If Yes: ♦ Year diagnosed: _____

♦ Gestational: Yes No

♦ Neuropathy: Yes No

♦ Controlled with: Diet

Oral Medication (list) _____

♦ Last fasting blood sugar: _____

5. Asthma Yes No

If Yes: ♦ Year diagnosed: _____

♦ ER visits/last 2 yrs: _____

♦ Hospitalizations last 2 years: _____

♦ Steroids last 2 years: Yes No

6. Shortness of breath Yes No

If Yes, ♦ Can walk _____ blocks

♦ Stairs: _____ flights

7. Trouble Sleeping? Yes No

If Yes: ♦ Since? _____ date ended? _____

♦ Morning headaches Yes No

♦ Daytime drowsiness Yes No

♦ Restless sleep Yes No

♦ Snoring Yes No

♦ Awakenings at night Yes No

♦ Observed apneas Yes No

Office Use: sleep study ordered _____ initials

8. Sleep Apnea Syndrome Yes No

If Yes: ♦ Year diagnosed: _____

♦ Last sleep study: _____ month/year

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◆ CPAP used: Yes No

9. Heartburn/esophagitis/hiatus hernia? Yes No (Please circle the one which you have had)

If Yes: ◆ Year diagnosed: _____

◆ Upper GI series? Yes No

◆ Endoscopy? Yes No

10. Belching up acid or sour fluid. Yes No

11. Coughing or choking at night? Yes No

Office Use: *UGI/endoscopy*

12. Gallbladder disease? Yes No Since _____?

If Yes: How was it diagnosed? Ultrasound Physical Exam (Gallbladder removed)

13. Leakage of urine with laughing/coughing/sneezing? Yes No Since _____?

If Yes: ◆ Wear pads frequently? Yes No

15. Low back strain/Pain/Sciatica? (**Please circle which one**) Yes No Since _____?

If Yes: ◆ Seen by Chiropractor? Yes No

◆ Orthopedic Surgeon? Yes No

◆ Seen by Family Doctor? Yes No

◆ Medications taken: _____

16. Pain in Hips/Knees/Ankles/Feet? (**Please circle which one**) Yes No

If Yes: Since _____?

◆ Seen by Chiropractor? Yes No

◆ Orthopedic Surgeon? Yes No

◆ Seen by Family Doctor? Yes No

◆ Medications taken _____

17. Weight related injuries and trauma: _____

18.. Bra size (females only): _____

Skin depressions from bra straps? Yes No

Do you have shoulder pain? Yes No

PAST MEDICAL HISTORY

Female Patients:

Number of pregnancies: _____ Age at first period: _____

Number of live births: _____ Date of last period: _____

Miscarriages/abortions: _____

C-Sections? _____ Date/s? _____

Obstetric complications: _____

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Do you presently use:

Birth control pills Yes No List type: _____
 Date Started? _____

Estrogens Yes No List type: _____
 Date Started? _____
 Other Contraceptive method: _____

When was your last mammogram? Date _____ **Results** _____

Have you had:

- Hepatitis ? / Date: _____ Blood Transfusion ? / Date: _____
- AIDS/HIV Exposure? / Date: _____ Colitis? / Date: _____ Kidney Disease? / Date: _____
- Bleeding Abnormality? / Date: _____ Thyroid Problems ? / Date: _____
- Cancer, type: _____ / Date diagnosed?: _____ / In remission? Yes No

Would you accept a blood transfusion in an emergency situation? _____

Please list below all serious illnesses and hospitalizations you have experienced in adulthood:

Major Illness	Date	Treatment

Surgical Procedures	Date

Allergies:

Allergic to any medications?: Yes No
 Medication? Year Started ?

Allergic to: **Surgical tape:** Yes No Yr. started _____ **Latex:** Yes No Yr. started _____
Iodine: Yes No Yr. started _____

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Medications:

Please list all medications you currently use:

Medication	Dose	How often?	Start Date?	Reason taking it?

Do you use tobacco: Yes No Frequency: _____

Are you willing to quit? Yes No

Have you ever used tobacco? Yes No How many Years? _____
How many packs a day? _____

Do you use alcohol: Yes No Frequency: _____

Drug Use (social): Yes No Frequency: _____ Type: _____

Any history of abuse: _____

FAMILY HISTORY

Family Member	Living?	Age	If Deceased, age	Illness/Cause of death
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Sibling:				

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Sibling:				
Sibling:				
Sibling:				

Please indicate if there is a family history of:

Obesity

Lung disease, Asthma or Emphysema

Diabetes

Kidney Disease

High Blood Pressure

Bleeding tendency or Blood Disorder

Heart Disease

Breast Cancer

High Blood Cholesterol

Colon Cancer

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Personal Physicians:

Please list all the physicians under whom you receive medical care:

	Name	Address/Location	Telephone
Primary Care Physician	_____	_____	_____
	_____	_____	_____
Internist	_____	_____	_____
	_____	_____	_____
Gynecologist	_____	_____	_____
	_____	_____	_____
Orthopedist	_____	_____	_____
	_____	_____	_____
Psychiatrist	_____	_____	_____
	_____	_____	_____
Psychologist	_____	_____	_____
	_____	_____	_____
Therapist	_____	_____	_____
	_____	_____	_____
Nephrologist	_____	_____	_____
	_____	_____	_____
Other (Specify)	_____	_____	_____
	_____	_____	_____

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Patient Name

Date of Birth

Address

Social Security Number

City, St Zip

Phone #

I authorize _____ (name of your doctor or hospital) to release copies of my medical records, created during the course of my diagnosis and treatment at your facility, and for continued patient care, to:

La Jolla Weight Management - 858-457-3287 (fax)

858-457-4917 (phone)

Approximate Dates of Service for requested Medical Records: _____

I understand the information is released for continued patient care and may not be provided in whole or in part to any other agency, organization or person. I hereby waive my/his/her rights to the privileges of confidentiality with respect to any HIV test result or mental health information or drug/alcohol information that may be contained in the medical record. The Healthcare provider, its employees and officers and attending physicians are released from legal responsibility or liability for the release of information to the extent stated and authorized herein. Records may be faxed to expedite continuing care. This authorization is valid for 180 days from date of signature unless revoked in writing earlier by the patient.

Signature of Patient

Date

Signature of Parent/Guardian/Legal Representative

Relationship to the Patient

This fax contains **CONFIDENTIAL INFORMATION** and is only for the individual or entity named in this document. Otherwise, you are hereby notified that disclosure, copying, distribution or other action to the content for this fax is strictly prohibited. If this is received in error, please contact sender immediately.

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REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

Patient Name (please print)

Date of Birth

Both before and after surgery we will need to contact you regarding test results, insurance information, referrals, etc. We will need your authorization to convey this protected health information in a way that is most convenient for you.

Designated method of contacting the patient (check all that apply)

___ OK to leave detailed messages on answering machine (___) _____

___ OK to leave detailed messages on voice mail (___) _____

___ OK to leave a message with family member (___) _____

___ Leave call back messages only (___) _____

___ Send detailed messages via e-mail _____
E-mail address

___ **Please check if your e-mail is confidential and SHOULD NOT be used**

Signature

Date

This authorization expires in 1 year _____ from the above date
2 years _____
No expiration _____