



The Garrison Center for Healthy Living

Overcoming Obesity with Hope, Education, Compassion & Commitment

Bariatric - Medical History Questionnaire

PATIENT INFORMATION

Patient Name: _____ **DOB** ____/____/____ **SSN:** _____-_____-_____

- Male
- Female

Marital Status:

- Single
- Married
- Divorced
- Widowed

Mailing Address: _____

City: _____

State & Zip: _____

Home Phone: _____ - _____ - _____

Cell Phone: _____ - _____ - _____

Email: _____

Mother's Maiden Name: _____

Reason for visit: _____ **Initial Date of Service:** ____/____/____

Referring Physician Name: _____

Address & Phone #: _____

Height: _____ ft. _____ in.

Weight: _____ lbs

Employer information

Patient Employment Status: _____

Retirement Date: ____/____/____

Employer/School Name: _____

Patient Occupation: _____

Work Phone #: _____

Employer Address: _____

City, State & Zip: _____

Responsible Party

Name of Person Responsible: _____

Relationship to Patient: _____

DOB: ___/___/___ **Phone #:** _____ - _____ - _____ **SSN:** _____ - _____ - _____

Address: _____

City, State, Zip code: _____

Patient Employment Status: _____

Employer/School Name: _____

Patient Occupation: _____

Work Phone #: _____ - _____ - _____

Employer Address: _____

City, State & Zip: _____

Nearest Relative

Name: _____ **Relationship to Patient:** _____

Home Phone #: _____ - _____ - _____ **Work Phone #:** _____ - _____ - _____

Name: _____ **Relationship to Patient:** _____

Home Phone #: _____ - _____ - _____ **Work Phone #:** _____ - _____ - _____

Name: _____ **Relationship to Patient:** _____

Home Phone #: _____ - _____ - _____ **Work Phone #:** _____ - _____ - _____

Primary Insurance Information

Carrier/Plan: _____ **Phone #:** _____ - _____ - _____

Address: _____

City, State, Zip Code: _____

Policy #: _____ Group #: _____

Name of Insured: _____ Insured's DOB: ____/____/____

Insured's Mailing Address: _____

City, State, Zip Code: _____

Insured's SSN: ____-____-____ Patients' Relationship to Insured: _____

Insured's Employment Status: _____ Insured's Employer: _____

Employer Address: _____ Work Phone #: ____-____-____

City, State, Zip Code: _____

Secondary Insurance Information

Carrier/Plan: _____ Phone #: ____-____-____

Address: _____

City, State, Zip Code: _____

Policy #: _____ Group #: _____

Name of Insured: _____ Insured's DOB: ____/____/____

Insured's Mailing Address: _____

City, State, Zip Code: _____

Insured's SSN: ____-____-____ Patients' Relationship to Insured: _____

Insured's Employment Status: _____ Insured's Employer: _____

Employer Address: _____ Work Phone #: ____-____-____

City, State, Zip Code: _____

INSURANCE AUTHORIZATION

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIM(S). I AUTHORIZE AND DIRECT MY INSURANCE CARRIER OR ITS INTERMEDIARIES TO ISSUE PAYMENT CHECK(S) DIRECTLY TO THE GARRISON CENTER AND/OR TO THE PHYSICIAN(S) WHO RENDERED THE SERVICES.

I UNDERSTAND THAT MY INSURANCE CARRIER MAY REQUIRE AN AUTHORIZATION NUMBER, PRECERTIFICATION AND/OR REFERRAL. WITHOUT THIS DOCUMENTATION, I UNDERSTAND THAT MY INSURANCE CARRIER MAY DENY BENEFITS. IF MY INSURANCE CARRIER DENIES PAYMENT FOR SERVICES RENDERED BY THE GARRISON CENTER AND SURGEONS WHO RENDERED SERVICE(S), I AGREE TO BE RESPONSIBLE FOR PAYMENT. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE SUCH AS, BUT NOT LIMITED TO, DEDUCTABLE AND CO-INSURANCE AMOUNT(S). I FURTHER UNDERSTAND THAT THE GARRISON CENTER CANNOT ACCEPT RESPONSIBILITY FOR COLLECTION OF MY CLAIM(S) OR FOR NEGOTIATING A SETTLEMENT ON A DISPUTED CLAIM.

I AM RESPONSIBLE FOR PAYMENT OF MY ACCOUNT WITH THE LIMITS OF YOUR CREDIT POLICY.

SIGNATURE OF PERSON RESPONSIBLE FOR PAYMENT _____

DATE: ____ / ____ / ____

PAST MEDICAL/SURGICAL HISTORY

Confidential Record: Information herein will be released to your insurance company for authorization for surgery. This form will be submitted to your insurance company with the Letter of Medical Necessity.

Name: _____

Date: ____/____/____

DOB: ____/____/____

Age: ____

Weight: ____

Height: ____

BMI: ____ (Staff will complete BMI)

PREVIOUS SURGERIES/PROCEDURES:

- 1. _____ Date: ____/____/____
- 2. _____ Date: ____/____/____
- 3. _____ Date: ____/____/____
- 4. _____ Date: ____/____/____
- 5. _____ Date: ____/____/____
- 6. _____ Date: ____/____/____

Hospitalizations (List diseases which have required hospitalization)

- 1. _____ Date: ____/____/____
- 2. _____ Date: ____/____/____
- 3. _____ Date: ____/____/____
- 4. _____ Date: ____/____/____
- 5. _____ Date: ____/____/____
- 6. _____ Date: ____/____/____

Illness: (Describe illnesses not requiring hospitalization. Please list any health condition(s) for which you are currently being treated i.e., diabetes, sleep apnea, high blood pressure, etc)

- 1. _____ Date: ____/____/____
- 2. _____ Date: ____/____/____
- 3. _____ Date: ____/____/____
- 4. _____ Date: ____/____/____
- 5. _____ Date: ____/____/____
- 6. _____ Date: ____/____/____

Injuries: (List and give approximate date)

- 1. _____ Date: ____/____/____
- 2. _____ Date: ____/____/____

- 3. _____ Date: ____/____/____
- 4. _____ Date: ____/____/____
- 5. _____ Date: ____/____/____
- 6. _____ Date: ____/____/____

Allergies: (Drugs, Latex, Environmental, other)

- 1. _____ Date: ____/____/____
- 2. _____ Date: ____/____/____
- 3. _____ Date: ____/____/____
- 4. _____ Date: ____/____/____
- 5. _____ Date: ____/____/____
- 6. _____ Date: ____/____/____

Current Medications: (List daily medication as well as those used as needed)

- Medication: _____ Dosage: _____ How Often? _____
- Medication: _____ Dosage: _____ How Often? _____
- Medication: _____ Dosage: _____ How Often? _____
- Medication: _____ Dosage: _____ How Often? _____
- Medication: _____ Dosage: _____ How Often? _____
- Medication: _____ Dosage: _____ How Often? _____

Vitamins, Supplements, & Herbs (Please list current Vitamins & Supplements)

- Type: _____ Amount: _____ How Often? _____
- Type: _____ Amount: _____ How Often? _____
- Type: _____ Amount: _____ How Often? _____
- Type: _____ Amount: _____ How Often? _____
- Type: _____ Amount: _____ How Often? _____
- Type: _____ Amount: _____ How Often? _____

Physicians (Please provide a list of current physicians)

Name	Phone	Fax	Email
Primary Care: _____			

Pulmonologist: _____

Gastroenterologist: _____

Orthopedist: _____

Neurologist: _____

Cardiologist: _____

Psychiatrist: _____

Endocrinologist: _____

Gynecologist: _____

Social History:

Occupation: _____ **Spouses' Occupation** _____

Of Children: _____ **General Health of Children:** _____

List hobbies or volunteer work in which you participate: _____

Personal Habits:

Do You Smoke? Yes No **How Often?** _____ **How Long?** _____ **When did you quit?** _____

Do You Drink? Yes No **How Often?** _____ **How Long?** _____ **When did you quit?** _____

Do You Use Drugs? Yes No **How Often?** _____ **How Long?** _____ **When did you quit?** _____

Have you *EVER* used drugs? Yes No **How Often?** _____ **How Long?** _____ **When did you quit?** _____

FAMILY HISTORY

RELATIONSHIP: **AGE:** **HEALTH:** **IF DECEASED, CAUSE:** **WEIGHT:**

MOTHER	_____	Good	Fair	Poor	_____	Thin	Average	Overweight
FATHER	_____	Good	Fair	Poor	_____	Thin	Average	Overweight
Brother	_____	Good	Fair	Poor	_____	Thin	Average	Overweight
Sister	_____	Good	Fair	Poor	_____	Thin	Average	Overweight
Brother	_____	Good	Fair	Poor	_____	Thin	Average	Overweight
Sister	_____	Good	Fair	Poor	_____	Thin	Average	Overweight
Brother	_____	Good	Fair	Poor	_____	Thin	Average	Overweight
Sister	_____	Good	Fair	Poor	_____	Thin	Average	Overweight
Brother	_____	Good	Fair	Poor	_____	Thin	Average	Overweight
Sister	_____	Good	Fair	Poor	_____	Thin	Average	Overweight

Have you or any blood relative had: (Check & give relationship)

- Stroke
- Blood Pressure
- Diabetes
- Overweight (20-99lbs)
- Obese (over 100lbs)
- Heart Disease
- Cancer
- Tuberculosis
- Bleeding Tendency
- Problems with Anesthesia
- Other (explain) _____

Review of Systems: Neurologic

Have you ever fainted? Yes No Have you ever had a convulsion? Yes No

PLEASE CHECK THE FOLLOWING:

Do You Have?

- Double vision
- Ringing in the ears
- Severe headaches
- Pain on one side of head
- Weakness in arms/legs
- Visuals disturbances
- Do headaches awaken you at night
- What relieves headaches

Review of Systems: Cardiorespiratory

- Have you had shortness of breath? YES NO
- Doing normal work? YES NO

- | | | |
|--|-----|----|
| ○ Does it awaken you at night? | YES | NO |
| ○ Do you have Chronic cough? | YES | NO |
| ○ Do you need more than one pillow to sleep? | YES | NO |
| ○ Do you have sleep apnea? | YES | NO |
| ○ Do you have swollen ankles? | YES | NO |
| ○ Do you have bleeding problems? | YES | NO |

Have you ever had a chest pain or tightness:

- | | | |
|--|-----|----|
| ○ When exerting yourself? | YES | NO |
| ○ After a heavy meal? | YES | NO |
| ○ Does the chest pain: | | |
| ▪ Radiate to the arm, neck or back? | YES | NO |
| ○ Abate when you rest? | YES | NO |
| ○ Climbing flights of stairs? | YES | NO |
| ○ Accompanied by wheezing | YES | NO |
| ○ Do you cough up sputum? | YES | NO |
| ○ Do you have phlebitis or inflamed leg veins | YES | NO |
| ○ Do you have varicose veins? | YES | NO |
| ○ Do you have palpitation or irregular heart rate? | YES | NO |
| ○ When excited or upset? | YES | NO |
| ○ Occur only at rest | YES | NO |
| ○ Do you have any bleeding or clotting problems? | YES | NO |

Review of Systems: Psychiatric:

- | | | |
|--|-----|----|
| ○ Do You have a history of psychiatric illness | YES | NO |
| ○ Anxiety | YES | NO |
| ○ Suicide Attempts | YES | NO |
| ○ Bi Polar or Manic depression | YES | NO |
| ○ Depression | YES | NO |
| ○ Obsessive-Compulsive disorder | YES | NO |
| ○ Hospitalizations | YES | NO |

Review of Systems: Gastrointestinal

- | | | |
|--|-----|----|
| ○ Do you have reflux or GERD | YES | NO |
| ○ Have you had pain in the stomach which: | | |
| ○ Occurs 1 or 2 hours after meals? | YES | NO |
| ○ Is brought on by eating fried or greasy foods? | YES | NO |
| ○ Awakens you at night | YES | NO |
| ○ Is relieved by antacid medications | YES | NO |
| ○ Is relieved by bowel movements | YES | NO |
| ○ Black Stools | YES | NO |
| ○ Is relieved by eating | YES | NO |
| ○ Occurs while eating or immediately after? | YES | NO |

Pain in big toe?	YES	NO
Back problems?	YES	NO
Cramps in legs?	YES	NO
Joint Pain or arthritis?	YES	NO
Difficulty ambulating/walking?	YES	NO

Describe difficulties:

STATEMENT OF LIMITATIONS: Describe the limitations (emotional, physical, employment) which morbid obesity imposes on you. **This section is required to complete the application-we will not process your chart without this page being filled out. Use separate piece of paper if necessary.**

Years you have been morbidly obese:

	Normal	Obese	Over 100 lbs (morbidly obese)
Childhood (1-10Yr.)	_____	_____	_____
Adolescence (11-18Yr.)	_____	_____	_____
Young Adult (18-30Yr.)	_____	_____	_____
Adult (30-60Yr.)	_____	_____	_____
Weight for the last 3 years: 2004	_____	2005 _____	2006 _____

Women weight retained after each pregnancy: lbs./Year _____/_____ lbs./Year _____/_____ lbs. /Year _____/_____

Medically supervised weight loss programs

Doctors who have treated you for obesity:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Recommended Programs (circle all that apply):

Optifast Medifast Xenical Phen-Fen Meridia Pondimin Diabetes Education

Previous Weight Loss Surgery

Weight Lost	Weight Regained	Length of Program	Estimated. Cost
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

Other Programs that you have attended for 6 months or more:

Program:	Year	Weight Lost	Weight Regained	# of Months	Length of Program	Estimated Cost

Weight Watchers						
Overeaters Anonymous						
Diet Centers						
Nutrisystem						
Jenny Craig						
Medications (non- prescription)						
Susan Powder						
Richard Simmons						
Slim Fast						
HMR						
Non-medically supervised (I.e., Atkins)						
South Beach Diet						
OTHER						

PHYSICAL EXERCISE

Program	Time Spent	Weight Lost	Weight Regained	Length of Program	Estimated Cost
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Bicycle					
Jogging					
Walking					
Swimming					
Spa Membership					
Aerobics					
VHS tapes/DVD					
Home gym equipment					
Personal Trainer					
Other					

PROTECTED HEALTH INFORMATION

I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (THE NOTICE). THIS NOTICE PROVIDES A COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY PERSONAL PROTECTED HEALTH INFORMATION (PHI). I HAVE HAD AN OPPORTUNITY TO REVIEW THIS INFORMATION BEFORE SIGNING THE FORM. I GRANT MY CONSENT TO THE GARRISON CENTER AND /OR ANY PHYSICIAN(S) PARTICIPATING IN MY CARE, RELEASING MY PHI (EITHER IN WRITING OR VERBALLY) TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. THIS INCLUDES ANY MEDICAL INFORMATION (INCLUDING DRUG AND ALCOHOL ABUSE TREATMENT INFORMATION, PSYCHIATRIC TREATMENT INFORMATION AND HIV-RELATED INFORMATION, AS WELL AS HIV TEST, IF APPLICABLE), WHICH MAY BE NEEDED TO PROCESS CLAIMS FOR MEDICAL INSURANCE OR MANAGED CARE BENEFITS RELATIVE TO THIS HOSPITALIZATION (INCLUDING PRECERTIFICATION AND VERIFICATION, IF NECESSARY) OR THAT WHICH MAY BE NEEDED TO CONDUCT CONTINUED CARE PLANNING.

SIGNATURE _____

DATE _____