

**SURGICAL WEIGHT MANAGEMENT
ASSOCIATES,LLC**

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GENERAL HEALTH QUESTIONNAIRE

Please complete the following and mail to the address above with a copy of your insurance card (back and front) to the attention of Brandi Dupre and our office will contact you when it is received.

PATIENT NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

HOME PHONE # _____ WORK _____ CELL _____

DATE OF BIRTH _____ SOCIAL SECURITY _____

GENDER (M, F) _____ MARITAL STATUS _____

EMAIL ADDRESS _____

IN CASE OF EMERGENCY CALL (NOT LIVING WITH YOU)

NAME _____ PHONE _____

ADDRESS _____

RELATIONSHIP _____

NEAREST RELATIVE (NOT LIVING WITH YOU)

NAME _____ PHONE _____

ADDRESS _____

RELATIONSHIP _____

PATIENT'S EMPLOYMENT

EMPLOYED BY _____

TYPE WORK _____

WORK PHONE _____

INSURANCE INFORMATION

INSURANCE COMPANY _____

PHONE _____

NAME OF INSURED _____ RELATIONSHIP _____

INSURED SSN# _____ GROUP # _____

INSURED ID OR MEMBER # _____

BILLING INFORMATION

PERSON RESPONSIBLE FOR THIS ACCOUNT RELATIONSHIP

ADDRESS PHONE

EMPLOYED BY WORK PHONE

WHO REFERRED YOU TO US? _____



GENERAL HEALTH INFORMATION

FAMILY DOCTOR _____

ADDRESS _____

PHONE _____ FAX _____

DO YOU HAVE A REFERRAL / LETTER OF MEDICAL NECESSITY FROM FAMILY DOCTOR? YES OR NO

DIET INFORMATION

HEIGHT _____ WEIGHT _____ BMI _____

(FOR OFFICE USE ONLY)

LIST ANY PHYSICIAN THAT TREATED YOU FOR DIET

NAME _____ WHEN _____

NAME _____ WHEN _____

NAME _____ WHEN _____

Which methods did you try and how much did you lose on each plan?

__Phen Fen _____ lbs __Redux _____ lbs __Meridia _____ lbs

__Xenical _____ lbs __Pondamin _____ lbs __Nutri-system _____ lbs

__Weight Watchers _____ lbs __Jenny Craig _____ lbs __TOPS _____ lbs

__Slimfast _____ lbs __Metabolife _____ lbs __ Other _____ lbs

List other programs tried

MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

- | | | |
|--------------------------------------------------|----------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Diabetes 250.01 | <input type="checkbox"/> High Blood Pressure 401.9 | <input type="checkbox"/> Varicose Veins 454.8 |
| <input type="checkbox"/> Acid Reflux 530.81 | <input type="checkbox"/> Arthritis 716.98 | <input type="checkbox"/> Sleep Apnea 780.57 |
| <input type="checkbox"/> Poor Sleep 780.50 | <input type="checkbox"/> Urine Incontinence 788.30 | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Stomach Problems 789.00 | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Pancreas Problems |
| <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Depression 311 | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> High Cholesterol 272.0 | <input type="checkbox"/> Urinary Problems 788.30 | <input type="checkbox"/> Gallbladder Problems |
| <input type="checkbox"/> Asthma 493.90 | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Mental/Neurological | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Circulation 454.8 | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other (list) |

Describe all medical problems:

MEDICATIONS (list all medications and doses for each medical condition, non prescription and prescription)

Medication	Dose	Medical condition taken for?
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
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(Please use additional page if necessary)

LIST ALL ALLERGIES TO MEDICATION AND THE REACTION IT CAUSES:

SURGICAL HISTORY

(Check all that apply)

- Gallbladder Stomach Liver Pancreas Colon
 Appendix Uterus Ovaries C-Section Tubes Tied
 Spleen Lung Trauma Laparoscopy Esophagus
 Heart Bypass Orthopedics Hernia Previous Bariatric Surgery Other

Describe all surgeries and approximate dates:

FAMILY HISTORY

Condition	Father	Mother	Father's Parent	Mother's Parent	Sibling	Child
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Bleeding Disorder	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____	_____	_____
Blood Disorder	_____	_____	_____	_____	_____	_____
Morbid Obesity	_____	_____	_____	_____	_____	_____

Others:

Menstrual History

Date of last menstrual period? _____ Could you be pregnant? _____
Date of last pregnancy? _____ Number of pregnancies? _____

Social History

Occupation _____ Position _____

Marital Status _____ Highest Grade Completed _____

Do you drink alcohol? _____ if yes, how much? _____

Do you smoke? _____ if yes, how much? _____

SYMPTOMS REVIEW

GENERAL ___ Fever ___ Weight loss ___ Weakness ___ Fatigue
 ___ Sweats ___ Appetite Loss ___ Chills

NEUROLOGICAL ___ Headache ___ Weakness ___ Numbness ___ Seizures
 ___ Tremors ___ Memory Changes ___ Fainting ___ Dizziness
 ___ Unsteady ___ Speech Problems ___ Nervousness
 ___ Gait ___ Disorientation ___ Behavioral Changes

PSYCHIATRIC ___ Anxiety ___ Depression ___ Mood Swings
 ___ Hallucinations ___ Difficulty Sleeping ___ Alcohol Abuse

EYES ___ Blurred Vision ___ Double Vision ___ Blindness ___ Eye Pain
 ___ Retina Problems ___ Cataracts ___ Glaucoma ___ Discharge

EARS ___ Ringing ___ Pain ___ Frequent Discharge ___ Drainage Color

NOSE ___ Bleeding ___ Sinus Problems ___ Pain ___ Frequent Infections

THROAT ___ Pain ___ Hoarseness ___ Ulcers ___ Difficulty Swallowing
 ___ Tooth Pain ___ Frequent Infections ___ Bleeding Gums

ENDOCRINE ___ Thyroid Problems ___ Heat or Cold Intolerance
 ___ Frequent Urination ___ Constant Thirst

LUNGS ___ Cough ___ Wheezing ___ Shortness of Breath ___ Congestion
 ___ Coughing up Blood ___ Sputum/color

CONTINUED ON NEXT PAGE

CONT. SYMPTOMS REVIEW

HEART

- Chest Pain Blood Pressure Palpitations Heart Murmur
- Shortness of breath Shortness while lying flat Ankle Swelling
- Blood Clots

GASTROINTESTINAL

- Abdominal Pain Nausea Vomiting Diarrhea Heartburn
- Constipation Blood in stool Difficulty Swallowing Rectal pain
- Loss of Appetite Changes in bowel pattern Rectal Bleeding
- Hemorrhoids Excessive thirst

URINARY

- Frequency Urgency Discharge Pain with urination
- Menstrual Problems Blood in urine Urination at night
- Prostrate Problems

MUSCULOSKELETAL

- Joint pain Joint Swelling Muscle Pain
- Decreased range of motion

SKIN

- Rashes Burning Itching Swelling Moles
- Bruise Easily Change in Hair/Nails

Please keep in mind that you will need a medical clearance from your primary healthcare physician prior to having surgery. Please have your doctor write a letter of medical necessity stating how long you've been treated, the duration of obesity, and that you are medically cleared for surgery.

Note: Please sign and date. This questionnaire will become a part of your medical chart.

Patient's Signature

Date