SURGICAL WEIGHT MANAGEMENT ASSOCIATES

Restoring Health…Renewing Lives

Eric Rau MD ▪ Fritz Rau MD ▪ David Rau MD ▪ Donald Schwab Jr MD

5619 Hwy 311 Ste B Houma, LA 70360 Phone 985-868-2206 Fax 985-868-2232

www.surgicalweightmanagement.com

PATIENT INFORMATION

Patient Name____ Today's Date __________________

Birth Date ______/______/________ Age __________Social Security #______________________________

Gender ☐ Male ☐ Female Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Race ☐ Caucasian ☐ Asian ☐ African American ☐ Hispanic ☐ Native American ☐ Hawaiian ☐ Other

Primary Language: ____

Street Address, City, State, Zip ____

Mailing Address (if different)____

Home Phone (______)________________Cell (______)_________________ Work (______)_________________

Email Address____

Employer ____

Occupation ________________________________ Status(Full/PartTime,Retired,etc)______________________

Emergency Contact Name (not living with you)____

Relationship ______________________________________ Phone # ________________________________

INSURANCE AND BILLING INFORMATION

Person Responsible for bill: ____

Birth Date______/______/________ Social Security # ____

PRIMARY INSURANCE	SECONDARY INSURANCE
Name	Name
Phone #	Phone #
Policy/Member#	Policy/Member#
Group#	Group#
Subscriber Name	Subscriber Name
Relation to Pt & DOB	Relation to Pt & DOB
Subscriber SSN	Subscriber SSN
Subscriber Employer	Subscriber Employer

______________________________ **Patient Name**

WEIGHT HISTORY

Height ___________________ Weight ___________________ BMI ___________________

Which surgery are you interested in? ☐ **LAP-BAND** ☐ **Gastric Sleeve** ☐ **Gastric Bypass**

☐ **Undecided** ☐ **Revision to a previous Bariatric Surgery**

Have you had prior surgery for weight loss? ☐ Yes ☐ No Type ______________________Date_____________

How long have you been overweight? ____

Have you been referred to us? ☐ Yes ☐ No If yes, by whom?___________________________________

How did you hear about us? ☐ Physician ☐ Friend / Family ☐ Television ☐ Radio ☐ Internet

☐ Magazine ☐ Billboard ☐ Other

Primary Care Physician or Internist: ____

List all physicians who have treated you for weight management:

Name ____ Phone # _________________________

Years Treated __________________ ☐ Prescribed Diet ☐ Prescribed Medication ______________________

Name ____ Phone # _________________________

Years Treated __________________ ☐ Prescribed Diet ☐ Prescribed Medication ______________________

Check any diet programs you have attempted. Note dates of each and how much weight was lost.

______ PhenFen	______ Yrs	______lbs lost	_______Redux	_______Yrs	_______lbs lost
_______Pondamin	______ Yrs	______lbs lost	_______Meridia	_______Yrs	_______lbs lost
_______TOPS	_______Yrs	______lbs lost	_______Xenical	_______Yrs	_______lbs lost
_______Nutri-system	_______Yrs	______lbs lost	___Weight Watchers	_______Yrs	_______lbs lost
_______Jenny Craig	_______Yrs	______lbs lost	_______Slimfast	_______Yrs	_______lbs lost
_______Metabolife	_______Yrs	______lbs lost	_______South Beach	_______Yrs	_______lbs lost
_______Atkins	_______Yrs	______lbs lost			

List any other diet or exercise programs, dates, and weight lost.

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____

____

______________________________Patient Name

MEDICAL AND SURGICAL HISTORY

CURRENT MEDICATIONS,VITAMINS ,& MINERALS Please list all prescribed and over-the-counter medications

Medication/Dose	Times per Day	Purpose

☐ Multiple Vitamin ☐ Calcium ☐ Vitamin B-12 ☐ Iron ☐ Vitamin D ☐ Vitamin A,D,E ☐ Calcium&VitaminD

ALLERGIES Please list all allergies including any known medication allergies and reactions

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____

SURGICAL HISTORY Please mark all surgeries you have had and note year surgery was performed

☐ Appendectomy
☐ Gallbladder Removal
☐ Bowel resection
☐ Hysterectomy
☐ Tubal Ligation
☐ Cesarean section
☐ CABG
☐ Knee Replacement
☐ Hip Replacement
☐ Breast Cancer, radiation
☐ Breast Cancer, biopsy
☐ Breast cancer, mastectomy
☐ Vasectomy
☐ Anti-reflux procedure
☐ Laminectomy
☐ Discectomy
☐ Peripheral Vascular procedure

List any additional surgeries and approximate dates: ____

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FAMILY HISTORY Please check below if you have a family history of:

☐ Obesity ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke ☐ Cancer

☐ Bleeding Disorder ☐ Early Death (Cause of Death__________________________)

SOCIAL HISTORY

Alcohol Use ☐ None ☐ Rare ☐ Occasional ☐ Frequent

Substance Abuse ☐ None ☐ Rare ☐ Occasional ☐ Frequent

Tobacco Use ☐ None ☐ Rare ☐ Occasional ☐ Frequent How much per day? ______________

☐ Past Tobacco User, # Years _______________, When/Year Quit __________________

______________________________**Patient Name**

MEDICAL HISTORY Please mark any of the following conditions you have. A nurse will review this information with you during your initial visit.

- ☐ Hypertension (High Blood Pressure) ☐ One Medication ☐ Multiple Medications
- ☐ Congestive Heart Failure ☐ Class 1 ☐ Class 2 ☐ Class 3 ☐ Class 4 ☐ Class 5
- ☐ Heart Attack ☐ Heart Stent(s) or CABG
- ☐ Angina (Chest Pain) ____
- ☐ Peripheral Vascular Disease ____
- ☐ Lower Extremity Edema (Swelling) ☐ Intermittent ☐ Requires treatment ☐ Stasis ulcers ☐ Disability
- ☐ DVT/PE (Blood Clots)
- ☐ Diabetes (Elevated Blood Sugars)
  - ☐ No treatment (diet) ☐ Treated with one pill ☐ Treated with more than one pill ☐ Treated with insulin
- ☐ Lipids (High Cholesterol) ☐ No treatment (diet) ☐ Treated with one pill ☐ Treated with more than one pill
- ☐ Gout
- ☐ Sleep Apnea ☐ no treatment ☐ CPAP machine
- ☐ Severe Obesity-Related Lung Disease
- ☐ Pulmonary Hypertension
- ☐ Asthma ☐ No treatment ☐ Meds without steroid ☐ Steroid ☐ Hospitalized within last 2 years
- ☐ GERD (Reflux) Treatment? ____
- ☐ Gallstones
- ☐ Liver Disease ____
- ☐ Back Pain ____
- ☐ Joint Pain ____
- ☐ Fibromyalgia ☐ treated with non-narcotic medications ☐ treated with narcotics
- ☐ Polycystic Ovarian Syndrome ☐ no medications ☐ medications
- ☐ Problems with Menstrual Cycle ☐ irregular periods ☐ heavy periods ☐ absence of periods
- ☐ Confirmed Mental Health Diagnosis Type____
  - Physician__________________________ Treatment _______________________________________
- ☐ Depression Treatment?____
- ☐ Urinary Incontinence
- ☐ Pseudotumor Cerebri
- ☐ Abdominal Hernia
- ☐ Functional Impairment ☐ Uses walker, cane, or crutch ☐ Uses wheelchair
- ☐ Other ____

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_______________________________________Patient Name

SLEEP HISTORY

	Frequently	Sometimes	Never
Do you wake up gasping for breath?			
Do you awaken with headaches?			
Do you fall asleep while reading?			
Do you have heartburn or "reflux" while sleeping?			
Do you have difficulty falling asleep or staying asleep?			
Do you wake up with a dry mouth, sore throat, or headache in the morning?			

	Yes	No
Do you use a CPAP or BiPAP?		
Have you ever been to a sleep lab for treatment or evaluation?		

MENSTRUAL HISTORY

Date of last menstrual period _______________ Could you be pregnant? _________________

Date of last pregnancy ____________________ Number of pregnancies ________________

REVIEW OF SYSTEMS

Please circle any of the following symptoms or conditions you are currently experiencing or those with which you have had significant problems in the past.

■ **GENERAL** Weakness Fatigue Fever Chills Sweats Weight Gain Weight loss Anemia

■ **NEUROLOGICAL** Headache Dizziness Weakness Numbness Seizures Tremors Memory Changes Fainting Unsteady gait Speech Problems Nervousness Disorientation Behavioral Changes

■ **PSYCHIATRIC** Anxiety Depression Mood Swings Hallucinations Difficulty Sleeping Alcohol Abuse

■ **EYES** Blurred Vision Double Vision Blindness Pain Retina Problems Cataracts Glaucoma

■ **EARS** Ringing Pain Frequent Discharge Drainage

■ **NOSE** Bleeding Sinus Problems Pain Frequent Infections

■ **THROAT** Pain Hoarseness Ulcers Difficulty Swallowing Tooth Pain Frequent Infections Bleeding Gums

■ **ENDOCRINE** Hypothyroidism Hyperthyroidism Heat or Cold Intolerance Frequent Urination Constant Thirst Hypoglycemia Cirrhosis Portal Hypertension

■ **LUNGS** Chronic Cough Wheezing Shortness of Breath Congestion Coughing up Blood Sputum

____Patient Name

■ **CARDIOVASCULAR** Chest Pain Chest Tightness High Blood Pressure High Triglycerides Palpitations

Mitral Valve Prolapse Heart Murmur Heart Attack Blood Clots Shortness of breath

Shortness of breath while lying flat Ankle Swelling Lower extremity edema Venous Stasis (Leg) Ulcers

■ **GASTROINTESTINAL** Abdominal Pain Nausea Vomiting Diarrhea Heartburn Constipation Ulcers

Blood in stool Difficulty Swallowing Rectal pain Loss of Appetite Gallstones H. Pylori

Changes in bowel pattern Rectal Bleeding Hemorrhoids Excessive thirst Colitis

■ **URINARY** Frequency Urgency Discharge Pain with urination Menstrual Problems Blood in urine

Prostrate Problems Frequent urinary tract infections Chronic Renal Disease

■ **MUSCULOSKELETAL** Back pain Joint pain Joint Swelling Muscle Pain Decreased range of motion Plantar Fasciitis

■ **SKIN** Rashes Burning Itching Swelling Moles Bruise Easily Change in Hair/Nails

Please list any specific questions or concerns that you may have, so that your surgeon can address them at your consultation:

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The above information is true and accurate to the best of my knowledge. (This questionnaire will become a part of your medical chart and will be reviewed by a medical professional during your initial appointment.)

Patient Signature____ Date___________________

Note:
(1) Medical clearance from your primary care physician or cardiologist is required prior to surgery.
(2) A letter of medical necessity from your primary care physician or cardiologist is also required by your insurance company before surgery can be approved. This letter must include how long you have been treated by your physician and how long you have been obese, list any obesity-related co-morbidities, and state that bariatric surgery is medically necessary for the patient.

**Please fax completed form to 985-868-2232 or bring it to our office.

**If you have not received a phone call from our office within three days of submitting this form, please call us at 985-868-2206. Our goal is to assist you timely. Thank you again for choosing our practice.