



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

WEIGHT HISTORY

Height _____ Weight _____ BMI _____

Which surgery/procedure are you interested in? LAP-BAND Gastric Sleeve Gastric Bypass
 ORBERA BALLOON 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: _____

_____ Patient Name

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

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

- | | | |
|---|--|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Gallbladder Removal | <input type="checkbox"/> Bowel resection |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Tubal Ligation | <input type="checkbox"/> Cesarean section |
| <input type="checkbox"/> CABG | <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Hip Replacement |
| <input type="checkbox"/> Breast Cancer, radiation | <input type="checkbox"/> Breast Cancer, biopsy | <input type="checkbox"/> Breast cancer, mastectomy |
| <input type="checkbox"/> Vasectomy | <input type="checkbox"/> Anti-reflux procedure | <input type="checkbox"/> Laminectomy |
| <input type="checkbox"/> Discectomy | <input type="checkbox"/> Peripheral Vascular procedure | <input type="checkbox"/> Past Gastric Surgery |

List any additional surgeries and approximate dates: _____

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 _____

_____ **Patient Name**

	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?			

SLEEP HISTORY

	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 _____
 Breast Feeding _____

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

_____ **Patient Name**

■ **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

Hepatic Insufficiency Severe Liver Damage

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

■ **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

Coagulopathy

■ **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 Hiatal Hernia

Diverticulosis Stricture Stenosis IBS Gastric Motility GI Bleed Achalasia Inflammatory Disease

GI Track Disorder

■ **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:

_____ Patient

Name

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.**
