Alvarado Surgical Weight-Loss Program

ALVARADO HOSPITAL

Advanced medicine. Personalized care.

6655 Alvarado Rd **Phone: (619) 229-3340** **Requested Procedure:________________**
San Diego, CA 92120 **Fax: (619) 229-3341** **Requested Surgeon:________________**
Email: sdbari@alvaradohospital.com

Last Name, First, Middle	Date of Birth	Gender	Marital Status M D S W
Street Address	Home Phone		Cell Phone
City State Zip code	Social Security Number		FAX Number
Employer's Name	Your E-mail Address		
Employer's Street Address	Work Phone		Drivers License No./State
City State Zip code	Occupation		Race/Ethnicity
Emergency Contact: Relationship	Cell Phone		Religious Preference
Street Address, City, State, ZIP	Home Phone		Work Phone

Insurance Information:

Primary Insurance	Secondary Insurance
Address	Address
Customer Service Phone Number	Customer Service Phone Number
Policy or ID number	Policy or ID number
Subscriber's Name & Relationship to Patient	Subscriber's Name & Relationship to Patient
Subscriber's Birth Date	Subscriber's Birth Date
Subscriber's Employer, Address, Telephone Number	Subscriber's Employer, Address, Telephone Number

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REFERRAL SOURCE

How did you hear about us? Friend/Former Patient ____________ TV ad Newspaper ad Internet Magazine

website: www.____________________ Physician's Name: ___________________________

Date Attended Seminar_________________________________

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.**

Signature: ____Date: ______________________

For Office Use Only:
Date of Physical: ________________ Date of Surgery: _______________ Auth #:_____________________

PATIENT HISTORY QUESTIONNAIRE

The information requested below is very important. To give you the best care and to obtain your insurance approval, we require complete answers. Please be thorough.

<table>
<tr><td colspan="2">Name:</td><td>Date:</td><td>Age:</td></tr>
<tr><td colspan="4">Occupation: (If retired or disabled, what did you do or what is your disability?)</td></tr>
<tr><td>Weight</td><td>Height</td><td>BMI</td><td>Body Frame (circle one)
Small Medium Large</td></tr>
</table>

WEIGHT HISTORY

What is your highest weight in the last 5 years? ________ Lowest weight in the last 5 years? _________

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

____

____

____

____

____

DIETARY HISTORY

Approximate age you first seriously dieted ____ Using the list below, mark the diets and diet programs you have tried:

Program		**Dates**	**Duration**	**Physician Supervised?**	**Max Loss**
Jenny Craig:	Yes ❑ No ❑				
Nutri-Systems	Yes ❑ No ❑				
Weight Watchers	Yes ❑ No ❑				
OptiFast	Yes ❑ No ❑				

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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 ❑	______________________________
Metabolife	Yes ❑	No ❑	______________________________
Atkins Diet	Yes ❑	No ❑	______________________________
Pritikin Diet	Yes ❑	No ❑	______________________________
Other:			______________________________

List any physician-supervised and documented weight-loss attempts:
____

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: ____

What do you do for exercise?
____

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:______________________		

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WEIGHT-RELATED ILLNESSES

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

1. Heart Disease

Yes ❑ No ❑ If Yes, Year Diagnosed ________

Do you have, or have you had:

- ❑ Angina
- ❑ Myocardial Infarction (MI or "heart attack")
- ❑ Coronary Artery Bypass Graft (CABG)
- ❑ Abnormal EKG
- ❑ Stress Test to Rule Out Cardiac Problems
- ❑ Palpitations
- ❑ Pacemaker model/serial #____________________
- ❑ AICD/Defibulator model/serial # ___________________

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 ❑

Morning headaches Yes ❑ No ❑

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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
CPAP used: Yes ❑ No ❑

9. Heartburn/esophagitis/hiatus hernia? Yes ❑ No ❑

If Yes: Year Diagnosed: ________
Upper GI series? Yes ❑ No ❑
Endoscopy? Yes ❑ No ❑
Medications: ____
Frequency of use:____________

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 ❑

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

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

If Yes: Wear pads frequently? Yes ❑ No ❑

15. Low back strain/Pain/Sciatica? Yes ❑ No ❑

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? Yes ❑ No ❑

If Yes: Seen by chiropractor? Yes ❑ No ❑
Orthopedic surgeon? Yes ❑ No ❑
Seen by family doctor? Yes ❑ No ❑
Medications taken ____

17. Weight-related injuries and trauma: ____

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18. Venous stasis disease? Yes ❑ No ❑

If Yes: Do you have edema? Yes ❑ No ❑ (edema is swelling in the lower legs or feet)

Scaly and thick skin? Yes ❑ No ❑

Leg ulcers? Yes ❑ No ❑

19. Gout? Yes ❑ No ❑

If Yes: Gouty Arthritis? Yes ❑ No ❑

Using medication? ____

20. 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: ________________

Obstetric complications: ____

Do you presently use*:*

Birth control pills Yes ❑ No ❑ List type: ___________________________________

Estrogens Yes ❑ No ❑ List type: ___________________________________

Other Contraceptive method: ____

When was your last mammogram? Date____________ Results___________________________

Male/Female Patients: Please identify which of the following childhood illnesses you have experienced:

❑ Measles ❑ Mumps ❑ Chickenpox ❑ Obesity

❑ Rheumatic fever ❑ Heart murmur ❑ Asthma ❑ Tonsillectomy

Have you had:

❑ Hepatitis ❑ Blood Transfusion ❑ AIDS/HIV Exposure

❑ Colitis ❑ Kidney Disease ❑ Bleeding Abnormality

❑ Thyroid Problems ❑ Cancer, type: __________________

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

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____

____

____

____

Major Surgery/Date

____

____

____

____

____

Allergies:

Allergy to any medications: Yes ❑ No ❑ If yes, please list medication and reaction:

____

____

____

Allergy to surgical tape: Yes ❑ No ❑ Latex: Yes ❑ No ❑ Iodine: Yes ❑ No ❑

Other Allergies:

____

Medications:

Please list all medications you currently use:

Medication	Dose	Frequency

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? _______________

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Do you use alcohol: Yes ❑ No ❑ Frequency: ____

Drug use (recreational): 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:				
Sibling:				
Sibling:				
Sibling:				

Please indicate if there is a family history of:

- ❑ Obesity
- ❑ Diabetes
- ❑ High blood pressure
- ❑ Heart disease
- ❑ High blood cholesterol
- ❑ Lung disease, asthma or emphysema
- ❑ Kidney Disease
- ❑ Bleeding tendency or blood disorder
- ❑ Breast Cancer
- ❑ Colon Cancer

SYSTEM REVIEW

Please circle all symptoms you currently experience, or have experienced in the past. Feel free to add any additional problems or information.

1. HEAD, EYE, EAR, NOSE AND THROAT: stuffy nose – runny nose – hay fever – sinus trouble – earache – headache – blurry vision – double vision – haloes around lights – loss of night vision – buzzing in ears – ringing in ears – discharge from ear – loss of hearing – dizziness – vertigo – loss of balance – sore throat – lump in throat – trouble swallowing – pain with swallowing – hoarseness

2. RESPIRATORY: cough – wheezing – shortness of breath at night – use of two pillows – blood in sputum – out of breath with exertion – wake up at night short of breath – wake up at night coughing or choking – asthma – emphysema – bronchitis

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3. CARDIOVASCULAR: palpitations – pounding heart – skipping heartbeat – pains in chest – pains in neck – pains in arms – squeezing of chest – heart attack – heart murmur – abnormal electrocardiogram – irregular heartbeat – high blood pressure – pain in legs – cold feet – blue toes – blue finger – loss of pulses

4. GASTROINTESTINAL: heartburn – nausea – vomiting – belching fluid in throat – burning in throat – food sticking in chest – pains in stomach – burning in stomach – acid stomach – diarrhea – constipation – pain with bowel movement – blood in stools – hemorrhoids – fissures – cramps – gassiness – irritable colon – colitis

5. GENITOURINARY: pain with urination – trouble starting urine – trouble stopping urine – small urine stream – blood in urine – kidney stones – bladder stones – kidney failure – nephritis – urinary tract infections – frequent urination – getting up at night to urinate – leakage of urine with cough or sneeze – decreased sex drive

Men: discharge from penis – loss of erection – painful erection

Women: vaginal discharge – vaginal bleeding – pain with intercourse – irregular periods – lack of orgasm

6. ENDOCRINE (GLANDULAR): low thyroid – hyperthyroid – goiter – Grave's disease – thyroid nodules – X-ray to thyroid – diabetes – adrenal gland tumor – frequent flushing – frequent heavy sweating

7. MUSCULOSKELETAL: pain in joints – swelling of joints – redness of skin over joints – warm joints – fluid in joints – arthritis – broken bones – sprains – low back pain – hip pain – knee pain – ankle pain – foot pain – flat feet – slipped disk – herniated disk – sciatica

8. NEUROLOGICAL: dizziness – vertigo – falling to the side – falling at night – numbness – tingling – pins and needles feelings – weakness of any muscles – twitching of muscles – weakness of grip – shakiness – tremors – fainting – convulsions – fits – loss of consciousness

9. PSYCHOLOGICAL: nervousness – anxiety – depression – thoughts of suicide – suicide attempts – hospitalization for emotional problems – psychiatric treatment – psychological counseling

OTHER: ____

PERSONAL PHYSICIANS

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

	Name	Address/Location	Telephone
Primary Care Physician			
Internist			
Gynecologist			

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Orthopedist ____
____

Psychiatrist ____
____

Psychologist ____
____

Therapist ____
____

Nephrologist ____
____

Other (Specify) ____
____

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PATIENT CONSENT

____	__________________
Patient Name	Date of Birth
____	______________________________
Address	Social Security Number
____	__________________________
City, State, ZIP code	Phone Number

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:

Alvarado Hospital Fax: 619-229-3341 / Phone: 619-229-3340

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

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REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

____ ______________________
Name of Patient/Guardian (please print) Date

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 voicemail ( ) ____________________________

____ Leave call back messages only ( ) ____________________________

____ Send detailed messages via e-mail _________________________________
E-mail address (please print legibly)

____ Please check if your e-mail is confidential and should NOT be used

____ ______________________
Signature Date

This authorization expires in (please check one):

❒ One year from the above date

❒ Two years from the above date

❒ No expiration

CONTACT INFORMATION:
Alvarado Hospital Surgical Weight-Loss Program
6655 Alvarado Road
San Diego, CA 92120
619-229-3340
800-258-2723

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