LONGSTREET CLINIC
Center for Weight Management

DATE: _____

Patient Screening For Balloon Insertion

DEMOGRAPHICS

_____ _____
NAME **EMAIL**

_____ _____
Address **Phone**

_____ _____ _____
Date of Birth **Marital Status** **Highest level of Education Completed**

_____ _____
EMERGENCY CONTACT **PHONE**

WEIGHT HISTORY

_____ _____ _____
CURRENT WEIGHT **HEIGHT** **WHAT IS YOUR GOAL WEIGHT?**

HOW MUCH WEIGHT DO YOU EXPECT TO LOSE WITH THIS PROGRAM? _____

MEDICAL HISTORY

Primary Care Physician _____ Referring Physician _____

MEDICATIONS

Name	Dosage	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES _____

PAST MEDICAL HISTORY (Please check all that apply)

_____ Heart Disease
_____ High Blood Pressure
_____ Diabetes/Pre-diabetes
_____ Renal/Kidney Disease
_____ Cancer
_____ Kidney Stones
_____ High Cholesterol/Triglycerides
_____ Sleep Apnea/Sleep Disorders
_____ Blood Clot/DVT
_____ Osteoarthritis
_____ Issues with Infertility
_____ Depression/Anxiety
_____ Other (please explain) _____

PAST SURGICAL HISTORY

_____

_____

Do you drink alcohol? YES NO Monthly Weekly More than once weekly Daily More than 1 drink per day

Do you smoke? YES NO Have you ever been a smoker? YES NO Packs per Day _____ **Year Quit** _____

How often do you exercise? Never Rarely Occasionally Frequently

Any prior Gastrointestinal Surgeries/Procedures **YES NO** explain_____

Any functional disorders that may inhibit swallowing or food passing through your GI tract? **YES NO**

Any diagnosis involving the GI tract**? Esophageal Stricture Heartburn/Reflux Hiatal Hernia**

Gastroparesis Stomach Ulcer Esophageal or Stomach Cancer Gastritis

Other? _____

Do you take medications that may irritate the GI system? **Aspirin Ibuprofen Naproxen**

NSAIDS Steroids Other:_____

Do you have allergies to products/Food containing Pork? **YES NO**

Have you ever been diagnosed with bulimia, binge eating disorder, compulsive overeating or other psychological eating disorders? **YES NO**

Are you pregnant or do you intend to become pregnant in the next 6 months? **YES NO**

Do you have a known history of**: Duodenal ulcer Diverticulitis Intestinal varacies**

Intestinal stricture/stenosis Small Bowel Obstruction Irritable Bowel Disease

Chron's Disease Intestinal/Colon Cancer Other:_____

Do you have a history of Alcoholism or drug addiction? **YES NO**