LONGSTREETCLINIC
Your Health. Our Specialty.
Center for Weight Management

We are delighted you have chosen the Longstreet Clinic Center for Weight Management your weight loss surgery. Our skilled and experienced surgeons, combined with our dedicated Bariatric Team, have designed a comprehensive program with proven success.

Enclosed in this packet are the materials you need to get started with the screening process for our program. This information is vital to maximize your opportunity for success.

Please complete the medical history form, answering all of the questions fully and honestly. We also recommend that you keep a photocopy of the completed form for your personal records. You may return this form via postal delivery, fax or simply stop by our office to drop it off.

Patient Information Form Directions

1. Please print with blue or black ink.
2. Make sure to fill out your demographic and insurance information.
3. Be sure to bring your Insurance card and driver's license/identification card with you to your appointment.
4. Complete every page of the application.
5. Every item on the application should be answered with a "yes", "no", or "n/a" for not applicable, do not leave anything blank.
6. Explain all "yes" answers.
7. Provide your primary care physician's first & last name, address, phone number and fax number.

Please allow sufficient time for postal delivery and initial processing of the patient information form once it has been received by our staff.

If you have any questions regarding how to complete your form, please contact our office at 770-534-0110 or our Bariatric Coordinator at 678-207-4016.

We know you are looking forward to your new life and we are proud to be part of this endeavor.

Thank you,

Robert L. Richard, MD, FACS
Miguel del Mazo, MD, MS, FACS

Name:_____

Bariatric Program Patient Information

PATIENT DEMOGRAPHIC

Patient's Name _____ Date of Birth _____

Personal Phone _____ Work Phone_____ Best way to reach you? _____

Email _____ Emergency Contact Name/# _____

Employer's Name _____ Occupation_____

Who referred you to our program? _____

MEDICAL HISTORY

Age_____ Height_____ Current Weight_____ BMI_____

Smoking History:

____ Current Smoker Packs per day ____ _____ Former Smoker Year Quit _____

____ Never Smoked _____ Smokeless Tobacco Products

Do you drink alcohol? **Yes** **No** How often _____ Type _____

Do you exercise? **Yes** **No** How often _____ Type _____

Have you had any prior weight loss surgery of any type? (If yes, please give the type of procedure, date of surgery, name, address and phone number of the surgeon and the facility where the surgery was performed.)

_____

_____

Have you ever taken Phen/Fen or Redux? _____

TREATING PHYSICIANS (*Please list all doctors you are currently seeing.)*

Name Address/Phone Number Reason

_____

_____

_____

_____

Name:_____

MEDICATIONS *(List all current **prescription, vitamins & over-the-counter** medications you use.)*

Medication Name	Amount/Dosage	How Often?	Reason/Prescribing M.D.

ALLERGIES *(Please list any allergies you have, including **foods**, **medications**, **metals** or **other substances**.)*

Type of Allergy	Reaction

SURGICAL HISTORY *Please list any previous surgeries you have had.*

Surgery	Reason	Dates	Complications

FAMILY HISTORY.

Medical/Psychiatric Conditions should include any suicide attempts, mental illnesses, and any alcohol drug or other types abuse.

	Age	Ht	Wt	***Medical/Psychiatric Condition***	***Family Member is Deceased?***
Mother	____	____	____	_____	____
Father	____	____	____	_____	____
Siblings	____	____	____	_____	____
	____	____	____	_____	____
	____	____	____	_____	____

Epworth Sleep Scale

0 = would NEVER doze **1 = SLIGHT chance of dozing** **2 = MODERATE chance of dozing** **3 = HIGH chance of dozing**

Sitting and reading _____
Watching TV _____
Sitting, inactive in a public place (theater, meeting, etc.) _____
As a passenger in a car for an hour without a break _____
Lying down to rest in the afternoon when circumstances permit _____
Sitting and talking with someone _____
Sitting quietly after lunch without alcohol _____
In a car, while stopping for a few minutes in traffic _____

TOTAL _____

Name:_____

PERSONAL MEDICAL HISTORY

- *Have you had or do you have any of the following illnesses or symptoms?* ***Please √ all that apply***

Arthritis/**Osteoarthritis** _____
Low Back Pain/Sciatica _____
Weight Bearing Joint Pain_____

Cancer_____ Type _____

Insulin Dependent Diabetes _____ **Type 1** **Type 2**
Non-Insulin Dependent Diabetes_____
Gestational/Pregnancy_____
Neuropathy (Numbness of Hands and/or Feet)_____
Thyroid Disease (Hyper)_____ (Hypo)_____

Belching Acid_____
Heartburn _____
Esophageal Reflux _____
Peptic Ulcer_____
Colitis _____
Gallbladder disease _____
Hiatal Hernia _____
Hepatitis (Type)_____
Bowel problems _____
IBS _____
Constipation _____
Diarrhea _____

Angina (Chest Pain)_____
Cardiac Arrest (Heart Attack)_____
Cardiac Bypass_____
Congestive Heart Failure_____
Heart Disease_____
Heart Murmur_____
High Blood Pressure/HTN_____
High Cholesterol _____
High Triglycerides_____

Kidney/Renal Disease_____ **STAGE** _____
Kidney Stones_____

Alcohol Abuse _____
Anxiety Disorder _____
Depression _____
Illegal Drug Abuse _____
Past Suicide Attempts _____
Previous Mental Health Counseling _____

Infertility_____
Hysterectomy_____
Menstrual Irregularity_____
# of Pregnancies_____
Type of Delivery_____
Is it possible you are currently pregnant?_____

Asthma_____
COPD _____
Emphysema_____
Shortness of Breath_____
TB/Tuberculosis _____
Obesity-Hypoventilation Syndrome _____

Infections/Rashes/Ulcers _____

SLEEP
Coughing/Choking at Night_____
Excessive Snoring_____
Narcolepsy_____
Nighttime Reflux_____
DIAGNOSED Sleep Apnea _____
Have you had a sleep study? _____
Do you use CPAP/BiPAP? _____

UROLOGY
Frequent Urinary Tract Infections_____
Leakage of Urine_____

Abnormal Bleeding_____
Blood Clots/DVT_____
Venous Stasis Disease_____

OTHER MEDICAL INFORMATION *Please list any other medical information not listed above, including illnesses, conditions, surgeries and hospitalizations.*_____

_____

Do you have any person or family history of abnormal bleeding? (If yes, please explain, include details and dates.

_____