Ellner Bariatric

Ellner Bariatric
5555 Reservoir Drive, Suite 203
San Diego, CA 92120

Fax to 619-286-7867
Phone 619-286-7866

Website: Ellnerbariatric.com

Requested Procedure:_____

Last name, First, Middle		Date of Birth / Sex	Marital Status M D S W
Street Address		Home Phone	Cell Phone
City	State Zip code	Social Security #	FAX Number
Employer's Name		Email Address	
Employer's Street Address		Work Phone	Drivers License# & 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
Subscribers Name	Subscribers Name
Relationship to Patient	Relationship to Patient
Subscriber's Employer, Address, Telephone Number	Subscriber's Employer, Address, Telephone Number

How did you hear about us? ☐ Former patient ☐ TV ☐ Newspaper ad ☐Internet ☐ Magazine ☐ Radio

website:www._____ **☐ Friend ☐ 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: _____

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PATIENT HISTORY QUESTIONNAIRE

The information requested in this questionnaire is very important. To give you the best care, and to obtain your insurance approval, we must have complete answers. Please be thorough.

Name:		Date:	Age:
Occupation: (If retired or disabled, what *did* you do or what is your disability?)			
Weight	Height	BMI	Body Frame – Circle One Small Medium Large

WEIGHT HISTORY

What is your highest weight in the last 5 years ?_____ What is your lowest weight in the last 5 years? _____

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

_____

_____

_____

DIETARY HISTORY

Approximate age when you first seriously dieted: _____

List the diets and diet programs you have tried:

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

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List any physician-supervised and documented weight loss attempt: _____

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:_____

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
- ❑ M.I. (myocardial infarction, "heart attack"), stroke, mini-stroke (TIA)
- ❑ CABG (coronary artery bypass graft)
- ❑ Abnormal EKG
- ❑ Stress test to rule out cardiac problems
- ❑ Palpitations, Fast Heartbeat (tachycardia), Slow Heartbeat (bradyarrythmia)

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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 ❑
   ♦Grinding of teeth/jaw Yes❑ No ❑
   ♦ Restless sleep Yes❑ No ❑
   ♦Snoring Yes❑ No ❑
   ♦Awakenings at night Yes❑ No ❑
   ♦Observed apneas Yes❑ No ❑
   ♦Arm/Leg Twitching(PLM's) Yes❑ No ❑
   ♦ExcessiveDaytime Fatigue/sleepiness Yes❑ No ❑

   Office Use: *sleep study ordered*

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:_____

   Office Use: ☐ *UGI/endoscopy ordered*

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10. Belching up acid or sour fluid. Yes❑ No ❑
11. Coughing or choking at night? Yes❑ No ❑

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: _____

_____

18. Venous Stasis Disease? Yes❑ No ❑

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

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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_____

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

Major Surgery	Date

Allergies:

Allergic to any medications?: Yes❑ No ❑ If Yes, please list medication and reaction:

_____

_____

_____

Allergic to: **Surgical tape**: Yes❑ No ❑ **Latex**: Yes❑ No ❑ **Iodine**: Yes❑ No ❑

Other Allergies:

_____

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Medications:

Please list all medications you currently use, including vitamins and supplements

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? _____

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

Drug Use (social): 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:				

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

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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 & 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

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:

_____

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Personal Physicians:

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

	Name	Address/Location	Fax &Telephone
Primary Care Physician	_____		
	_____		
Internist	_____		
	_____		
Gynecologist	_____		
	_____		
Orthopedist	_____		
	_____		
Psychiatrist	_____		
	_____		
Psychologist	_____		
	_____		
Therapist	_____		
	_____		
Nephrologist	_____		
	_____		
Other (Specify)	_____		
	_____		

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_____	_____
Patient Name	Date of Birth
_____	_____
Address	Social Security Number
_____	_____
City, St Zip	Phone #

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:

Ellner Bariatric (fax) 619-286-7867 (Phone) 619-286-7866

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

This fax contains **CONFIDENTIAL INFORMATION** and is only for the individual or entity named in this document. Otherwise, you are hereby notified that disclosure, copying, distribution or other action to the content for this fax is strictly prohibited. If this is received in error, please contact sender immediately.

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REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

Patient Name (please print) Date of Birth

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 voice mail (___) _____

____ Leave call back messages only (___)_____

____ Send detailed messages via e-mail _____
E-mail address

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

_____
Signature Date