

# Ellner Bariatric & Alvarado Surgical Weight Loss Program

Ellner Bariatric  
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 Websites: [Ellnerbariatric.com](http://Ellnerbariatric.com)  
[Stomaphyxsurgeon.com](http://Stomaphyxsurgeon.com)

Program Coordinator: (619) 229-3340  
 Fax Application to: (619) 229-3341  
 Or Mail to: 5555 Reservoir Drive, Suite 204  
 San Diego, CA 92120

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  Reader/Magazine

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: \_\_\_\_\_

For Office Use Only:

Date of Physical: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_ Auth #: \_\_\_\_\_

# Ellner Bariatric & Alvarado Surgical Weight Loss Program

## 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 <i>did</i> 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:*

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### DIETARY HISTORY

Approximate age when you first seriously dieted: \_\_\_\_\_

*List the diets and diet programs you have tried:*

Program	Yes?	No ?	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:

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

**List any other diets and/or weight loss methods you've tried:**

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*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")

? CABG (coronary artery bypass graft)

? Abnormal EKG

? Stress test to rule out cardiac problems

? Palpitations

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 \_\_\_\_\_

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◆ 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 ?

◆ 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 ?

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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: \_\_\_\_\_

#### ***Do you presently use:***

Birth control pills    Yes?    No ?    List type: \_\_\_\_\_

Estrogens    Yes?    No ?    List type: \_\_\_\_\_

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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:

**Medications:**

*Please list all medications you currently use (con't. on next page):*

Medication	Dose	Frequency

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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:				
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	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 #

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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) 619-229-3341**

**619-229-3340 (phone)**

**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

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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

This authorization expires in 1 year \_\_\_\_\_ from the above date  
2 years \_\_\_\_\_  
No expiration \_\_\_\_\_