# Ellner Bariatric

**5555 Reservoir Drive, Suite 203**
**San Diego, CA 92120**

**Phone: (619) 286-7866**
**Fax: (619) 286-7867**

**Websites: Ellnerbariatric.com**
**Stomaphyxsurgeon.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? ÿ Former patient ÿ TV ad ÿNewspaper ad ÿInternet ÿ Reader/Magazine**

**website:www._____ ÿ Friend ÿ 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 #:_____

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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<br>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")

   ? 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 _____

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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 ?

♦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 ?

12. Gallbladder disease? Yes? No ?

Office Use: ? *UGI/endoscopy*

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: _____

Other Contraceptive method: _____

***When was your last mammogram? Date_____ Results_____***

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***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** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

| 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: | | | | |
| 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:**

_____

## 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) 619-286-7867** **619-286-7866 (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

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 _____