

La Jolla Weight Management Medical Group, Inc.

**9850 Genesee Ave. #730
La Jolla, CA 92037**

**Phone: (858) 457-4917
Fax: (858) 457-3287**

Requested Surgeon: _____

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	<u>Race/Ethnicity</u> (for study purposes)	
Emergency Contact:	Relationship	Cell Phone	Religious Preference
Street Address, City, State, ZIP	Home Phone		Work Phone
Referring Physician	Address, City, Sate, ZIP		Work Phone
Primary Care Physician	Address, City, State, ZIP		Work Phone
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 ad Newspaper ad Internet Reader/Magazine

website: **www.** _____ Friend **Physician's Name:** _____

Date attended Seminar (if applicable) _____

I consent to any medical treatment or physical examination required for myself or the minor named above for whom I am legally responsible. 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. I have received a copy of the HIPPA Notice of Privacy Practices Pamphlet. ____ (Initials)

Signature: _____ Date: _____

For Office Use only:

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PATIENT HISTORY QUESTIONNAIRE

The information requested in this questionnaire is very important. To give you the best quality care, please try to complete all the answers to the best of your ability.

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

How long have you been suffering from Morbid Obesity? _____

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	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Dates	Duration	MD Supervised?	Max Loss
Jenny Craig:	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
Nutri-Systems	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
Weight Watchers	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
OptiFast	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
Medi Fast	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
Fen/Phen/Redux	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
Meridia	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
Lindora	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
T.O.P.S.	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
O.A.	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
Metabolife	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
Atkins Diet	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
Pritikin Diet	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
Other:	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____

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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: _____

Do you ever eat until you are uncomfortably full? Y/N

What do you do for exercise:

What is the number of times you exercise per week? _____

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

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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 _____

♦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 (Please circle the one which you have had)

If Yes: ♦Year diagnosed: _____

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◆Upper GI series? Yes No

◆Endoscopy? Yes No

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 Since _____?

If Yes: How was it diagnosed? Ultrasound Physical Exam (Gallbladder removed)

13. Leakage of urine with laughing/coughing/sneezing? Yes No Since _____?

If Yes: ◆Wear pads frequently? Yes No

15. Low back strain/Pain/Sciatica? Yes No Since _____ ?

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 (please circle the area/s affected?)

If Yes: Since _____?

◆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, since _____?

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 Since _____?

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

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Female Patients:

Number of pregnancies: _____ Age at first period: _____
Number of live births: _____ Date of last period: _____
Miscarriages/abortions: _____
C-Sections? _____ Date/s? _____
Obstetric complications: _____

Do you presently use:

Birth control pills Yes No List type: _____
Date Started? _____
Estrogens Yes No List type: _____
Other Contraceptive method: _____

When was your last mammogram? Date _____ Results _____

Please check which of the following childhood illnesses you have experienced and when they occurred?:

Measles /Date _____ Mumps/ Date: _____ Chickenpox/ Date: _____
 Rheumatic fever/ Date: _____ Heart murmur/ Date: _____
 Asthma/ Date: _____ Tonsillectomy/ Date: _____

Have you had:

Hepatitis ? / Date: _____ Blood Transfusion ? / Date: _____
 AIDS/HIV Exposure? / Date: _____ Colitis? / Date: _____ Kidney Disease? / Date: _____
 Bleeding Abnormality? / Date: _____ Thyroid Problems ? / Date: _____
 Cancer, type: _____ / Date diagnosed?: _____ / In remission? Yes No

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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Surgical Procedures	Date
_____	_____
_____	_____
_____	_____

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Allergies:

Allergic to any medications?: Yes No If Yes, please list the medication, the year it first occurred and reaction:

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

Medications:

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

Medication	Dose	How often?	Start Date?	Reason taking it?

Medication	Dose	How often?	Start Date?	Reason taking it?

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				

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Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Sibling:				
Sibling:				
Sibling:				
Sibling:				

Please indicate if there is a family history of:

- | | |
|--|--|
| <input type="checkbox"/> Obesity
<input type="checkbox"/> Diabetes
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> High Blood Cholesterol | <input type="checkbox"/> Lung disease, Asthma or Emphysema
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Bleeding tendency or Blood Disorder
<input type="checkbox"/> Breast Cancer
<input type="checkbox"/> Colon Cancer |
|--|--|

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SYSTEM REVIEW

Please check off or circle any of these if they've happened to you over the last 12 months. Please add a date when you first started having the problem/s. Feel free to add any additional problems or information.

HEAD, EYE, EAR, NOSE & THROAT

<i>Nose bleeds</i>
<i>hay fever/allergies</i>
<i>sinus trouble</i>
<i>earache</i>
<i>headaches</i>
<i>blurry vision</i>
<i>ringing in ears</i>
<i>loss of hearing</i>
<i>dizziness – vertigo</i>
<i>trouble swallowing</i>
<i>Eye disease or injury</i>

<i>Date Started?</i>	<i>Date Stopped?</i>	<i>Or Still ongoing?</i>

RESPIRATORY

<i>cough</i>
<i>asthma</i>
<i>emphysema</i>
<i>bronchitis</i>
<i>blood in sputum</i>
<i>wake up at night coughing or choking</i>

CARDIOVASCULAR

<i>palpitations</i>
<i>skipping heartbeat</i>
<i>pains in chest</i>
<i>heart attack</i>
<i>heart murmur</i>
<i>pain in legs</i>
<i>loss of pulses</i>

GASTROINTESTINAL

<i>vomiting</i>
<i>constipation</i>
<i>pain with bowel movement</i>
<i>blood in stools</i>
<i>hemorrhoids</i>

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<i>irritable colon</i>			
<i>colitis</i>			

GENITOURINARY

	<i>Date Started?</i>	<i>Date Stopped?</i>	<i>Or Still ongoing?</i>
<i>pain with urination</i>			
<i>trouble starting urine</i>			
<i>trouble stopping urine</i>			
<i>blood in urine</i>			
<i>kidney stones</i>			
<i>bladder stones</i>			
<i>kidney failure</i>			
<i>urinary tract infections</i>			
<i>leakage of urine with cough or sneeze</i>			
<i>decreased sex drive</i>			

ENDOCRINE

<i>low thyroid</i>			
<i>hyperthyroid</i>			
<i>goiter</i>			
<i>Grave's Disease</i>			
<i>thyroid Nodules</i>			
<i>adrenal gland tumor</i>			
<i>frequent flushing</i>			

MUSCULOSKELETAL

<i>redness of skin over joints</i>			
<i>fluid in joints</i>			
<i>arthritis</i>			
<i>broken bones (which ones?)</i>			
<i>low back pain</i>			
<i>slipped disk</i>			
<i>sciatica</i>			

NEUROLOGICAL:

<i>dizziness – vertigo</i>			
<i>numbness</i>			
<i>tingling</i>			
<i>pins and needles feelings (where?)</i>			
<i>weakness of any muscles (where?)</i>			
<i>tremors</i>			

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<i>convulsions</i>			
<i>Loss of consciousness</i>			

<i>PSYCHOLOGICAL</i>	<i>Date Started?</i>	<i>Date Stopped?</i>	<i>Or Still ongoing?</i>
<i>anxiety</i>			
<i>depression</i>			
<i>thoughts of suicide</i>			
<i>suicide attempts</i>			
<i>hospitalization for emotional problems</i>			
<i>psychiatric treatment</i>			

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 #

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:

La Jolla Weight Management - 858-457-3287 (fax)

858-457-4917 (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 () _____

OK to leave a message with family member () _____

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 _____