

OBESITY SURGERY CENTER of LOUISIANA

4150 Nelson Rd., STE. B6

Lake Charles, LA 70605

(337) 433-1303

Bariatric Surgery Application Form

Today's Date: _____

Personal Data

Full Name: _____

Birth Date: _____ Social Security #: _____

Address: _____

City, State, Zip: _____

Home Phone #: _____ Cell Phone: _____

E-mail address: _____

Place of Employment: _____

Occupation: _____ Work Phone: _____

Marital Status: Single/Married/Divorced/Widowed Spouse's Name: _____

Referral Type: Former patient/Physician/Friend/Hospital/ Internet/Newspaper

Whom may we thank for referral: _____

Emergency Contact Information

Name: _____ Phone#: _____

Relationship: Spouse/Son/Daughter/Mother/Father/Friend/Other _____

Insurance Information

Insurance Company: _____

Policy Holder: _____

DOB and SS# of policy holder: _____

Do you have a secondary insurance policy? _____

Physician List

Primary Care Physician

Name: _____

Address: _____

Phone: _____ Fax: _____

Cardiologist

Name: _____

Address: _____

Phone: _____ Fax: _____

Pulmonologist

Name: _____

Address: _____

Phone: _____ Fax: _____

Gastroenterologist

Name: _____

Address: _____

Phone: _____ Fax: _____

Gynecologist

Name: _____

Address: _____

Phone: _____ Fax: _____

Psychiatrist/Psychologist

Name: _____

Address: _____

Phone: _____ Fax: _____

Other: _____

Health History

Allergies: _____

List all medications currently taking with dosages, include any herbal or over the counter medications? _____

Please list all prior surgical operations (Indicate if performed by laparoscope or open) and list any past hospitalizations:

Obesity Related Health Conditions

Please fill this section out to the best of your knowledge

- | | | |
|---|-----|----|
| 1. Do you have high blood pressure?
If yes, what medication(s) do you take? _____ | Yes | No |
| 2. Have you ever seen a cardiologist, had any heart tests, had a heart attack or any other heart problems?
If yes, please explain: _____ | Yes | No |
| 3. Do you have cholesterol problems?
If yes, what medication do you take? _____ | Yes | No |
| 4. Do you have shortness of breath or trouble breathing?
If yes, explain: _____ | Yes | No |
| 5. Do you have swelling in your legs?
If yes, are you taking medication for this? _____ | Yes | No |
| 6. Do you have diabetes or elevated blood sugar?
If yes, what medications do you take? _____ | Yes | No |
| 7. Do you have thyroid problems, requiring medication?
If yes, what medication do you take? _____ | Yes | No |

- | | | |
|--|-----|----|
| 8. Do you suffer from heartburn or acid reflux?
If yes, what medications do you take? _____ | Yes | No |
| 9. Have you ever been treated for a stomach ulcer?
If yes, please list dates and treatment: _____ | Yes | No |
| 10. Do you have pain in your back? | Yes | No |
| hips? | Yes | No |
| knees? | Yes | No |
| ankle? | Yes | No |
| feet? | Yes | No |
| back? | Yes | No |
| neck? | Yes | No |
| If yes, please indicate if you are under a physicians care and/or if you are taking medications for this pain? _____ | | |
| 11. Do you have arthritis?
If yes, what medications do you take? _____ | Yes | No |
| 12. Do you suffer from depression?
If yes, are you in counseling and/or you taking medication for this? _____ | Yes | No |
| Have you ever been treated for alcohol abuse?
If yes, how long have you been sober? _____ | Yes | No |
| Have you ever been treated for drug abuse?
If yes, how long have you been clean? _____ | Yes | No |
| Have you ever had an eating disorder?
Please explain: _____ | Yes | No |
| 13. Do you have gout?
If yes, what medications do you take? _____ | Yes | No |
| 14. Have you ever had a blood clot or pulmonary embolism?
If yes, explain give date and treatment: _____ | Yes | No |
| 15. Do you have any problems with infertility?
Please explain: _____ | Yes | No |
| 16. Do you have sleep apnea?
If yes, when and where were you tested? _____
Do you wear a CPAP or BI-PAP? _____ | Yes | No |

Sleep Apnea Self Test

- | | | |
|---|-----|----|
| Do you snore? | Yes | No |
| Have you been told that you stop breathing during sleep? | Yes | No |
| Do you wake up gasping for breath? | Yes | No |
| Do you awaken with headaches? | Yes | No |
| Do you fall asleep while reading? | Yes | No |
| Have you fallen asleep while driving or stopped at a light? | Yes | No |
| Do you have jerking movements while sleeping? | Yes | No |
| Do you feel exhausted after 8 hours of sleep? | Yes | No |

17. Do you have chronic or severe headaches? Yes No
 If yes, what medication do you take? _____
18. Do you leak urine when you cough or sneeze? Yes No
19. Have you ever been diagnosed with any form of Cancer? Yes No
 If yes, please explain and give date Cancer free? _____

20. Do you have any other health problems not listed? Yes No
 If yes, please explain _____

Social History

- Do you smoke? Yes No
 If yes, how may packs per day and when did you start? _____
- If you have a history of smoking, when did you quit? _____
- Do you use other forms of tobacco products? Yes No
 Explain what products and when did you start? _____
- Are you committed to refrain from using tobacco products starting
 2 weeks prior to surgery and **not** restart? Yes No
- Do you drink alcohol? Yes No
 If yes, what type and how often? _____

Family History

	Mother/Father	Grandparents	Brothers	Sisters	Other
Obesity					
Diabetes					
Heart Disease					
High Blood Pressure					
Cancer & Type					
Arthritis					
Early Death & Cause					

Please give additional information if necessary: _____

Please describe briefly how living with obesity affects your daily living. Further, please express how you feel having bariatric surgery will change your life.

Please review and make sure the information given in this application is accurate to the best of your knowledge. Any false information could delay insurance approval. If you fail to disclose health history you could risk causing unnecessary complications with surgery.

Patient Signature