

**Personal Information**    Lap/Open Gastric Bypass    Lap-Band™

Date attended orientation seminar: \_\_\_\_\_ Today's date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Home Address: \_\_\_\_\_ Apt. \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Cellular #: \_\_\_\_\_ Beeper #: \_\_\_\_\_

Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

Gender:                     Male                     Female

Ethnic Group:    Caucasian                     African American                     Asian  
                          Hispanic                     American Indian                     Other

Marital Status:            Never married            Married            Divorced  
                                  Widowed                     Separated

Spouses Name: \_\_\_\_\_

**Contact Person(s)**

This information is vital to us if we need to contact you urgently. Occasionally people move or have new phone numbers and do not update our office.

NEXT OF KIN (NOT LIVING WITH YOU)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Home: (    ) \_\_\_\_\_ Work: (    ) \_\_\_\_\_

# Personal Medical History

	Have you been diagnosed with or do you suffer from each of the following?	Are you currently being treated for it?	Are you currently taking medication for it?
	Check if yes	Check if yes	Check if yes
<b>Head and Neck</b>			
Glaucoma			
Cataracts			
Hearing Loss			
Vertigo			
Tinnitus			
Migraine Headaches			
<b>Cardiovascular</b>			
High Blood Pressure			
Angina			
Pulmonary Hypertension			
Chest Pain with effort			
High Cholesterol			
High Blood Fats (Lipids)			
Irregular Heart Beat			
Heart Palpitations			
Congestive Heart Failure			
Leg Ulcers			
Varicose Veins			
Ankle Swelling			
<b>Respiratory</b>			
Sleep Apnea			
Shortness of Breath at Rest			
Shortness of Breath with Activity			
Emphysema			
Chronic Cough			
Wheezing			
Asthma as a child			
Asthma as an adult			
<b>Musculo-skeletal</b>			
Arthritis			
Ankle Pain			
Osteoarthritis			
Rheumatoid Arthritis			
Back Pain			
Knee Pain			
Plantar Fasciitis			
Heel Spurs			
<b>Gastrointestinal</b>			
GERD			
Heartburn			
Stomach Ulcer			
Duodenal Ulcer			
Constipation			
Number of bowel movements per day _____		Number per week _____	
Days between bowel movements _____			

	Have you been diagnosed with or do you suffer from each of the following?	Are you currently being treated for it?	Are you currently taking medication for it?
	Check if yes	Check if yes	Check if yes
Vomiting <input type="checkbox"/> Everyday <input type="checkbox"/> Most Days <input type="checkbox"/> Most Weeks <input type="checkbox"/> Occasionally			
Diarrhea <input type="checkbox"/> Everyday <input type="checkbox"/> Most Days <input type="checkbox"/> Most Weeks <input type="checkbox"/> Occasionally If everyday, how many times per day _____			
<b>Gallbladder Disease</b>			
Gall Stones			
Inflammation/Infection			
<b>Genito-urinary</b>			
Urinary Frequency (over 6 x per day)			
Urinary Retention			
Recurrent Urinary Tract Infection			
Kidney Stones			
Kidney Disease			
Renal Failure			
Gout			
Stress Incontinence (leakage of urine) <input type="checkbox"/> Everyday <input type="checkbox"/> Most Days <input type="checkbox"/> Most Weeks <input type="checkbox"/> Occasionally If everyday, how many times per day _____			
<b>OB/GYN</b>			
Irregular periods			
Excessively Heavy Periods			
Excessively Painful Periods			
Difficulty in Conceiving			
Infertility – with or without treatment			
Excess Body Hair or Acne			
<b>Endocrinology</b>			
Diabetes			
Hypothyroid			
Hyperthyroid			
Goiter			
Graves Disease			
<b>Neurological</b>			
Numbness/Tingling-hands			
Feet			
Front or side of thigh			
Seizures			
Weakness – Hands			
Weakness – Feet			
Epilepsy			
Pseudotumor Cerebri			
<b>Skin</b>			
Dermatitis			
Urticaria			
Rashes			
Open sores			
<b>Hematology</b>			
Anemia			
Heparin Exposure			
When? _____	Why? _____		





Do you currently have a hernia?  Yes  No  
 If so, what type? (Check all that apply)  
 Umbilical  Hiatal  Inguinal (groin)  Ventral

Have you had a previous blood transfusion?  Yes  No

If so, date \_\_\_\_\_  
 Reason \_\_\_\_\_

Have you had an allergic reaction to tape?  Yes  No

Have you had any food allergies  Yes  No

DRUG	IF ALLERGIC (PLEASE CHECK)	INDICATE REACTION
No known Drug Allergies		
Aspirin		
Codeine		
Demerol		
Erythromycin		
Iodine		
Keflex		
Morphine		
Penicillin		
Sulfa		
Tetracycline		

**Latex Allergy Screening Questionnaire**

Do you have an allergy to any latex products?  Yes  No

Have you experienced local swelling, itching or dermatitis associated to contact with Latex?  Yes  No

Do you have a history of wheel or blister formation on contact with latex products?  Yes  No

Are you allergic to:

Kiwi  Yes  No  
 Banana  Yes  No  
 Avocado  Yes  No  
 Chestnuts  Yes  No

Does your occupation involve exposure to NRL?  
 (NATURAL RUBBER LATEX)  Yes  No

Other Allergy? \_\_\_\_\_

## Surgical History – MUST BE COMPLETED

Please indicate with a check any of the following surgeries you have had and indicate the year of surgery.

Type of Surgery	Had Surgery	Year
Adenoidectomy		
Angioplasty		
Ankle Surgery		
Appendectomy		
Back Surgery		
Breast Augmentation		
Breast Reduction		
Breast Biopsy		
Carpal Tunnel Surgery		
Cesarean Section		
Cholecystectomy (Gallbladder)		
Coronary Bypass		
D&C		
<b>Gastric Bypass</b>		
Hemorrhoidectomy		
Hernia Repair		
Hysterectomy		
Knee Surgery		
<b>Lap Band</b>		
Lasik		
Liposuction		
Lumbar Laminectomy		
Mastectomy		
Oral Surgery		
Ovarian Cystectomy		
Panniculectomy		
Pilonidal Cystectomy		
<b>Previous Weight Loss Surgery</b>		
Prostate Surgery		
Tonsillectomy		
Tubal Ligation		
VBG		
Wisdom Teeth		

Any problems with anesthesia?  Yes  No

If yes, please describe \_\_\_\_\_

\_\_\_\_\_



## Weight and Weight Loss History

(This page needs to be filled out thoroughly for insurance)

\* Please note that we are unable to accommodate any patient weighing over 450 pounds.

Height: ft. \_\_\_\_\_ in. \_\_\_\_\_ Weight: \_\_\_\_\_  
BMI: \_\_\_\_\_

Age of obesity onset:

- 0-2 years old                       12 – 18 years old                       Pregnancy  
 2-12 years old                       Young Adult                       Middle Age

How many years have you been at your present weight? \_\_\_\_\_ years

How many years have you been obese? \_\_\_\_\_ years

Greatest single weight loss: \_\_\_\_\_ pounds

Weight loss was sustained for: \_\_\_\_\_ months

How many times have you lost weight? \_\_\_\_\_

Were there any particular events that lead to significant weight gain?

- Loss of a loved one                       Trauma-accident or illness  
 Pregnancy                       Loss of employment  
 Other \_\_\_\_\_

Weight at specific ages:

Birth weight: \_\_\_\_\_

Age 5 \_\_\_\_\_

Age 13 \_\_\_\_\_

Age 18 \_\_\_\_\_

Age 25 \_\_\_\_\_

Age 40 \_\_\_\_\_

Any additional weights Known with dates: \_\_\_\_\_

## Social Data

Do you drink coffee?  Yes  No How many cups per day? \_\_\_\_\_

Do you smoke cigarettes  Yes  No If yes, how long? \_\_\_\_\_

Do you smoke cigars?  Yes  No How many per day? \_\_\_\_\_

How long ago did you stop smoking? \_\_\_\_\_ years  
\_\_\_\_\_ months

Do you drink alcohol?  Yes  No

If yes, how often?

Everyday  Most Days  Most Weeks  Most Months  Rarely

If yes, when drinking do you tend to binge to excess?  Yes

No

Do you have a history of drug or alcohol addiction?  Yes  No

If yes, how long have you been alcohol or drug free? \_\_\_\_\_

Months

What treatment did you receive, check all that apply

Residential treatment  Counseling  Support groups such as AA

I realize I must be smoke free for at least 30 days and that I may be asked to submit to a urine or blood Nicotine Screening 3 weeks prior to surgery.

Being able to change lifestyle habits and improve your health will determine your compliance and motivation.

## Social Profile

### Family Structure

Do you have any children?  Yes  No

How many children/grandchildren in each of the following age groups do you have living with you:

Include nieces, nephews or other dependants

\_\_\_\_\_ 0-2 years old                      \_\_\_\_\_ 8-12 years old                      \_\_\_\_\_ 18-25  
years old  
\_\_\_\_\_ 2-8 years old                      \_\_\_\_\_ 12-18 years old                      \_\_\_\_\_ over 25  
years old

Do you have a support person friend?  Yes  No  
Do they live with you?  Yes  No

### Combined Household Income

\_\_\_\_\_ Less than \$20,000                      \_\_\_\_\_ \$40,000-\$59,999                      \_\_\_\_\_ \$80,000-  
\$99,999  
\_\_\_\_\_ \$20,000-\$39,999                      \_\_\_\_\_ \$60,000-\$79,999                      \_\_\_\_\_ \$100,000  
or more

If employed, please state what level of activity your job involves:

Little (sedentary job)     Moderately active                       Very active

Do you enjoy your work?  Yes  No

If you are unemployed, How long? \_\_\_\_\_

What is the reason? (Check one)

- Physically unable to work                       Emotionally unable to work  
 Lack of available jobs in the field                       Appearance inappropriate for position sought  
 Lack of skills

Are you currently disabled or on disability?  Yes  No

If so, how long? \_\_\_\_\_

### Education

- 8<sup>th</sup> grade or less                       High school graduate                       College graduate  
 Some high school                       Some college                       Any post graduate work

## Detailed Diet History

**(This page is submitted to insurance company and must be filled out thoroughly)**

Fill in the dates you participated in the following diet programs, the **pounds lost**, **pounds regained** and the **time spent** in each program.

Name of diet program	Dates Followed/Taken		Number of months	Pounds lost	Pounds regained
	From	To			
Acupuncture					
Weight Watchers					
Nutrisystem					
Pritkin					
Scarsdale					
Diet Center					
Jenny Craig					
Dexatrim					
Grapefruit Diet					
Rice					
Atkins					
Slim Fast					
O.A.					
Herbal Diets					
Hypnosis					
Tops					
Teeth Wiring					
Calorie Counting					
Richard Simmons					
Exercising					
Low Fat					
Cabbage Diet					
American Heart Association					
Radar Institute					
Duke University Programs					
Structure House					
Inpatient Psychiatric Programs					
Outpatient Psychiatric Programs					
Optifast					
Carefast					
Medifeast					
Meridia					
Zenical					
Fastin					
Ionamin					
Phenteramine/Fenfluramine					
Redux					
<b>Other:</b>					

Details of any other weight loss **(including/Especially Any Surgical Weight Loss Procedure)**

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**Note: If you have Cigna, Aetna, BCBS-AL or BCBS-FL you must submit documentation of a 6-month medically supervised diet and exercise program.**

# Food Frequency Form

How often do you eat the following foods? (Put an "X" on the line where appropriate.)

	More than once a day	Once/day	2-3 times/week	Seldom	Never
Milk					
Cheese, yogurt					
Ice cream					
Meat, fish, poultry					
Eggs					
Peanut butter, nuts					
Dry beans, peas, tofu, soy					
Citrus fruits, juice (eg. Orange, grapefruit, tomato)					
Dark green, leafy or deep orange vegetables (eg. Collards, broccoli, carrots, squash, sweet potatoes)					
Other fruits, vegetables, potatoes					
Bread, cereals, rice, pasta					
Sweets (cakes, donuts, pies, cookies, candy)					
Salty snacks (eg. potato chips, corn chips, tortilla chips, pretzels)					
Soda, Kool-Aid					
Alcohol (beer, wine, etc.)					
Coffee, tea					
Vitamins, herbs, other supplements					
Fast foods					

# Nutrition Follow-Up Before Surgery

Patient Name:

Date: \_\_\_\_\_

Operation/Date of Operation:

Weight:                      Height:                      BMI:

%IBW:                      Adjusted Body Wt:

Weight History Since Initial Nutrition Assessment:

Medications:

Exercise Frequency:

Dietary Intake:              Breakfast:

Lunch:

Dinner:

Snacks:

Beverages:

Fast Food Frequency:

**Assessment:**

**Plan/Education:**

**Patient Signature:** \_\_\_\_\_

**Dietitian Signature:** \_\_\_\_\_



# New Patient Food Questionnaire

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Please describe your typical meal (including foods and beverages). If cooked at home, please include how the food is cooked (baked, fried, broiled, steamed, etc.):

**BREAKFAST**

**LUNCH**

**DINNER**

What do you drink during the day?

Do you consume alcohol? If so, what type, how much and how often?

What types of snacks do you enjoy?

Who does most of the meal preparation in your home?

Typically, are most of your meals made from scratch or from convenience/boxed items?

How often do you grocery shop?

How many times a week do you eat fast food? What types of fast food do you eat?



Authorization for Release of Information

**Advanced Surgical Associates**

2376 Cypress Circle, Suite 103  
Conway, South Carolina 29526  
Telephone: 843-347-3900  
Fax: 843-347-3930

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone# \_\_\_\_\_ Social Security # \_\_\_\_\_

Person or Organization Authorized to RELEASE the Protected Health Information

Person or Organization Authorized to RECEIVE the Protected Health Information

\_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Purpose of the Information: \_\_\_\_\_

This authorization will expire in 90 days unless otherwise specified: \_\_\_\_\_

**Description of information to be disclosed**

- |  |   |
|--|---|
| <input type="checkbox"/> All PHI in medical record | <input type="checkbox"/> Special test/therapy |
| <input type="checkbox"/> History and physical      | <input type="checkbox"/> Nursing information  |
| <input type="checkbox"/> Consult report            | <input type="checkbox"/> ER information       |
| <input type="checkbox"/> Operative report          | <input type="checkbox"/> Medication Sheets    |
| <input type="checkbox"/> Pathology report          | <input type="checkbox"/> Labs                 |
| <input type="checkbox"/> Physician's Orders        | <input type="checkbox"/> Other: _____         |

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. \_\_\_\_\_ (initial)

**I understand that:**

1. I may refuse to sign this authorization and that it is strictly voluntary
2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving revocation.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee; if I ask for it.
5. If requested, I may receive a copy of this form after I sign it.

I have read the above and authorize the disclosure of the protected health information as stated.

\_\_\_\_\_  
Patient's Signature \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

**Advanced Surgical Associates**

2376 Cypress Circle, Suite 103

Conway, South Carolina 29526

Telephone: 843-347-3900

Fax: 843-347-3930

**Authorization for Release of Insurance**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

I am interested in having surgery with Advanced Surgical Associates. Therefore, I give permission for the release of any information to determine eligibility, benefits, co-payments or any out-of-pocket expenses.

I also give permission for any insurance company to inform Advanced Surgical Associates of the reasonable and customary reimbursements for my surgical procedure.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

Birthdate: \_\_\_\_\_

Insurance #: \_\_\_\_\_

Group # \_\_\_\_\_

**Advanced Surgical Associates**

**2376 Cypress Circle, Suite 103**

**Conway, South Carolina 29526**

**Telephone: 843-347-3900**

**Fax: 843-347-3930**

**Program Fee:**

If you are considering the Laparoscopic Adjustable Gastric Band procedure for weight loss surgery (not the Roux-en-Y Gastric Bypass), please indicate this on the top of your Personal Information packet. Simply check the box labeled Lab Band on the Personal Information. Please note that the Program fee of \$380.00 **must be** submitted when you return your packet and include a copy of your insurance card front and back.

After the pre-determination phase of insurance pre-approval should your insurance company deny payment for the Laparoscopic Adjustable Gastric Band you will be notified. At this time, if you decide you no longer want to proceed with the Band, but that you would like to seek insurance approval for the Roux-en-Y Gastric Bypass procedure, you will be required to submit another \$300.00 Program fee. This fee will cover the additional work of contacting your insurance for another procedure, writing another pre-cert letter, submitting the paperwork for predetermination, etc.

It is important that you know which procedure you want to have and which procedure your insurance company is likely to pay for. Many insurance companies have exclusions against the Laparoscopic Adjustable Gastric Band.

If you are requesting that we initially submit to insurance for approval of the Laparoscopic Adjustable Gastric Band, please sign this form and return it with your Personal Information Packet.

*I understand that if insurance does not approve the Laparoscopic Adjustable Gastric Band procedure and I then request Advanced Surgical Associates to re-submit to insurance for gastric bypass, that I will be required to pay an additional \$300.00 program fee.*

\_\_\_\_\_  
Signature/Print

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date