



## Harbin Clinic Bariatric Center

1825 Martha Berry Blvd. Rome, GA

(706) 378-8140 / 1-800-803-2065

### *Patient Information*

#### Patient Demographics

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
\_\_\_\_\_ Work Phone: \_\_\_\_\_  
\_\_\_\_\_ Cell Phone: \_\_\_\_\_  
City State Zip County Email: \_\_\_\_\_  
Social Security #: \_\_\_\_\_

Marital Status: \_\_\_\_\_ May we contact your spouse: Y N  
Spouse's Name: \_\_\_\_\_

Emergency Contacts: \_\_\_\_\_  
Name Relationship Phone Alternate Phone  
\_\_\_\_\_  
Name Relationship Phone Alternate Phone

Are you employed? Y N  
Full time Part time Student Homemaker Retired Self Employed

#### Insurance Information

Employer's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Primary Insurance Carrier:** \_\_\_\_\_  
Address: \_\_\_\_\_ Policy Effective Date: \_\_\_\_\_  
\_\_\_\_\_ Customer Service #: \_\_\_\_\_  
\_\_\_\_\_ Policy or ID #: \_\_\_\_\_  
City State Zip Group #: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Secondary Insurance Carrier:** \_\_\_\_\_  
Address: \_\_\_\_\_ Policy Effective Date: \_\_\_\_\_  
\_\_\_\_\_ Customer Service #: \_\_\_\_\_  
\_\_\_\_\_ Policy or ID #: \_\_\_\_\_  
City State Zip Group #: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

## Weight History

Current Weight: \_\_\_\_\_ Max. Weight: \_\_\_\_\_ Lowest Adult Weight: \_\_\_\_\_  
Height: \_\_\_\_\_ Date of Max. Wt: \_\_\_\_\_ Date of lowest Weight: \_\_\_\_\_  
BMI: \_\_\_\_\_

How would you describe your current weight? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

At what weight have you felt your best or *think* you would feel your best? \_\_\_\_\_

How does your weight affect your daily activities? \_\_\_\_\_  
\_\_\_\_\_

Why do you want to lose weight? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Why are you considering surgery to help you lose weight? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How do you think your life would change if you reach your weight goal? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Age when you first remember being overweight: \_\_\_\_\_  
Age when you first began dieting: \_\_\_\_\_

### **Medication Prescribed by a Physician for Weight Loss**

Medications may be listed as both generic and name brand. Check the one prescribed to you.

- |  |                                      |                                      |
|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Acutrim         | <input type="checkbox"/> Obalan      | <input type="checkbox"/> Stacker 2   |
| <input type="checkbox"/> Adipex-P        | <input type="checkbox"/> Orlistat    | <input type="checkbox"/> Coritslim   |
| <input type="checkbox"/> Anorex          | <input type="checkbox"/> Phentermine | <input type="checkbox"/> Ephedrine   |
| <input type="checkbox"/> Dexatrim        | <input type="checkbox"/> Phentrol    | <input type="checkbox"/> Relacore    |
| <input type="checkbox"/> Dexfenfluramine | <input type="checkbox"/> Pondimin    | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Didrex          | <input type="checkbox"/> Redux       | _____                                |
| <input type="checkbox"/> Fastin          | <input type="checkbox"/> Sanorex     | _____                                |
| <input type="checkbox"/> Fenfluramine    | <input type="checkbox"/> Tepanol     |                                      |
| <input type="checkbox"/> Ionamin         | <input type="checkbox"/> Topamax     |                                      |
| <input type="checkbox"/> Mazanor         | <input type="checkbox"/> Tenuate     |                                      |
| <input type="checkbox"/> Meridia         | <input type="checkbox"/> Xenical     |                                      |

## WEIGHT LOSS HISTORY

Most insurance companies require documented evidence of previous weight loss attempts, so it is very important that you complete this in detail.

Method	Ages	# of Times tried	Weight lost	Comments/Weight Regain
Weight Watchers				
TOPS				
First Place				
Nutri-System				
Jenny Craig				
LA Weight Loss				
Richard Simmons				
Overeaters Anonymous				
Herbal Life				
Dietitian				
Slim Fast				
Liquid Diet				
Cabbage Soup Diet				
Mayo Clinic Diet				
Scarsdale Diet				
Atkins				
South Beach Diet				
Sugar Buster				
High Carbohydrate, Low Fat				
Starvation				
Behavior Modification				
Psychotherapy				
Hypnosis				
Surgery				
Diet Books				
Calorie Counting				
Dr. Vitkins				
Dr. Jagiella				
Dr. Martin				
Exercise				
Other (Please describe)				

***Please enclose any documentation confirming your weight loss efforts.***

## Medical History

Have **you** ever had any of the following medical problems? (choose **one** in each box that applies)

<b>Hypertension (high blood pressure)</b>	<input type="checkbox"/> No Personal History <input type="checkbox"/> Borderline, no medication <input type="checkbox"/> Diagnosis of hypertension, no medication <input type="checkbox"/> Treatment with single medication <input type="checkbox"/> Treatment with multiple medications <input type="checkbox"/> Poorly controlled by medication, organ damage
<b>Congestive Heart Failure</b>	<input type="checkbox"/> No personal history or symptoms of congestive heart failure <input type="checkbox"/> Symptoms with more than one ordinary activity <input type="checkbox"/> Symptoms with ordinary activity <input type="checkbox"/> Symptoms with minimal activity <input type="checkbox"/> Symptoms at rest
<b>Ischemic Heart Disease</b> (Coronary Artery Disease, Ischemic means that the heart is not getting enough blood and oxygen)	<input type="checkbox"/> No history of ischemic heart disease <input type="checkbox"/> Abnormal ECG, no active ischemia <input type="checkbox"/> History of heart attack or take medications to prevent it <input type="checkbox"/> Had surgeries or stents for heart attack <input type="checkbox"/> Active ischemia
<b>Chest Pain</b>	<input type="checkbox"/> No chest pain symptoms/angina <input type="checkbox"/> Chest pain with extreme exertion (running, swimming, etc.) <input type="checkbox"/> Chest pain occurs with moderate activity or exertion <input type="checkbox"/> Chest pain occurs with minimal exertion (walking across a room) or “at rest” <input type="checkbox"/> Unstable chest pain/angina
<b>Peripheral Vascular Disease</b> (A disease of the blood vessels characterized by narrowing and hardening of the arteries)	<input type="checkbox"/> No symptoms of peripheral vascular disease <input type="checkbox"/> Cramping pain and weakness in the legs with medication <input type="checkbox"/> Transient ischemic attack (ie TIA or ‘mini-stroke’) <input type="checkbox"/> Procedure for peripheral vascular disease <input type="checkbox"/> Stroke, loss of tissue secondary to ischemia
<b>Lower Extremity Edema (swelling)</b>	<input type="checkbox"/> No symptoms of lower extremity edema <input type="checkbox"/> Intermittent lower extremity edema, not requiring treatment <input type="checkbox"/> Symptoms requiring treatment, diuretics, elevation or hose <input type="checkbox"/> Stasis ulcers <input type="checkbox"/> Disability, decreased function, hospitalization
<b>DVT/PE</b> (Deep Vein Thrombosis/ Pulmonary Embolism)	<input type="checkbox"/> No history of DVT/PE <input type="checkbox"/> History of DVT resolved with medication <input type="checkbox"/> Recurrent DVT long term medication <input type="checkbox"/> Previous pulmonary embolism <input type="checkbox"/> Recurrent pulmonary embolism, decrease function, hospitalization <input type="checkbox"/> Vena Cava filter placed
<b>Glucose Metabolism</b>	<input type="checkbox"/> No symptoms or evidence of diabetes <input type="checkbox"/> Elevated fasting glucose <input type="checkbox"/> Diabetes, controlled with oral medication <input type="checkbox"/> Diabetes, controlled with insulin <input type="checkbox"/> Diabetes, controlled with insulin and oral medication <input type="checkbox"/> Diabetes, with severe complications (retinopathy, neuropathy, renal failure, blindness)
<b>Abnormal Lipids such as high cholesterol, high bad cholesterol</b>	<input type="checkbox"/> Not present <input type="checkbox"/> Present, no treatment required <input type="checkbox"/> Controlled with lifestyle change <input type="checkbox"/> Controlled with single medication <input type="checkbox"/> Controlled with multiple medications <input type="checkbox"/> Not controlled
<b>Gout/Hyperuricemia</b> (excess uric acid in the blood)	<input type="checkbox"/> No symptoms of gout/hyperuricemia <input type="checkbox"/> Hyperuricemia, no symptoms <input type="checkbox"/> Hyperuricemia, medications <input type="checkbox"/> Joint disease due to gout <input type="checkbox"/> Destructive joints

	<input type="checkbox"/> Disability, unable to walk
<b>Obstructive Sleep Apnea Syndrome</b>	<input type="checkbox"/> No symptoms or evidence of sleep apnea <input type="checkbox"/> Sleep apnea symptoms (negative sleep study or not done) <input type="checkbox"/> Sleep apnea diagnosis by sleep study (no oral appliance) <input type="checkbox"/> Sleep apnea requiring oral appliance such as CPAP <input type="checkbox"/> Sleep apnea with significant hypoxia or oxygen dependent <input type="checkbox"/> Sleep apnea with complications (pulmonary hypertension, etc.)
<b>Obesity Hypoventilation Syndrome</b>	<input type="checkbox"/> No symptoms of obesity SOB (shortness of breath) <input type="checkbox"/> Lack of oxygen on room air <input type="checkbox"/> Severe SOB <input type="checkbox"/> Pulmonary Hypertension <input type="checkbox"/> Right heart failure
<b>Pulmonary Hypertension</b>	<input type="checkbox"/> No symptoms or indication of pulmonary hypertension <input type="checkbox"/> Symptoms associated with PH (tiredness, SOB, dizziness, fainting) <input type="checkbox"/> Confirmed Pulmonary Hypertension diagnosis <input type="checkbox"/> Well controlled on anticoagulants and/or calcium channel blockers <input type="checkbox"/> Stronger medications and/or oxygen
<b>Asthma</b>	<input type="checkbox"/> No symptoms of asthma <input type="checkbox"/> Intermittent mild symptoms, no medication <input type="checkbox"/> Symptoms controlled with oral inhaler (such as albuterol) <input type="checkbox"/> Well controlled with ongoing daily medication <input type="checkbox"/> Symptoms not well controlled with medication <input type="checkbox"/> Hospitalized within last 2 years or history of intubation
<b>GERD</b> (gastroesophageal reflux disease)	<input type="checkbox"/> No history of GERD <input type="checkbox"/> Intermittent or variable symptoms, no medication <input type="checkbox"/> Intermittent medication <input type="checkbox"/> Take prescribed medication (H2 blocker or low dose PPI) <input type="checkbox"/> Take high dose medications <input type="checkbox"/> Meet criteria for antireflux surgery, or prior surgery for GERD
<b>Liver Disease</b>	<input type="checkbox"/> No history of liver disease <input type="checkbox"/> Mild enlargement of the liver, normal liver function test, fatty change <input type="checkbox"/> Modest hepatomegaly, LFT alteration, fatty change <input type="checkbox"/> Moderate to marked hepatomegaly, fatty change <input type="checkbox"/> Mild inflammation, mild fibrosis <input type="checkbox"/> Definite NASH (nonalcoholic steatohepatitis), cirrhosis, hepatic dysfunction by LFT's <input type="checkbox"/> Hepatic failure, transplant indicated or done
<b>Back Pain</b>	<input type="checkbox"/> No symptoms of back pain <input type="checkbox"/> Intermittent symptoms not requiring treatment <input type="checkbox"/> Symptoms requiring non narcotic treatment <input type="checkbox"/> Degenerative changes or positive objective findings, symptoms requiring narcotic treatment <input type="checkbox"/> Surgical intervention done or recommended pending weight loss <input type="checkbox"/> Failed previous surgical intervention with existing symptoms
<b>Musculoskeletal Disease</b> (problems with muscle and bone such as joint disease)	<input type="checkbox"/> No symptoms of musculoskeletal disease <input type="checkbox"/> Pain with community ambulation <input type="checkbox"/> Non narcotic pain medication required <input type="checkbox"/> Pain with household ambulation <input type="checkbox"/> Surgical intervention required <input type="checkbox"/> Awaiting or past joint replacement or other disability
<b>Fibromyalgia</b> (chronic disorder with widespread pain, tenderness, and stiffness of muscles)	<input type="checkbox"/> No history of fibromyalgia <input type="checkbox"/> Treatment with exercise <input type="checkbox"/> Treatment with non narcotic medication <input type="checkbox"/> Treatment with narcotics <input type="checkbox"/> Treatment with narcotics; surgical intervention done or recommended <input type="checkbox"/> Disabling, treatment not effective

<b>Polycystic Ovarian Syndrome (PCOS)</b>	<input type="checkbox"/> No history of polycystic ovarian syndrome <input type="checkbox"/> Symptoms of PCOS, no treatment <input type="checkbox"/> Take birth control pills <input type="checkbox"/> Take Metformin (Glucophage) or TZD (thiazolidinedione) <input type="checkbox"/> Combination therapy <input type="checkbox"/> Infertility
<b>Psychosocial Impairment</b>	<input type="checkbox"/> No impairment <input type="checkbox"/> Mild impairment in psychosocial functioning but able to perform all primary tasks <input type="checkbox"/> Moderate impairment in psychosocial functioning and unable to perform some primary tasks <input type="checkbox"/> Severe impairment in psychosocial functioning and unable to perform most primary tasks <input type="checkbox"/> Severe impairment in psychosocial functioning and unable to function
<b>Depression</b>	<input type="checkbox"/> No symptoms of depression <input type="checkbox"/> Mild and episodic not requiring treatment <input type="checkbox"/> Moderate accompanied by some impairment, may require treatment <input type="checkbox"/> Moderate with significant impairment, treatment indicated <input type="checkbox"/> Severe, definitely requiring intensive treatment <input type="checkbox"/> Severe requiring hospitalization
<b>Confirmed Mental Health Diagnosis</b>	<input type="checkbox"/> None <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Anxiety/Panic Disorder <input type="checkbox"/> Personality disorder <input type="checkbox"/> Psychosis
<b>Stress Urinary Incontinence</b> (leaky urine when you laugh, cough, or sneeze)	<input type="checkbox"/> No history of stress urinary incontinence <input type="checkbox"/> Minimal and intermittent <input type="checkbox"/> Frequent but not severe <input type="checkbox"/> Daily occurrence, requires sanitary pad <input type="checkbox"/> Disabling <input type="checkbox"/> Operation ineffective
<b>Pseudotumor Cerebri</b> (benign intracranial hypertension. An abnormal condition such as headaches with dizziness, nausea, and/or pain behind the eyes)	<input type="checkbox"/> No symptoms of pseudotumor cerebri <input type="checkbox"/> Headaches with dizziness, nausea, and/or pain behind the eyes, no visual symptoms <input type="checkbox"/> Headaches with visual symptoms and/or controlled with diuretics <input type="checkbox"/> Patient has had MRI to confirm PTC, is well controlled with oral diuretics <input type="checkbox"/> Patient is well controlled with stronger medications <input type="checkbox"/> Patient requires narcotics or has had (or needs) surgical intervention

**List all additional medical illness:**

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Arthritis					
Early Death (Cause)					
<b>Physicians</b>					

Please list all physicians that are currently or recently caring for you

Primary Care Physician \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Gynecologist \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Cardiologist \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Pulmonologist \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Psychiatrist / Psychologist \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Orthopedic \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Other \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Referring Physician**

Referring Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Address: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How did you hear about Harbin Clinic Bariatric Center? \_\_\_\_\_  
 \_\_\_\_\_

**Procedure Preference**

Which surgical procedure are you currently most interested in?

**Gastric Bypass**     **Lap-Band**     **Realize Band**     **Sleeve Gastrectomy**     **No Preference**