Patient Name _____ Date of Birth _____
(Last) (First)

Weight Loss Patient Information Packet

Sts. Mary and Elizabeth Bariatric Office
1850 Bluegrass Avenue
Louisville, KY 40215

P: (502) 361-6059

F: (502) 361-6296

LAPBAND OF LOUISVILLE SURGICAL ASSOCIATES

Name_____Social Security # _____

Address_____City_____State___ Zip _____

Home Phone _____ Work Phone _____Cell _____

Email Address _____

Date of Birth ___/___/___ Age ___ Gender: M/F Marital Status _____

Employer _____Position _____

Primary Care Doctor _____Phone# _____

Insurance Information

PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD (FRONT AND BACK) TO AVOID A DELAY IN PROCESSING

	Primary	**Secondary**
Insurance Name	_____	_____
ID Number	_____	_____
Group Number	_____	_____
Subscriber Name	_____	_____
Subscriber DOB	____/____/_____	_____
Subscribers SS#	_____	_____

Height _____

Weight _____

BMI _____

for Office Use Only

Seminar Date _____

Date received _____

LSA / Self pay / Exclusion

Physicians caring for you

Name	Specialty	Phone#
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Weight and Diet History

My obesity started:

- ☐ In childhood _____
- ☐ At puberty _____
- ☐ As an Adult _____
- ☐ After Pregnancy _____
- ☐ After Traumatic Event _____
- ☐ Other _____

General Questions

- ☐ I snack between meals
- ☐ I eat large meals at one sitting (gorge)
- ☐ I eat a lot of sweets
- ☐ I drink regular soft drinks or “sweet” tea

- ☐ I have forced myself to vomit after eating (binge and purge)
- ☐ I am ***currently*** forcing myself to vomit after eating.

  How often? _____

Please List Prior Attempts at Weight Loss

(BE SPECIFIC-Critical for Insurance approval *DO NOT LEAVE BLANK*)

(Weight Watchers, diets, Medications, etc)

Program or Modality Dates Length of Time Wt Loss

_____

_____

_____

_____

_____

_____

_____

Have you been part of a **MEDICALLY SUPERVISED DIET PROGRAM**?

☐ NO

☐ YES

Dates Clinic/Physician

_____

_____

_____

Medical History

☐ **Heart Disease**

___Angina

___Heart attack (MI)

___CABG (coronary bypass)

___Angioplasty

☐ **High Cholesterol**

☐ **High Blood Pressure**

Number of years? _____

☐ **Diabetes**

Number of years _____

Controlled with… Diet _____ Insulin _____ Meds _____

☐ **Asthma**

☐ **Sleep Apnea**

Number of years_____ Date of last sleep study _____

____Snoring?

____CPAP?

____Daytime drowsiness?

☐ **Heartburn (GERD)**

- Number of years _____
- Medications _____
- Endoscopy? _____ Date of last scope _____

☐ **Lower Back Pain**

☐ **Joint Pain**

☐ **Thyroid Disease**

____ **Are you Missing Teeth

How Many ____

Dentures or Partials Y/N

____Do you use a wheelchair or scooter all or most of the time?

Smoking History

Current Smoker? _____

Years as smoker? _____

Packs per day? _____

Did you ever smoke _____

How long since you quit? _____

Are you using or have you used any "*recreational drugs*"? _____

Type _____ Date last used _____

Do you drink alcohol? Never ___ Rarely ___ Regularly___

PREVIOUS SURGERIES

Procedure Date Complication

_____

_____

_____

_____

_____

_____

_____

CURRENT MEDICATIONS

Drug Name Dose Frequency

_____

_____

_____

_____

_____

_____

CURRENT MEDICATIONS (cont)

_____

_____

_____

_____

_____

_____

ALLERGIES

Do you have an allergy to latex? _____

List all allergies (medications, foods, environmental….)

_____

_____

_____

_____

_____

FAMILY HISTORY

	Mother	Father	Sibling
Morbid Obesity			
Diabetes			
High Blood Pressure			
Stroke			
Heart Attack (Age?)			
Heart Disease			
Cancer (Age/Type?)			

My signature below confirms that I have viewed/attended the Lap-Band seminar in its entirety. I understand the risks and benefits of the procedure and understand that if I have any questions regarding the Program, I can contact the Bariatric Office at (502) 361-6059

_____

Signature *Name (Print)* *Date*

Email is the most efficient way of contact to process insurance and paperwork. May we notify you via email Y / N

Please mail or fax to :

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Please tell us how you found us (Check all that apply)

- ☐ **Internet site/search**
- ☐ **Family member**
- ☐ **Friend**
- ☐ **Physician referral _____ (name)**
- ☐ **Newspaper**
- ☐ **Billboard**
- ☐ **Other**