The Surgical Specialists of Louisiana
The Surgical Specialists of Mississippi

New Patient Information

(Please complete all items in ink)

Name		Date of Birth	Age	Gender ☐Male ☐Female
Address		City	State	Zip
Home Phone (include area code) ☐May leave confidential message	Cell Phone (include area code) ☐May leave confidential message		Work Phone (include area code) ☐May leave confidential message	
What is the best number to contact you between 9:00 AM and 5 PM? ☐Home ☐Cell ☐Work				
E-Mail Address*	Social Security Number	Marital Status ☐Single ☐Married ☐Divorced ☐Widow	Race/Ethnicity: ☐Caucasian ☐Asian ☐African American ☐Hispanic ☐Native American ☐Other: _____	
Employment status: ☐Full Time ☐Part Time ☐Self Employed ☐Homemaker ☐Student ☐Retired ☐Disabled ☐Unemployed				
Employer Name		Occupation ☐I am disabled		
Emergency Contact		Emergency Contact Phone Number (include area code) ☐May leave confidential message		
Referral Source: ☐Family ☐Friend ☐Patient _____ ☐Doctor _____ ☐Billboard ☐Internet ☐T.V. ☐Magazine ☐Newspaper ☐Radio ☐Other: _____				
I have attended a seminar given by Surgical Specialists of LA or MS ☐No ☐Yes If YES, Date? _____ (mm/dd/yyyy) What City or location?				

Primary Insurance Information (Please complete even if you have supplied us with a copy of your insurance card)

Insurance Company			
Claims Mailing Address/City/State/Zip			
Policy Holder Name (**if insurance is through a spouse please list spouses' information here**)	Date of Birth	Social Security Number	Policy Holder Phone No.
Member ID/Policy Number	Group Number	Phone Number for Customer Service	

Secondary Insurance Information

☐I do not have a secondary insurance

Insurance Company			
Claims Mailing Address/City/State/Zip			
Policy Holder Name (**if insurance is through a spouse please list spouses' information here**)		Date of Birth	Social Security Number
Member ID/Policy Number	Group Number	Phone Number for Customer Service	

I authorize my insurance company to pay directly any and all claims submitted by Surgical Specialists of LA and MS. I accept responsibility for any unpaid balance following reimbursement or should insurance deny coverage for services for any reason and will pay the balance in a timely manner.

Signature _____Date_____

* My Signature on this document authorizes The Surgical Specialists of LA and The Surgical Specialists of MS to communicate via e-mail address. **Initial:** _____

** My Signature on this document authorizes Surgical Specialists of MS and LA to request copies of any and all medical records from any source pertinent to my medical care. **Initial:** _____

Name:_____ DOB:_____ Today's date:_____

Please list all physicians whose care you are under. *Please place a ☑ next to the doctor's if they know you are interested in Bariatric Surgery*. Please complete this section in full. (Please use the back for additional doctors)

Specialty	First, Last Name	Address/City/State/Zip	Phone Number (with area Code)	They know you are interested in surgery?

Please list all major surgeries you have experienced in adulthood. (Please use the back for additional procedures)

Surgery	Reason for Surgery	Date	Surgeon

Have you had any of the following diagnostic procedure?, If so, briefly describe when the test was performed and the results.

Check if Yes	Procedure	Procedure Date (month/year)	Results
	COLONOSCOPE (scope of colon)		
	EGD (scope of stomach)		
	EKG		
	HEART CATH / ANGIOGRAM		
	STRESS TEST		
	PACE MAKER		
	SLEEP STUDY		
	US of GALLBLADDER		
	UPPER GI SERIES (x-rays of abdomen)		

Name:_____ DOB:_____ Today's date:_____

Please indicate the main reason for your visit today?

- ☐ General Surgery Consult
- ☐ Weight loss surgery Consult

  What procedure are you interested in? ☐Roux-en Y Gastric Bypass ☐Adjustable Band (LAP-BAND, REALIZE) ☐ Duodenal Switch
  ☐Revision to a previous Bariatric Surgery ☐Gastric Sleeve ☐POSE ☐ROSE ☐ Undecided
  ☐ Other _____
- ☐ Medically Supervised weight loss program (diets and/or pills)

WEIGHT HISTORY: **☐I prefer not to answer these questions.**

What was your birth weight? _____lbs _____ounces

How much did you weigh at 18 years old? _____ pounds

What is your highest lifetime weight? _____ pounds

Over the past 5 years, what was your **lowest** weight? _____ pounds

Over the past 5 years, what was your **highest** weight? _____ pounds

What is the most weight you have ever lost on a diet, with medication, and/or exercise? _____ pounds

At what age did you begin gaining excess weight? _____years old

If known, please provide a brief explanation for the weight gain at this time: _____

_____

_____

How much weight would you like to lose through this weight loss program? _____ pounds

If known, please provide a brief explanation for your decision to lose weight at this time in your life? _____

_____

_____

List three lifetime goals you wish to achieve after achieving a healthier weight:

1. _____
2. _____
3. _____

Please list any known food allergies: _____

Please list any vitamins, minerals, dietary supplements, fiber tablets, herbal medications, DHEA, or garlic pills: _____

_____

Name:_____ DOB:_____ Today's date:_____

Please list PREVIOUS DIET ATTEMPTS: ☐**I prefer not to answer these questions.**

Check Yes	DIET PROGRAM	Start Date	How many months? 1. Less than 3 months 2. 3-6 months 3. 7-12 months 4. 12-24 months 5. More than 24 months	What was the outcome? 1. No weight loss 2. Some weight loss 3. Loss desired weight, but regained it all 4. Loss desired weight, but regained it some of it back 5. Loss desired weight and has kept it off	Ability to lose weight? 1. Very difficult 2. Difficult 3. Moderately Difficult 4. Moderately Easy 5. Easy 6. Very easy
	Jenny Craig				
	Acupuncture				
	Prescription medications for weight loss				
	Doctor Supervised weight loss program				
	Nutri-System				
	Dieticians/Nutritionist				
	Weight Watchers				
	Sugar Busters				
	Atkins				
	LA weight loss				
	Medi Center				
	Optifast				
	Medifast				
	Other _____				

Describe your activity level (select one only)

- ☐ **Inactive**: no regular physical activity with a sit down job.
- ☐ **Light**: active during the day, but no organized physical activity during leisure time
- ☐ **Moderate** : Very active during the day, Occasionally involved in activities such as weekend golf, tennis, jogging, swimming, or cycling
- ☐ **Vigorous**: consistent lifting, stair climbing, heavy construction, etc or regular participation in jogging, swimming, cycling or active sports at least three times per week.
- ☐ **Very Vigorous**: participation in extensive physical exercise for at least 60 minutes per session, 4 times per week.

What type of exercise and how often do you participate in it currently? ☐**I prefer not to answer these questions**

Type of exercise	How many minutes a day?	How many days a week?

Name:_____ DOB:_____ Today's date:_____

NUTRITIONAL ASSESSMENT ☐**I prefer not to answer these question**

NUTRITION: Select the answer that best fits your eating pattern.	**How often do you eat this food?** 1. Rarely or never 2. Occasionally (2-3 times/month) 3. Sometimes (1-3 times/week) 4. Moderately (4-6 times/week) 5. Daily 6. More than once a day	**How difficult would it be to decrease this food?** 1. Extremely difficult/impossible 2. Difficult 3. Moderately difficult 4. Moderately easy 5. Easy 6. Very easy
Starch: bread, cereal, biscuits, potatoes, pasta, and rice		
Fried food (chicken, fish, French fries)		
Processed meat: Hamburgers, sausages, Bacon (> 2 slices), or canned meat		
Rich additives: butter, gravies, sauces, peanut butter, salad dressings, and mayonnaise		
Alcoholic beverages: 4 standard drinks for men or 2 for women		
Whole milk (1 cup), including milk coffee (cappuccinos, lattes, hot chocolates)		
Sweetened beverages (sweet tea, regular soda)		
Dessert: Ice cream, frozen yogurt, cookies, pie, cake, candy bars		
Salty snacks: chips, pretzels, and nuts		

ACTIVITY: Choose an answer that best fits your daily activity	**How often do you do the following activities?**	**How difficult would it be to decrease this activity?**
Use a computer for at least 2 hours a day		
Use the car when you could walk, cycle, or use public transport instead		
Use an elevator instead of taking the stairs for less than two floor		
Watch TV or videos for about 3 hours a day or more		
Usually try to find a parking spot as close as possible to the building		

BEHAVIOR: Choose an answer that best fits your daily routine.	**How often do you do the following activities?**	**How difficult would it be to decrease this activity?**
Eat out at fast food restaurant (Burger king, Wendy, McDonalds, etc..)		
Have a **second serving of food**		
Skip breakfast		
Snack after 8 pm		
Eat an unusually large amount of food in an uncontrollable manner		
Finish a meal within 10 minutes		
Eat more when stressed or emotional		
Eat more due to hunger all the time		
Purge after a meal to rid of food		

Name:_____ DOB:_____ Today's date:_____

MEDICAL CONDITIONS

Please indicate if you have had any of the following medical conditions:

HEART

- ☐ Coronary Heart Disease
- ☐ Coronary heart disease with Stent placement
- ☐ Coronary heart disease with heart bypass surgery
- ☐ Heart Attack, date:_____
- ☐ Congestive Heart Failure (fluid around heart)
- ☐ Atrial fibrillation
- ☐ PVC
- ☐ Other arrhythmias
- ☐ Cardiomegaly (enlarged heart)
- ☐ Cardiomyopathy weakened heart)
- ☐ Murmur
- ☐ Mitral valve prolapse
- ☐ Peripheral vascular disease (poor circulation)
- ☐ Superficial thrombophlebitis
- ☐ Deep vein thrombophlebitis
- ☐ DVT (bloodclot) of lower leg
- ☐ History of DVT of lower leg
- ☐ History of PE (pulmonary embolism)
- ☐ CVA (Stroke)
- ☐ TIA (mini Stroke)
- ☐ Hypertension (high blood pressure)
  Year diagnosed:_____
- ☐ High cholesterol
- ☐ High triglycerides

ENDOCRINE

- ☐ Diabetes, Type I (childhood onset), Year diagnosed:_____
- ☐ Diabetes, Type II (adult onset), Year diagnosed:_____
- ☐ Diabetes (type II) during pregnancy
- ☐ Diabetes (type II) with neuropathy (numbness or pain to feet)
- ☐ Diabetes (type II) with retinopathy (vision impairment)
- ☐ Diabetes Type II, Uncontrolled
- ☐ Glucose intolerance
- ☐ Hypothyroidism
- ☐ Hyperthyroidism (graves disease)
- ☐ Goiter
- ☐ PCOS (polycystic ovary disease)
- ☐ Infertility
- ☐ Cushings Disease
- ☐ Menstrual Irregularity
- ☐ Fibroids

PULMONARY

- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Pulmonary hypertension
- ☐ Pneumonia date of last episode:
- ☐ Oxygen dependent
- ☐ Obstructive Sleep Apnea
  Year diagnosed:_____
  CPAP/BiPAP setting:_____

GASTROINTESTINAL

- ☐ Hiatal hernia
- ☐ Peptic Ulcer
- ☐ Esophageal Stricture
- ☐ GERD (belching acid)
- ☐ Barrett's esophagus
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease
- ☐ Irritable Bowel Syndrome (colitis/spastic colon)
- ☐ Pancreatitis
- ☐ Hepatitis C
- ☐ Fatty Liver
- ☐ Cholelithiasis (gallstones)
- ☐ Liver Disease due to alcohol
- ☐ Chronic liver disease
- ☐ Cirrhosis of the liver
- ☐ Cirrhosis of liver due to alcohol
- ☐ Cirrhosis of liver due to Hepatitis C

MUSCULOSKELETAL

- ☐ Arthritis
- ☐ DJD (osteoarthritis)
- ☐ DJD of the Knee
- ☐ DJD of the Hip
- ☐ DJD of ankle/foot
- ☐ DJD of lower back
- ☐ Rheumatoid Arthritis
- ☐ Herniated disk
- ☐ Chronic back pain
- ☐ Chronic lower back pain
- ☐ Plantar fasciitis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Lupus
- ☐ Stasis Ulcers
- ☐ Osteoporosis
- ☐ Osteoporosis, Post menopausal

HEMATOLOGIC

- ☐ Anemia, nonspecific
- ☐ Anemia due to iron deficiency
- ☐ Sickle cell anemia
- ☐ Pernicious anemia
- ☐ Bleeding disorder
- ☐ History of abnormal platelet count
- ☐ HIV/AIDS

UROLOGIC

- ☐ Urinary stress incontinence (leakage of urine)
- ☐ Interstitial Cystitis
- ☐ Kidney Stones
- ☐ BPH (enlarged prostrate)
- ☐ Chronic kidney disease
- ☐ Chronic kidney disease requiring dialysis
- ☐ Chronic kidney disease due to diabetes
- ☐ Chronic kidney disease due to hypertension

PSYCHOLOGICAL

- ☐ Mild Depression
- ☐ Moderate Depression
- ☐ Major Depression
- ☐ Bipolar Disorder
- ☐ Suicidal Attempts
- ☐ Schizophrenia
- ☐ Anxiety
- ☐ Panic Attacks
- ☐ Psychiatric Hospitalization date:_____
- ☐ ADHD
- ☐ ADD
- ☐ Previous history sexual/ physical abuse
- ☐ Anorexia
- ☐ Bulimia
- ☐ Binge eating

OTHER

- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Lung Cancer
- ☐ Uterine Cancer
- ☐ Prostrate Cancer
- ☐ Other Cancer _____
- ☐ Cellulitis (skin infection)
- ☐ MRSA (resistant staph infection)
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Migraine headaches
- ☐ Pseudotumor Cerebri
- ☐ Panniculitis
- ☐ Excessive Abdominal Skin

☐ **I do not have any of these conditions.**

Name:_____ DOB:_____ Today's date:_____

REVIEW OF SYMPTOMS

Please indicate if you have had any of the following SYMPTOMS within the last month:

GENERAL
- ☐ Fevers
- ☐ Seizures
- ☐ Morning Headaches
- ☐ Snoring
- ☐ Daytime Drowsiness/Fatique
- ☐ Restless Sleep
- ☐ Witnessed Apnea (Stop breathing in sleep)
- ☐ Frequent Skin Infections Where:_____
- ☐ Bruising easily

GENITOURINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Urinary urgency
- ☐ Lack of bladder control
- ☐ Frequent urinary tract infections
- ☐ Frequent kidney stones

GASTROINTESTINAL
- ☐ Frequent vomiting (not related to a virus)
- ☐ Frequent diarrhea
- ☐ Frequent pains in stomach
- ☐ Frequent nausea
- ☐ Frequent constipation
- ☐ Blood in stools
- ☐ Heartburn

EYES, EARS, THROAT
- ☐ Double vision
- ☐ Visual changes due to diabetes
- ☐ Tearing
- ☐ Blind spots
- ☐ Bleeding gums
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Trouble or Pain with swallowing (787.90)
- ☐ Food sticking to chest or throat

NEUROLOGICAL
- ☐ Confusion
- ☐ Poor Balance
- ☐ Difficulty with speech or memory
- ☐ Numbness in extremities
- ☐ Frequent migraines
- ☐ Seizures

PSYCHOLOGICAL
- ☐ Depression
- ☐ Anxiety
- ☐ Panic attacks

HEMATOLOGY
- ☐ Easy bruising
- ☐ Bleeding tendency

MUSCULOSKELETAL
- ☐ Neck Pain
- ☐ Ankle pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Foot pain
- ☐ Herniated / bulging disc
- ☐ Weakness in any muscles
- ☐ Back Pain

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Swelling of ankles
- ☐ Lower extremities swelling
- ☐ Shortness of breath on exertion
- ☐ Palpitations
- ☐ Irregular heartbeat/skipping
- ☐ Arm numbness and tingling
- ☐ Abnormal EKG

RESPIRATORY
- ☐ Coughing
- ☐ Frequent wheezing
- ☐ Shortness of breath
- ☐ Frequent Pneumonia
- ☐ Blood in sputum
- ☐ Oxygen Dependent

ENDOCRINE
- ☐ Excessive urinating
- ☐ Excessive Drinking
- ☐ Thyroid Nodules

SKIN
- ☐ Frequent rashes
- ☐ Frequent boils
- ☐ Frequent irritation under skin folds

FEMALE ONLY CONDITIONS
- ☐ Using birth control pills
- ☐ Method of birth control: _____
- ☐ Menstruating
- ☐ Heavy Menstruation
- ☐ Approximate Date of last period: _____
- ☐ Menopausal
- ☐ Nipple discharge
- ☐ Vaginal discharge
- ☐ Using estrogen
- ☐ Last Pap Smear _____ (year)
- ☐ Last Mammo _____ (year)

☐ **I do not have any of these conditions.**

Name:_____ DOB:_____ Today's date:_____

EPWORTH SLEEPINESS SCALE

Please complete the following questions to determine if you have symptoms of SLEEP APNEA.

☐I prefer not to answer these questions

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

Situation	Chance of Dozing			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting inactive in a Public Place	0	1	2	3
Sitting quietly after a lunch (i.e. movies, meeting) without alcohol	0	1	2	3
In a car, while stopping for a few minutes in traffic	0	1	2	3

0= Would never doze off
1= Slight chance of dozing
2= Moderate chance of dozing
3= High chance of dozing

Score: _____

FAMILY HISTORY

Please indicate if you have the following medical conditions in your family:

- ☐ High blood pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Colon Cancer
- ☐ Eating disorders
- ☐ Obesity
- ☐ Diabetes
- ☐ Sleep Apnea
- ☐ Breast Cancer
- ☐ Premature heart disease (heart attack before age 50)

Name:_____ DOB:_____ Today's date:_____

MEDICATIONS

Please list ALL medications you currently use, including dose, frequency, and reason for use. Please be accurate and use your prescription bottles to assist you with the spelling.

Medication	Dose and Frequency	START DATE	Reason Prescribed

Please list ALL **Vitamins and Supplements** you are currently taking:

Vitamins and supplements	Brand Name	Dose and Frequency

Are you allergic to any medications? _____

_____

Name:_____ DOB:_____

SOCIAL HISTORY
Please complete the following information:

☐ I am currently smoking

How many a day? _____

How many years have you been smoking? _____

☐ I am no longer using tobacco products.

Quit date: _____

Years of use _____

**** It is recommended that you quit all tobacco products at least 2 weeks before surgery to reduce the risk of complications****

Do you use alcohol?

1.	Never	3.	Once per week	5.	Every day
2.	Once per month	4.	More than once per week	6.	In the past

☐ Prior treatment for substance abuse/chemical dependency (drugs or alcohol)

Recovery program completed date;_____

☐ Prior use of marijuana or cocaine.

How long drug/alcohol free? _____

☐ Unable to walk 200 feet without assistance.

Do you use? ☐Cane ☐Walker ☐Wheelchair

☐ I am bed-ridden