

INFORMATION PACKET

INITIAL APPOINTMENT



WELCOME TO LIFEWEIGH BARIATRICS

Everyone at LifeWeigh Bariatrics (LWB) is looking forward to your first visit to our center and to help you achieve your weight loss goals. Whether you decide to use your insurance plan or finance the cost of weight loss surgery, it is not an easy task. We would like to be your partner to help simplify the process. We have gathered as much information as possible to help you get started.

If you have questions please call us at **866-922-4LWB (4592)**.

Our Staff practices a comprehensive holistic team approach with multi-disciplinary medical caregivers who participate in the diagnosis and ongoing treatment of overweight patients. Our mission is to assist each patient in achieving their weight loss and health objectives through comprehensive care and education of unmatched quality and value.

**Please fill out and
bring this
completed packet
to your first
appointment**

INTRODUCING THE LIFEWEIGH STAFF:

Bariatric Surgeon: Dr. Jeffrey Rosen is the lead surgeon for LWB. He is board-certified in general surgery and has been in practice for over 13 years. Dr. Rosen has taught Bariatric surgery to many surgeons around the country. He has been involved in almost 1000 weight loss surgeries. He has also served as Co-medical director in the Trauma department at Good Samaritan Hospital in the past. His dedication to advancing knowledge of surgical techniques and technology are reflected in his active memberships in various medical associations including American Society of Bariatric Surgery, the Society for Critical Care Medicine, the Society for American Gastrointestinal Endoscopic Surgeons, and the Chicago Medical Society. In the academic arena, Dr. Rosen is an Affiliate Clinical Instructor at the Midwestern University College of Osteopathic Medicine, and his research has been published in various medical publications, including the Journal of Trauma and Surgical Endoscopy. Dr. Rosen received his medical degree from the University of Illinois at Chicago, where he also served his residency.

Bariatric Surgeon: Dr. Allen Mikhail is a surgeon at LifeWeigh Bariatrics with special interests in Laparoscopic Roux-en Y Gastric Bypass, Adjustable Gastric Banding, Sleeve Gastrectomy, Gastrointestinal Surgery and Endoscopic procedures. His specialized training in Advanced Laparoscopic and Bariatric Surgery at the Cleveland Clinic shows his dedication to minimally invasive surgery and committed interest in the treatment of obesity. He is board-certified in surgery by the American Board of Surgery. He has been the investigator on many research grants and has published numerous papers, abstracts and book chapters related to nutrition, laparoscopic gastrointestinal and bariatric surgery. Memberships in professional and scientific societies include the American College of Surgeons, Society of Laparoendoscopic Surgeons, American Society for Metabolic and Bariatric Surgery (ASMBS) and Society of American Gastrointestinal and Endoscopic Surgeons (SAGES).

Certified Bariatric Nurse and Patient Care Liaison: Barb MacTaggart, RN, BSN, CBN has been with our bariatric group for over 5 years and has over 20 years experience in the nursing field. She has taught many nurses, medical assistants and other professionals on the care required for our patients. Recently, Barb completed her bariatric nursing certification from the American Society for Metabolic and Bariatric Surgery.

Registered Nurse and Patient Care Liaison: Linda Tsampis, RN, MA, MFT is our nurse and patient care coordinator for the Merrillville, Indiana office. Linda received her degree in Nursing from Indiana University. She received a Masters Degree in Marriage and Family Therapy, is a Doctoral Candidate, and completed all but her dissertation at the Adler School of Professional Psychology in Chicago, Illinois. With over twenty-five years in the medical field, Linda has combined her extensive background in Behavioral Health with the field of nursing. She has specialized for the past ten years in Disease Management, counseling individuals to be the best they can be in body, mind, and spirit.

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Administrative Assistant and Insurance Specialist: Barbie Bartolomei has been working for us in an administrative capacity for over 1 year including the functions of marketing, front office work and patient advocate. Barbie also assists patients in the insurance process.

Administrative Assistant and Cardio Technician: Anne Grusak, CCT is a Certified Cardiology Technician with a background in echocardiology which she earned from the Allied Health Institute in Merrillville, Indiana. She is also trained in CLSI Venipuncture and Skin Puncture Procedures through Cross Country Education. Anne worked in cardiac rehabilitation before joining the LifeWeigh team in 2007.

Patient Advocate: PJ Stough joined the LifeWeigh team in October of 2009. PJ had gastric bypass surgery July 21, 1999 and lost 162 pounds. Inspired by the way surgery changed/saved her life, she began working with bariatric patients on an informal basis. In 2002, she joined The Kane Center as their Bariatric Coordinator where she worked with patients, conducted informational seminars and ran support groups. PJ has also worked as a manager of a weight loss program in Arlington Heights and started a Lap-Band program at a surgery center in Chicago. She is a Certified Support Group Leader and a member of the American Society for Metabolic and Bariatric Surgery (ASMBS) and the Obesity Action Coalition (OAC). For the past five years, she has also served as the Chairperson for the Northern Illinois Walk from Obesity.

Practice Manager: Gail R. Rosen, RN, BSN, MBA, MS is our practice manager and has extensive clinical experience in the Intensive Care Unit, Cardiac Care Units at several hospitals in Indiana and Illinois. Gail has received a Master of Science and Master in Business Administration from University of St Francis.

Dietitian: Sherrill Johnson, RD, LDN, CPT has over twelve years of experience educating and counseling patients in the area of weight management. Sherrill did her undergraduate degree in Food and Nutrition at the University of Illinois at Champaign-Urbana and completed her dietetic internship at Hines VA Hospital. Sherrill is also passionate about fitness and has recently earned her personal training certificate.

Dietitian: Dana Petersen, MS, RD, LDN is a registered and licensed dietitian who has a passion for nutrition, exercise and people. She has clinical experience in weight management and bariatric surgery. She enjoys giving presentations and developing new ways to make nutrition easy to understand and implement. Dana graduated from Purdue University and completed her dietetic internship at the University of Houston. Dana recently earned her Masters Degree in Nutrition and Wellness from Benedictine University. She has also attained a certificate of training in Adult Weight Management through the American Dietetic Association.

Exercise Physiologist: Joey Bonavota, MS has been working in the field of bariatrics since 2002. He is an alumni of Eastern Illinois University, where he received both his Bachelor and Masters degree in the field of exercise science. He has also gained practical experience in the field of cardiac rehabilitation. When his is not working in the clinic, you can usually find him promoting various clothing lines, hosting parties and events, and modeling in hair and fashion shows. Joey brings a unique prospective into the field of exercise science through these previous endeavors. He has a restless schedule but he wouldn't want it any other way.

Congratulations on beginning your weight loss journey. We look forward to seeing you soon.

FIRST APPOINTMENT CHECKLIST

Please bring the following items to your first appointment.

Please bring the following documents to your first visit:

- Completed Patient Questionnaire (attached to this document). This information helps LWB customize a weight loss program especially for you.
- Insurance Card and related information: Please call your insurance company before your first visit to inquire about benefits for weight loss surgery. Please document the date, time you called and who you spoke with. The insurance section of this packet is important to getting your weight loss surgery approved. The more information you can help us provide to the insurance company, the more likely they will approve surgery.
- Please include a summary and documentation (if available) of all weight loss attempts
 - If you have been to a non-physician specialist or program that may of instructed you on dieting or healthy eating habits please obtain all notes (even if they are just notes documenting your weight) from your past visits. Notes from the past 5 years only are needed.
Example:
 - Visits with a Registered dietitian
 - A supervised weight loss program such as Jenny Craig or Weight Watchers
- Provide recent office notes from your Primary Care Physician
- Provide consultation notes from any other medical specialist you have seen (i.e. Cardiology, Orthopedic, and Pulmonary)
 - **Physician Specialist Notes**
If you have been to a specialist to treat any weight-related symptoms, please try to gather the doctor's notes from your past appointments. Notes from only the past 5 years are needed. We listed the following specialists as examples:
 - Cardiologist: a specialist dealing with any conditions involving the heart and heart problems.
 - Endocrinologist: A specialist dealing in the diseases of glandular organs, such as diabetes. The only notes needed would be if you have a history of diabetes or thyroid problems; you do not need to gather notes if you have other types of glandular problems.
 - Pulmonologist: A specialist dealing with your respiratory tract or lungs, such as asthma.
 - Orthopedic surgeon: A specialist dealing with bones, such as back, knee or foot pain.
 - Neurologist: A specialist who diagnoses and treats disorders of the nervous system.
- Recent labs and test results from physical exams and other related tests
 - **Medical Test Results**
The following tests are helpful in evaluating your health. Please review the list and bring in any test results that you may have already had in the past year. If you do not have current tests, we will ask that you make an appointment with your primary care doctor to gather the necessary results before or soon after your first appointment.
FEMALES
Pap Smear
If you are 18 years old or younger you do not need this test
If you are older than 18 years of age and are sexually active
If you are older than 35 years of age and are not sexually active
Breast Exam
If you are less than 20 years old you do not need this test
If you 20-39 years old you need a breast exam within the past 3 years
If you are 40 or greater your breast exam must be less than 1 year old
Mammogram
If you are 39 years old or younger you do not need this test
If you are older than 39 years of age, please provide results of this test
MALES AND FEMALES
Rectal Exam
If you are 49 years old or younger you do not need any tests
If you are older than 49 years of age you need one of the following:
 - A rectal exam less than 1 year old; or
 - A sigmoidoscopy less than 5 years old; or
 - A colonoscopy less than 10 years old

IMPORTANT INSURANCE INFORMATION

LWB is a partner with you in the insurance approval process. We will help you in this process using our experience. At your first visit, please have as much documentation as possible. At that point, we will review your documentation and contact your insurance carrier to begin the approval process.

- If you have an HMO/EPO/POS insurance plan, please make sure that you obtain an authorization letter from your primary care physician before your first visit.
- If your insurance has been approved for Gastric Bypass or LAP-BAND® surgery elsewhere, please notify us as this will speed up your insurance approval process.
- LWB is not in-network with all managed care plans. However, many policies have out-of-network benefits. Contact your insurance company for a full explanation of benefits.
- The hospital is most likely in-network with your insurance plan, which means your insurance policy will most likely cover a substantial amount of the hospital bill.
- LWB will bill your insurance company for the first appointment. Insurance companies frequently pay for clinic visits even if they deny surgery later.
- If you are a surgical candidate, a deposit or support fee may be required at your pre-operative visit.

*If you have questions, please call us at **866-922-4LWB (4592)**.*

Financing: If you do not have insurance or if your insurance carrier will not cover weight loss surgery, you can look to LWB for help. Financing your surgery offers many advantages such as fixed rates and a simple application process. Please call us at 866-922-4LWB (4952) or ask us at your first visit.

Below is a list of other options that could be available to you.

- Withdrawal from savings or investment accounts
- Loan from 401K plan
- Loan from life insurance policy
- Loan from friend or relative
- Advance or loan from employer
- Tax refund
- Credit cards
- Home equity loan

You will be responsible for the cost of your first visit at the time services are rendered.

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LifeWeigh Bariatrics
Healthy Living Through Teamwork

PATIENT INFORMATION RECORD

Please complete prior to your first appointment.

Patient Name: _____
Last Name First Name Middle Initial

Social Security Number (SSN#): _____

Home Address: _____

City/State/Zip Code: _____

Date of Birth: _____ Age: _____ Sex: Male ___ Female ___

Marital Status: Married ___ Single ___ Divorced ___ Widowed ___

Home Phone: (____) _____ Work Phone: (____) _____

Cell Phone: (____) _____ Other (____) _____

E-mail: _____

Referred By: _____ (if physician, full name)

Best number to be reached during the day (please circle one):

Home Work Cell Other

PRIMARY INSURANCE INFORMATION (PLEASE PROVIDE CARD)

Medicare HMO PPO No insurance / Self pay Other _____

Subscriber's Name: _____
Last Name First Name

Subscribers Social Security # _____

Subscriber's Date of Birth: _____

Policy ID#: _____ Group#: _____

Subscriber's relationship to Patient: _____

SECONDARY INSURANCE (IF APPLICABLE)

Medicare HMO PPO No insurance / Self pay Other _____

Subscriber's Name: _____
Last Name First Name

Subscribers Social Security # _____

Subscriber's Date of Birth: _____

Policy ID#: _____ Group#: _____

Subscriber's relationship to Patient: _____

REFERRAL INFORMATION

Referring Physician: _____

Phone Number: _____

Primary Physician (if different from above): _____

Phone Number: _____

Is your insurance through your Employer? ___ Yes ___ No

If yes, Name of Employer: _____ Are you full-time or part-time?

DRIVER'S LICENSE

Drivers License Number: _____

State: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone number: _____

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MEDICARE PATIENTS, PATIENTS WITH A MANAGED CARE INSURANCE, PRIVATE INSURANCE OR NO INSURANCE, PLEASE SIGN THIS SECTION

COMMERCIAL INSURANCE, MANAGED CARE AND SELF INSURED MEMBERS LIFETIME AUTHORIZATION

I authorize the release of any medical information necessary to process my insurance claim(s). I assign and request that benefits payable for physician services be made directly to LifeWeigh Bariatrics. I request that this authorization apply to all insurance claims, present and future, for this physician group.

I understand that I am responsible for payment of any balance not paid by my insurance company.

DATE _____ PRINT PATIENT (OR INSURED'S) NAME _____

SIGNATURE OF PATIENT (OR INSURED) _____

PLEASE BRING REFERRAL AND INSURANCE CO-PAY (IF APPLICABLE) TO THE FRONT DESK WHEN RETURNING THIS FORM. THANK YOU.

Release of Information: I authorize the release of any medical information necessary to process this claim or provide medical information to any physician or medical facility.

Printed name: _____

Signed by Patient or authorized Guardian: _____

Date: _____

Specific release for mental health, drug or alcohol abuse or HIV information:

1) I hereby specifically authorize information that may include mental health, drug or alcohol abuse or HIV and related diseases, to release any and all information contained in my past or current medical records to the persons and organizations and for the purpose stated in Release of Information above.

2) By initialing the diagnosis(es)/condition(s) below, I do not consent to the release of such medical information, if any, to third party payors and understand I am personally responsible for payment.

Mental Health _____ Drug and Alcohol Abuse _____ HIV _____

Disclosure is limited to:

1) Records regarding admission and treatment for the following medical condition or injury:

2) Records for the period (dates) from _____ to _____

3) The following specified information: _____

4) No limitations placed on dates, history of illness, or diagnostic and therapeutic information.

Consent for Treatment:

I (we) voluntarily request treatment from Dr. Rosen and his associates for the treatment of my condition. This treatment may include physical exam, blood tests, EKG, pulmonary function test, urinalysis, Lap Band adjustment, wound/incision care.

I allow Dr. Jeffrey Rosen and LifeWeigh to enter my medical information into the quality improvement module for a clinical integration program if Dr. Rosen or his appointee feels this is appropriate. This information allows physicians to determine quality of care while providing privacy protection for the patient.

Signature of patient _____ Date _____

Printed name of patient _____

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LIFEWEIGH BARIATRICS PATIENT QUESTIONNAIRE

The Patient Questionnaire is designed to help us understand your weight loss history and customize a weight loss program especially for you.

Directions: Please **print legibly** and bring to your first appointment

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

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

Ethnicity: Caucasian African American Hispanic or Latino Native American or Alaskan Native
 Asian or Pacific Islander Other: _____

Occupation: _____

How far by car (in hours or minutes) is your home from our office? _____

How did you first hear about LWB Center (please circle all that apply)?

Other Patient Doctor TV Radio Newspaper Internet

Other: _____

If you first heard about us from a doctor, what is the name, phone number, address and specialty of the doctor?

Name: _____ MD or DO

Physician Information: Please list all doctors that you have seen and helping in your care:

| Name MD or DO or other (NP, PA) | Address | Phone | Specialty Primary or other Please list type | Do you want us to send an Update Letter to this doctor |
|----------------------------------------|---------|-------|---------------------------------------------------|-----------------------------------------------------------------|
| | | | | |
| | | | | |
| | | | | |

Date of Last Annual Physical exam with your doctor: _____

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Weight/Diet History

1. At what age did you start to become overweight? _____
2. What was your weight ranges between the ages of 15 and 20? Minimum _____ Maximum _____
3. What has been your weight during the past 5 years? Minimum _____ Maximum _____
4. What has been your weight during the past 1 year? Minimum _____ Maximum _____
5. What has been the maximum weight you have ever weighed? _____
6. Please circle how many times have you tried an unsupervised (those that you do on your own) diets in your life? Try to make an educated guess if you do not know the exact amount of times.

0 1-5 6-10 11-25 26-50 50-100 >100
7. List the supervised diet plans you have tried in your life (supervised diets include the following: Physician/dietitian supervised diet, Weight Watchers, Medifast, Optifast, LA Weight Loss center, Jenny Craig and others). Do not list unsupervised diets like Atkins, Slimfast, or anything else that you have done on your own.

| Year | Supervised | Diet Name | Duration 3,6,9 months etc. | Wt. Lost | Wt. Regained Y or N | Documentation Available Y or N |
|------|------------|-----------|-------------------------------|----------|------------------------|--------------------------------------|
| | | | | | | |
| | | | | | | |
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8. Please list below any medication you have tried including: Phen-fen, Phenteramine, Meridia Redux, Xenical, or Metabolife.

| Year | Supervised | Diet Name | Duration 3,6,9 months etc. | Wt. Lost | Wt. Regained Yes or No | Documentation Available? Yes or No |
|------|------------|-----------|-------------------------------|----------|---------------------------|------------------------------------------|
| | | | | | | |
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9. What is the most weight you have lost during any diet program? _____

OB\GYN History

10. If female, please answer the following questions.

- a. How many times have you been pregnant? _____
- b. How many live births? _____
- c. Do you have Polycystic Ovarian Syndrome? YES or NO
- d. After childbirth, has your weight: increased stayed the same decreased
- e. What type of birth control method do you use? _____
- f. If you are pre-menopausal, do you have any problems with your periods?
(Note, if you are on birth control pills or shots to regulate your periods check yes)

YES or NO

If yes, please circle: Heavy Painful Irregular -Describe _____

- g. If you are post menopausal are you on hormone replacement therapy? YES or NO
- h. Have you ever had problems with infertility? YES or NO

If yes, please describe: _____

- i. Please give the last date(Month/Year) had the following exams:
Pelvic exam ___/___/___ Breast exam ___/___/___
Mammogram ___/___/___ Pap Smear ___/___/___

If any were abnormal please explain: _____

Family History

11. What percentage of people on your mother's side of the family are overweight? _____%
12. What percentage of people on your father's side of the family are overweight? _____%
13. Does anyone in your **family** have the following:

| Disease | YES or NO | What relationship to you | Further explanation |
|-----------------------------------------------------------------|-----------|--------------------------|---------------------|
| Diabetes | YES or NO | | |
| Thyroid | YES or NO | | |
| Adrenal | YES or NO | | |
| Heart | YES or NO | | |
| Hypertension | YES or NO | | |
| Abnormal Cholesterol/Triglycerides | YES or NO | | |
| Cancer | YES or NO | | |
| Bleeding or Clotting disorders Blood clots or heavy bleeding | YES or NO | | |
| Other major diseases | YES or NO | | |

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Exercise History

14. Do you exercise routinely? YES or NO

If yes, please answer the following:

Frequency (how often) _____

Intensity circle one light somewhat hard hard {heavy} very hard

Time (minutes) _____

Type (walk, bicycle, etc.) _____

How long have you been doing this program? _____

15. If you do not exercise, what is your primary limitation that makes exercise difficult?

_____ Lack of Time _____ Lack of Motivation _____ Lack of access to equipment

_____ Physical pain (please describe) _____

_____ Other (please describe) _____

16. What exercise equipment do you have available? *Circle all that apply.*

Home Equipment:

Treadmill Stationary Bike Rowing Machine Pool
Elliptical Gazelle Aerobics Videos Other _____

Fitness Center Membership? YES or NO

Curves Membership? YES or NO

17. How far can you walk without having difficulty? *Please circle one.* < 1 block <1/2 mile <1 mile >1 mile

When you go past this distance what limits your ability to continue? _____

Please rank these in terms of severity (0→5) with "0" being minimal and "5" being severe:

Shortness of breath _____ Chest pain _____ Fatigue or tired _____

Muscular pain in calf or thigh _____ Pain in joints (which ones) _____

Other _____

How many stairs can you climb without difficulty? _____

Medical History

18. Do you have asthma, bronchitis, cough, shortness of breath or wheezing, or any other lung problems? YES or NO

If yes, do you use inhalers? YES or NO

If yes, how often: daily 2x/day 3x/day only as needed Other _____

19. Do you have any heart problems: Tachycardia, Fast heart rate, irregular heart rate or chest pain? YES or NO

If yes, please describe: _____

20. Have you had any heart tests besides EKGs? YES or NO

If yes, please describe: _____

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21. Do you have any of the following significant stomach or intestinal problems? *If yes, then please describe:*

| | | Description |
|----------------------------------------------|-----------|-------------|
| Stomach/Esophageal Ulcers or other disorders | YES or NO | |
| Gastritis | YES or NO | |
| Hiatal Hernia | YES or NO | |
| GERD, Heartburn, Reflux | YES or NO | |
| Crohn's Disease | YES or NO | |
| Irritable bowel syndrome | YES or NO | |
| Chronic Diarrhea | YES or NO | |
| Other: | | |

22. Have you had any pain in the upper part of your stomach when you eat greasy or spicy foods (gall bladder symptoms)? YES or NO *If yes, please describe:* _____

23. Have the whites of your eyes ever turned yellow (jaundice)? YES or NO
If yes, please describe: _____

24. Have you ever had an Upper GI (where you swallow barium to see what your stomach looks like) or an upper endoscopy (where a scope is placed down your throat in order to look at your stomach) or Lower GI or lower endoscopy (colonoscopy or other exam)? YES or NO
If yes, please list the tests and dates and results: _____

25. Do you have any problems with your back? YES or NO
If yes, please describe location and pain type: _____
Is the pain associated with weight gain or previous accident/injury? _____

26. Do you have any of the following problems? *If yes, please explain:*

| | | |
|----------------------------------------------------------|-----------|--|
| Hip or pelvic pain | YES or NO | |
| Knee problems | YES or NO | |
| Varicose veins | YES or NO | |
| Ankle or foot swelling | YES or NO | |
| History of blood clots in the legs (DVT) | YES or NO | |
| History of blood clots in the lungs (Pulmonary Embolism) | YES or NO | |
| Bleeding problems: excessive bleeding or easily bruised | YES or NO | |
| Other: | | |

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27. Do you have any problems with your skin (rashes, irritations or infections) due to your weight? YES or NO
If yes, please describe: _____

28. Do you have any problems with your bladder leaking urine if you cough, sneeze or strain? YES or NO
If yes, please describe: _____

29. Have you had any problems with your thyroid? YES or NO
If yes, please describe: _____

30. Do you have diabetes? YES or NO
If yes, how many years: _____

31. Do you have high blood pressure? YES or NO
If yes, how many years: _____

32. Do you have a known problem of an elevated cholesterol, triglycerides or elevated LDL?
YES NO UNKNOWN

33. Do you have problems with Sleeping Disturbances (Please circle all the following that occur):

| | | |
|-----------------------------------------------------------------------------------------------|---|---|
| Do you have Sleep apnea (stop breathing for 10-15 seconds)? Witnessed or by a sleep study? | Y | N |
| Do you have loud snoring? | Y | N |
| Have you fallen asleep while driving a car? | Y | N |
| Have you fallen asleep while at school or work? | Y | N |
| Can you make it through an average day without taking a nap? | Y | N |
| Do you wake up at night to urinate? | Y | N |
| Have you woken up choking/coughing/gasping for air? | Y | N |
| Do you typically wake up with headaches in the morning? | Y | N |
| Are you chronically tired? | Y | N |
| Do you toss and turn at night? | Y | N |
| Are you on a CPAP or BiPap Machine? | Y | N |

34. Please summarize your known medical problems (such as diabetes, high blood pressure, etc.)

| Medical Problem(s) (e.g. diabetes, high blood pressure) | How long have you had the condition(s)? |
|------------------------------------------------------------|-----------------------------------------|
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35. Please summarize all of your past surgeries:

| Type of Surgery | Year | Any complications? If so, please describe |
|-----------------|------|-------------------------------------------|
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| | | |

36. Please list your current medications including: inhalers, birth control pills/shots, over-the-counter medications, vitamins, minerals and herbal supplements.

| Name of medications | Dosage | How frequently do you take this medication in a day? |
|---------------------|--------|------------------------------------------------------|
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37. Do you have allergies to any medications? YES or NO

If yes, please list the medications: _____

38. Have you been on any kind of steroids in the last 12 months? YES or NO

If yes, please list: _____

39. Are you currently smoking? YES or NO *If yes, how many cigarettes per day?* _____

If yes, how long have you been smoking? _____ yrs

40. Have you ever smoked? YES or NO *If yes, how long ago did you quit?* _____

Psychological History

41. Have you seen a mental health professional such as a psychiatrist or psychologist for treatment in the last 2 years? YES or NO

Have you been hospitalized for a psychiatric condition in the last 2 years? YES or NO

If yes, please describe: _____

42. In the past two years have you:

- Experienced severe anxiety or panic attacks? YES or NO
- Experienced feelings of depression? YES or NO
- Are you on any medications for depression, anxiety, or other psychological reasons? YES or NO

If yes, please list those medications: _____

Diet History

43. How many meals do you consume per day? _____ How many snacks? _____

Do you prefer sweets over other types of food? YES or NO

Other: _____

44. Do you have any food allergies? YES or NO If yes, please list _____

45. Do you (*circle all that apply*): Over eat Over Indulge or binge eat?

Note: (Over eating is when you plan to eat a normal amount and you overeat but not to the point of feeling like you may vomit. Over indulgence is when you plan to eat too much but not to the point of wanting to vomit. Binge eating is defined as eating a large amount of food during a short period of time, typically no more than 2 hours, **while feeling out of control to stop eating.**)

Do you purge (make yourself vomit after a meal)? YES or NO

If yes, how often? _____

46. How many soft drinks/sodas do you consume per day? Diet _____ Regular _____

47. How many cups of coffee or tea do you consume per day? _____ cups of coffee _____ cups of tea

Do you add (*circle all that apply*): sugar artificial sweeteners creamer

48. Do you consume (drink) alcohol? YES or NO If yes, how often? _____

49. How much water do you drink per day? _____

50. How often do you eat at a fast food restaurant? _____ At a table service restaurant? _____

Thank you. We are looking forward to working with you.
Please call us with any questions 866-922-4LWB (459)