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 and health goals. Whether you decide to go the surgical route, or the non-surgical route, managing weight is not an easy task. We would like to be your partner to help you decide which path is best for you, and to support you along every step of the way. 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 patients who struggle with weight. Out 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 complete this packet and return to the office before your first appointment.

Due to high patient demand and limited availability of appointments, we have instituted a $250 no-show fee. You must give advance notice to cancel or reschedule your initial consultation.

Also, please note: Any future appointment no-shows (after your initial consultation) will result in a $50 fee.

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

FIRST APPOINTMENT CHECKLIST

Please bring the following documents to your first visit:

- ☐ Completed Patient Questionnaire (you must return this portion prior to your appointment). This information helps LWB customize a weight loss program especially for you.
- ☐ Insurance Card and related information (you must return this portion prior to your appointment): 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 have 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 and consultation notes from any other medical specialist you have seen (i.e. Cardiology, Orthopedic, and Pulmonary)

☐ 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.

Labs
Please bring any bloodwork you have had done with your Primary Care Provider or any specialists you have seen in the past year

EKG
Please bring a copy of your EKG and any other cardiac tests you have had in the past year.

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 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, if you are a surgical patient.
- LWB will bill your insurance company for the first appointment. Insurance companies frequently pay for clinic visits even if they deny surgery later.
- A $300.00 program fee will be required at your initial one-on-one 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 or obesity treatment, 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.

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

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 ___

Martial 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:_____

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 the LifeWeigh Medical Team for the treatment of my condition. This treatment may include but is not limited to: physical exam, blood tests, EKG, pulmonary function test, urinalysis, Lap Band adjustment, wound/incision care.
I allow the LifeWeigh Team to enter my medical information into the quality improvement module for a clinical integration program if the LifeWeigh Medical Team feels this is appropriate. This information allows physicians to determine quality of care while providing privacy protection for the patient.
I allow the LifeWeigh Team to download my medications from the Electronic Medical Record retrieval system.

Signature of patient_____ Date_____
Printed name of patient_____

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****.*

Name: _____ Date: _____

City: _____ State: _____

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, or NP or PA

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)*	The Primary Care Doctor will always get update letter. Do you want us to send an update letter to any of the following doctors?
				Yes or No
				Yes or No
				Yes or No

Date of Last Annual Physical exam with your doctor: _____

Pharmacy Information

Pharmacy Name (i.e. Walgreens, Target, etc): _____

Pharmacy Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

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

8. Please list below any medication you have tried including: Phen-fen, Phentermine (Adipex), Phendimetrazine (Bontril), Diethylpropion, Meridia Redux, Xenical, Contrave, Saxenda, Belviq, Orlistat, Alli, or Metabolife.

Year	Medication	Side Effects	Duration 3,6,9 months etc.	Wt. Lost	Wt. Regained Yes or No	Documentation Available? Yes or No

9. What is the most weight you have lost during any diet program? _____

10. Which diet program, including unsupervised programs (such as Atkins, Whole 30, SlimFast, calorie counting, etc) has worked best for you? _____

OB\GYN History

11. 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. Are you pregnant? YES or NO If yes are Breastfeeding? YES or NO.

    ii. Date of your last menstrual period:_____

Family History

12. What percentage of people on your mother's side of the family are overweight? _____%

13. What percentage of people on your father's side of the family are overweight? _____%

14. Does anyone in your **family** have the following:

Disease		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		

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 inhaler*s? 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: _____

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) History of blood clots in the lungs (Pulmonary Embolism)	YES or NO YES or NO	
Bleeding problems: excessive bleedir or easily bruised	YES or NO	
Other:		

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)?

35. Please summarize all of your past surgeries:

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

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?

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?* _____
If yes, how many packs per day on average? ½ 1 2
If yes, how long did you smoke? _____ yrs

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
- Any history of substance or alcohol abuse? YES or NO
- Do you use any recreational or street drugs? YES or NO

Nutrition 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. Do you drink any other beverages (juice, milk, etc?) _____

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

Typical Diet: Please Describe your most common eating and drinking habits for each category. Enter "0" if you do not eat or drink during that meal or snack

Meal/ Snack	**Time of Day**	**Typical foods eaten/ beverages drank and who prepared food (ex: self, spouse, restaurant, cafeteria, fast food, etc)**
Breakfast		
Morning snack		
Lunch		
Afternoon snack		
Dinner		
Evening snack		
Late night snack		
Grazing (small amounts throughout day)		

Do you have any barriers when it comes to eating choices (financial, time, cooking skills, etc)? YES or NO.

If "YES", please elaborate: _____

Social History:

52. What are your typical work hours?
    _____
53. Do you travel for your job? YES or NO _____
54. Who lives at home with you?_____
55. Do you feel like you have good social support for your weight journey? YES or NO. If "Yes", who are your primary support people? _____
56. Do you use any recreational drugs: YES or NO. If "Yes", what kind, and how many times per week?
    _____

Specific to Weight Loss Medications:

57. Do you have a History of:
    a. Seizures: YES or NO
    b. Glaucoma: YES or NO
    c. Cardiovascular disease: YES or NO
    d. Eating Disorder: YES or NO
    e. Substance abuse? YES or NO
    f. Pancreatitis? YES or NO

58. If you answered "Yes" to any of the above questions, please elaborate:
    _____
    _____

59. Do you or anyone in your family have a history of medullary thyroid cancer or MENII? YES or NO

Stress

60. On a scale from 1-10, how would you rate your average stress levels currently? _____
61. What are some of the major stressors in your life? _____
62. How do you cope with stressors in your life? _____

Goals

63. How is your weight affecting your life?
    _____
    _____
    _____
64. What is your goal for this program?
    _____
    _____
    _____

65. What are some of your barriers that have prevented you from achieving your weight goals in the past (example: hunger, cravings, stress, time, lack of knowledge, etc)?

_____
_____
_____

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