



Authorization of Attendance at Informational Seminar & Return of Medical Records Policy

By signing this form I verify that I have attended the informational seminar presented by Dr. Stanley Hoehn or Dr. Christopher Kowalski. Attendance includes **arrival at the scheduled beginning of the seminar and presence until the end of the Power Point presentation by the surgeon.** With my signature, I agree that my questions about the procedures have been answered and my expected participation with the program guidelines is understood. With my signature, I agree that it is understood that any medical records obtained for determination of qualification for surgery **will not be returned to me** if I am not a candidate for surgery with this program. The records will be destroyed 30 days after notification of non-candidacy.

Name (printed) _____

Signature _____

Today's Date _____ Date of Seminar Attendance _____

Surgeon Preference (circle): Stanley Hoehn Christopher Kowalski

PRIMARY CARE PHYSICIAN

 Doctor's Name Degree (MD or DO)

 Doctor's Address City State Zip Code

 Doctor's Phone Fax Number –if known Medical Specialty

How long has this doctor provided your medical care? _____

Please list the name, phone number and specialty of your other Health Care Providers:

Name of Doctor	Phone Number	Medical Specialty	Medical Record(s) To Be Sent
_____	_____	_____	Yes or No
_____	_____	_____	Yes or No
_____	_____	_____	Yes or No
_____	_____	_____	Yes or No
_____	_____	_____	Yes or No

DISEASE HISTORY

How many years have you been overweight? _____

How many years have you been trying to lose weight? _____

How long have you been researching or thinking about weight loss surgery? _____

MEDICAL ISSUES RELATED TO OBESITY

Please answer all questions related to your current and/or past medical history.
 Place an "X" beside Yes or No for *every* question.

<u>Cardiovascular Disease</u>	<u>YES</u>	<u>NO</u>	<u>RN/MD Notes (for office use only)</u>
High Blood Pressure	_____	_____	_____
Congestive Heart Failure	_____	_____	_____
Ischemic Heart Disease	_____	_____	_____
Heart Stress Test	_____	_____	_____
Heart Attack	_____	_____	_____
Stents placed in Heart	_____	_____	_____
Heart Catheterization	_____	_____	_____
Anginal Chest Pain	_____	_____	_____
Peripheral Vascular Disease	_____	_____	_____
Stroke	_____	_____	_____
Lower Leg Edema/Swelling	_____	_____	_____
Blood Clot in Leg or Lung	_____	_____	_____
Vena Cava Heart Filter	_____	_____	_____

<u>Metabolic Disease</u>	<u>YES</u>	<u>NO</u>	
Diabetes Mellitus Type 1	_____	_____	_____
Diabetes Mellitus Type 2	_____	_____	_____
Fasting glucose > 99 mg/dL	_____	_____	_____
Oral medication for diabetes	_____	_____	_____
Insulin use	_____	_____	_____
Eye/Kidney Problems	_____	_____	_____
High Cholesterol or Lipids	_____	_____	_____
Gout/High Uric Acid Levels	_____	_____	_____

<u>Pulmonary</u>	<u>YES</u>	<u>NO</u>	
Sleep Study	_____	_____	_____
Sleep Apnea	_____	_____	_____
CPAP/BIPAP use	_____	_____	_____
Hypoxemia-low oxygen level	_____	_____	_____
Pulmonary Hypertension	_____	_____	_____
Asthma	_____	_____	_____
Inhaler use due to Asthma	_____	_____	_____

<u>Gastrointestinal</u>	<u>YES</u>	<u>NO</u>	
Heartburn/reflux/GERD	_____	_____	_____
Heartburn Medication Used	_____	_____	_____
Past Anti-reflux surgery	_____	_____	_____
Barrett's Esophagus	_____	_____	_____
Crohn's Disease or Colitis	_____	_____	_____
Gallstones	_____	_____	_____
Gallbladder Removal	_____	_____	_____
Abnormal Liver Tests	_____	_____	_____

<u>Musculoskeletal</u>	<u>YES</u>	<u>NO</u>	
Back Pain	_____	_____	_____
Back Pain requiring meds	_____	_____	_____
Hip, Knee, Ankle Pain	_____	_____	_____
Joint Pain requiring meds	_____	_____	_____
Fibromyalgia	_____	_____	_____
Joint Replacement	_____	_____	_____
Back Surgery	_____	_____	_____

<u>Reproductive (Female)</u>	<u>YES</u>	<u>NO</u>	
Polycystic Ovarian Syndrome	_____	_____	_____
Infertility	_____	_____	_____
Menstrual Irregularities	_____	_____	_____
Hysterectomy	_____	_____	_____

<u>General</u>	<u>YES</u>	<u>NO</u>	
Stress Urinary Incontinence	_____	_____	_____
Sanitary pad use for leakage	_____	_____	_____
Pseudotumor Cerebri	_____	_____	_____

Non-Prescription Items, Vitamins and Minerals Currently Taking

Name	Dose	Frequency	Purpose	When Started

ALLERGIES to medications, latex, other substances

Allergic Substance Name	Reaction to Substance (rash, breathing, etc)

List any **SURGERY** (Please write "Lap" if done laparoscopically)

List ANY OTHER Medical Problems/Surgeries not listed above:

FAMILY HISTORY of Medical Problems (Parents, Grandparents, Siblings, Aunts and Uncles).
Please mark all that apply.

- | | |
|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Disease or Heart Attack | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Clotting Disorder |

DIET HISTORY

Weight History (Highest weight each year, in pounds)

2004_____ 2005_____ 2006_____ 2007_____ 2008_____ 2009_____

Please fill out the diet history form completely, with as much detail as possible. The information on this form is used for your Medical Necessity letter that is submitted to your insurance company. Documentation should reflect ALL weight loss efforts attempted, including Physician Supervised, Commercial Programs, Prescription Diet Pills, Behavior Modification, Unsupervised Diets and Over-the-Counter Diet Aids.

Program	Date	Duration	Dr. Supervised?	Max Wt Loss
Jenny Craig				
Nutri-System				
Weight Watchers				
Optifast/Medifast				
Fen-Phen/Redux				
Meridia				
Alli				
Bulimia/purging after eating				
Anorexia				
T.O.P.S.				
O.A.				
Acupuncture				
Metabolife				
Atkins Diet				
Pritikin Diet				
South Beach Diet				
Low-fat Diet				
Doctor Supervised Diets				
Zone Diet				
Beverly Hills Diet				
Grapefruit Diet				
Slim 4 Life				
Other Diets:				

