



SURGICAL GROUP OF JOHNSON CITY, MPC

2333 Knob Creek Road • Suite 16 • Johnson City, TN 37604 • (423) 975-0764 • Fax (423) 975-0141

Scott D. Watson, M.D., F.A.C.S.

Michael J. Hodge, M.D., F.A.C.S.

PLEASE PRINT

PATIENT INFORMATION

ACCT. # _____

(LAST)	(FIRST)	(MIDDLE)	PATIENT SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
PATIENT NAME: _____			BIRTH DATE: _____ AGE: _____
ADDRESS: _____			PATIENT STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> EMPLOYED <input type="checkbox"/> UNEMPLOYED
CITY, STATE: _____ ZIP: _____			<input type="checkbox"/> MARRIED <input type="checkbox"/> RETIRED <input type="checkbox"/> DISABLED
HOME PHONE NO.: _____ / _____			<input type="checkbox"/> DIVORCED <input type="checkbox"/> FULL-TIME STUDENT
2ND PHONE NO.: _____ / _____ (NEAREST RELATIVE OR FRIEND)			<input type="checkbox"/> WIDOW <input type="checkbox"/> PART-TIME STUDENT
REFERRING PHYSICIAN: _____			<input type="checkbox"/> OTHER
PATIENT SOCIAL SEC. NO.: _____			PATIENT'S EMPLOYER: _____
			EMPLOYER'S PHONE NO.: _____ / _____

INSURANCE HOLDER'S INFORMATION (IF INSURANCE NOT THROUGH PATIENT'S EMPLOYMENT)

NAME: _____	EMPLOYER: _____
ADDRESS: _____ (IF DIFFERENT FROM PATIENT)	EMPLOYER'S PHONE NO.: _____ / _____
CITY, STATE: _____	GUARANTOR'S SOCIAL SEC. NO.: _____
ZIP CODE: _____	GUARANTOR'S BIRTH DATE: _____
TELEPHONE NO.: _____ / _____	RELATION TO GUARANTOR: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER

INSURANCE INFORMATION

ORDER OF CLAIM SUBMISSION:		
1. INS. CO.: _____	2. INS. CO.: _____	3. INS. CO.: _____
(IF INSURANCE NOT IN PATIENT'S NAME)		
INSURED'S NAME: _____	INSURED'S NAME: _____	INSURED'S NAME: _____
IS PATIENT'S CONDITION RELATED TO:		IF YES, SEND BILL TO: _____
A. EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	
B. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	
<input type="checkbox"/> SELF PAY <input type="checkbox"/> CO-PAY _____	HMO: <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF YES, NAME OF MEDICAL DOCTOR _____		

ASSIGNMENT AND RELEASE

I hereby authorize and direct my insurance benefits to be paid directly to the Physician. I am financially responsible for all services to me, including the balance remaining after payment of possible insurance benefits and including all costs connected with the collection of this account. I also authorize release of any medical information necessary to process this claim. To the best of my knowledge, the information given is correct.	
PATIENT SIGNATURE _____	DATE _____
(PARENT OR GUARDIAN IF MINOR)	

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE

PATIENT NAME _____

Weight History

Current Weight: _____ Maximum Weight: _____ Lowest Adult Weight: _____

Height: _____ Age of Max. Weight: _____ Age of Lowest Weight: _____

BMI: _____

How would you describe your current weight? _____

At what weight have you felt your best or *think* you would feel your best? _____

How does your weight affect your daily activities? _____

Why do you want to lose weight? _____

Why are you considering surgery to help you lose weight? _____

How much weight would you like to lose? _____

Highest acceptable weight: _____ Desired lowest weight: _____

How do you think your life would change if you reach your weight goal? _____

What are the attitudes of the following people about your attempt(s) to lose weight?

	Negative	Indifferent	Positive
Spouse			
Children			
Parents			
Employer			
Friends			

Do these attitudes affect your weight loss or gain? _____

Age when you first remember being overweight: _____

Age when you first began dieting: _____

PATIENT NAME _____

A number of different ways of losing weight are listed below. Please indicate any methods you have used by filling the appropriate blanks.

Method	Ages	No. of Times	Weight Lost	Comments
Weight Watchers				
TOPS (Take Off Pounds Sensibly)				
Other commercial weight-loss programs:				
Registered Dietitian				
Overeaters Anonymous				
Prescription diet pills				
Non-prescription diet pills				
Herbs, herbal supplements				
Liquid Diets				
Cabbage Soup Diet				
Mayo Clinic Diet				
Cleveland Clinic Diet				
Scarsdale Diet				
Physician-supervised diet				
High protein, low carbohydrate (such as Adkins Stillman Sugar-Busters, Protein Power)				
High carbohydrate, low fat				
Starvation				
Body wraps or passive exercise table				
Behavior modification				
Psychotherapy				
Hypnosis				
Surgery: (liposuction, gastric bypass, wired jaws, etc.)				
Diet books:				
My own system: What?				
Other:				

Were any of these diets supervised or recommended by a physician? _____

What is the reason you usually go off a diet? _____

PATIENT NAME _____

Exercise History

How physically active are you? (circle one)

Very Active Active Average Inactive Very Inactive

What do you do for physical activity and how often do you do it?

Activity	Number of Times / Week	How Long
<input type="checkbox"/> Walking		
<input type="checkbox"/> Bicycling		
<input type="checkbox"/> Swimming		
<input type="checkbox"/> Water Exercises		
<input type="checkbox"/> Golf - walking		
<input type="checkbox"/> Golf - cart		
<input type="checkbox"/> Tennis		
<input type="checkbox"/> Aerobics		
<input type="checkbox"/> Weight training		
<input type="checkbox"/> Other		

Is there anything that prevents you from being physically active? _____

What activities do you like to do for fun? _____

Are you committed to incorporating physical activity into a long-term weight management program? Yes No Why?

Food History

What are your favorite foods? _____

Are there foods you dislike or refuse to eat?

List any food allergies: _____

How do you decide when to stop eating? _____

Do you eat or drink for reasons other than hunger or thirst? Yes No

Do you like to drink water? Yes No

Do you drink milk? Yes No

Which? Whole 2% 1% Skim

Do you drink juices, sweet tea, or regular sodas? Yes No

If yes, how much a day? _____

Do you eat sweets? Yes No

If yes, how often? _____

Do you know how to make smooth, blenderized food? Yes No

Do you know how to measure food and beverages accurately? Yes No

Do you understand how to read food labels? Yes No

Do you understand the consequences of not complying with postop good guidelines? Yes No

Do you understand the long-term changes in food intake that will be necessary for all occasions after surgery for the rest of your life? Yes No

Circle the equipment you already have: Blender Food Processor Measuring Cup

How fast do you eat? Slow Medium Fast

List your typical diet:

Breakfast: _____

Morning Snack: _____

Lunch: _____

Afternoon Snack: _____

Dinner: _____

Evening Snack: _____

Sleep History

Please check all that apply:

- Excessive daytime sleepiness
- Fall asleep driving or reading
- Loud snoring
- Observed apneas (breath-holding) in sleep
- Sleep alone with no witness or apnea
- Poor cognitive function or memory
- Wake up snoring
- Choke or gasp when sleeping
- Tired when wake-up in the morning
- Morning headache
- Ischemic heart disease
- History of stroke
- Mood disorder (i.e. Depression)
- High blood pressure
- Large Neck
 - 17.5" Men 16" Women
- Frequent urination at night
- Other _____

Cardiac History

Please check all that apply:

- Been seen by a cardiologist
- Chest pain or angina
- History of heart attack
- History of heart surgery
- Abnormal heart beats
- Heart murmur or abnormal valve
- Abnormal stress tests or EKG
- Short of breath after walking 2 blocks
- Unable to walk on treadmill for 20 minutes
- Peripheral vascular disease
- History of smoking
- Diabetes or high blood pressure

Gynecological History

Ladies only please.

Please check all that apply:

- | | | |
|------------------------------------------------------------|-----|----|
| Do you have regular periods (26-33 days)? | Yes | No |
| Do you have excessively heavy periods? | Yes | No |
| Have you had problems with infertility? | Yes | No |
| Have you suffered from excess body hair or acne? | Yes | No |
| Has a doctor told you that you have polycystic ovaries? | Yes | No |
| Do you have a history of gestational diabetes? | Yes | No |
| Are you current on your pap smear and mammogram screening? | Yes | No |

Family History

Indicate if there is a family history of:

- Obesity
- Diabetes
- High blood pressure
- Heart disease
- High cholesterol
- Osteoporosis
- Lung disease, asthma, or emphysema
- Kidney disease
- Bleeding tendency or blood disorder
- Breast cancer
- Colon cancer
- Endocrine or metabolic disorders

PATIENT NAME _____

Physicians

Please list all physicians that are currently or recently caring for you.

	Name	Address	Telephone
Primary Care Physician	_____	_____	_____
Internist	_____	_____	_____
Gynecologist	_____	_____	_____
Orthopedist	_____	_____	_____
Psychiatrist	_____	_____	_____
Psychologist	_____	_____	_____
Therapist	_____	_____	_____
Other	_____	_____	_____

Referring Physician

Referring Physician: _____ Phone Number: _____

Address: _____ Fax Number: _____

How did you hear about our office? _____
