Weight Loss Institute of Arizona

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How did you hear about WLIA?			
Last Name:		First Name:	
Preferred Phone #:		Alternate Phone:	
Previous Name/Maiden Name:		Social Security #:	
Date of Birth:	Sex:	Race:	Marital Status:
Address Line 1: City:		Address Line 2: State: ZIP:	
Email Address:			
Doctor's Name:		Doctor's Phone #	
Employer's Name:		Emergency Contact Name:	
Employer's Phone #		Emergency Contact Phone #	
Occupation:			

EVEN IF YOU HAVE ALREADY GIVEN YOUR INSURANCE PLEASE STILL FILL OUT

Name of Insurance Company	Address of Insurance Company:	City:	State:	Zip:
Insurance Company Phone Number for Providers:				
If policy holder is different than patient, please list his or her Name, Relationship, DOB, and SSN.				
ID Policy Number:	Group Number:	Insurance Company Number:		
Secondary Insurance Company, Address, City, State, Zip				
Name of Company:	Address:	City:	State:	Zip:
Secondary ID Policy Number:	Secondary Group Number:	Secondary Insurance Company Number:		
If patient is under 18, please provide the Responsible Party Information.				
Name:	Relationship:	Contact Number:		
Employer Company:	Work Number:	Position:		

I herby authorize my insurance company to pay directly any and all claims submitted to the Weight Loss Institute of Arizona, L.L.C. I accept responsibility for any unpaid balance following insurance reimbursement or should insurance deny coverage for services for any reason and will pay the balance in a timely manner. My signature on this document and my initials on each page thereafter permit W.L.I.A. to communicate with me through e-mail. My signature also allows W.L.I.A. to request copies of all medical records from any source pertinent to my medical care. A copy of your insurance card(s) and identification will be requested to accompany this application.

Signature _____ Date: _____

Medications, Vitamins, and Drug List

Medication	Dose	Frequency	Reason for Use

Are you currently taking Warfarin, Coumadin, Lovenox, Heparin, or other drug for your blood? Yes, No.
Do you or have you had a problem with your blood being too thick or too thin? Yes, No.

Allergies List

Medication/Allergy	Allergic Reaction

Do you have any allergies? Yes, No. *If yes*, please list reaction(s).

Are you allergic to surgical tape? Yes, No. *If yes*, please list reaction(s).

Are you allergic to latex? Yes, No. *If yes*, please list reaction(s).

Medical Information:

CONSTITUTIONAL (circle all that apply):

Weight change, loss of appetite, fever, weakness, bleeding problems, fatigue

DERMATOLOGY (circle all that apply):

Bruising, rash, moles, lumps, dry or sensitive skin, hives, keloid formation, skin cancer

ENDOCRINOLOGY (circle all that apply):

Fatigue, excessive sweating, excessive thirst, excessive urination, weight loss, sleep disturbance, cold intolerance, heat intolerance

NEUROLOGY (circle all that apply):

Headache, tingling, numbness, seizures, insomnia, dizziness, gait abnormality

OPHTHALMOLOGY (circle all that apply):

Loss of vision

HEMATOLOGY (circle all that apply):

Pulmonary embolism, deep venous thrombosis, varicose veins, easy bleeding, bruising, swollen glands, loss of appetite

SLEEP HISTORY (circle all that apply):

History of sleep apnea, loud snoring, history of falling asleep during usual waking hours, has a CPAP machine

ENT/RESPIRATORY (circle all that apply):

Asthma, bronchitis, emphysema, recent wheezing, pneumonia, cold, cough, nosebleed, hearing loss, change in voice, sore throat

CARDIOLOGY (circle all that apply):

Chest pain, chest pressure, palpitations, recent myocardial infarction, past myocardial infarction, shortness of breath, murmurs, dizziness, edema

GASTROENTEROLOGY (circle all that apply):

Rectal bleeding, peptic ulcer disease, crohns disease, ulcerative colitis, nausea, heartburn, vomiting, difficulty swallowing, abdominal pain, diarrhea, constipation, change in bowel habits, blood in stool

MUSCULOSKELETAL (circle all that apply):

Joint pain (ankle, knee, foot, hip, back), shortness of breath

PHYSCOLOGY (circle all that apply): Depression, tension/stress, sleep disturbances, suicidal ideation, eating disorder, anxiety
GENITOURINARY MALE: Difficulty urinating, painful urination, increased urinary frequency, hernia, kidney disease, hard testicle
GENITOURINARY FEMALE: Stress incontinence, heavy periods, increased urinary frequency, pelvic pain, painful periods, vaginal discharge, difficulty urinating
OTHER (please list any other medical conditions):

If you have sleep apnea, when were you diagnosed? Date: _____ Do you use a CPAP or BiPAP machine? Yes , No. Setting

Surgery History

Date of Surgery	Type of Surgery	Open / Lap

Hospitalization History

Date Admitted	Date of Discharge	Reason

Family Medical History

Do you have a family history for any of the following diseases?	Yes	No	*If yes*, what family member?
Congestive heart failure			
Chrohn's disease			
Ulcerative colitis			
Colon cancer			
Breast cancer			
Thyroid cancer			
Adrenal problems			
Obesity			

Your Pharmacy Information

Name of Company	
Location	
Phone	
Fax	

Social Information

Do you take any herbal supplements? Yes, No. *If yes,* please list.

Do you use illegal substances? (Circle) Currently use, used in the past, sometimes, never.

Do you use tobacco? (Circle) Currently use, used in the past, sometimes, never.

Do you consume alcohol? (Circle) Currently use, used in the past, sometimes, never.

Medical History for the Past 5 Years with weight documented:

2013	Provider	Phone	Fax
2012	Provider	Phone	Fax
2011	Provider	Phone	Fax
2010	Provider	Phone	Fax
2009	Provider	Phone	Fax
2008	Provider	Phone	Fax

Dietary History

Diet Program	Yes	No	Doctor Supervised	Duration	Pounds Lost
Jenny Craig					
Nutrisystems					
Weight Watchers					
Opti/Medi Fast					
Phen/Fen					
Meridia					
Lindora					
TOPS					
O.A.					
Acupuncture					
Other (List)					
Other (List)					

Patient Weight History

Birth weight ___ ____ ● High school weight _____ ● Marriage weight? _____

Is your body frame large, medium, or small? _____

What is your height? _____ ● what was your highest weight in past five years? _____

What was your lowest weight in past five years? _____

Exercise Routine

What type of exercise do you do?	Duration/Frequency	Home/Gym/Outdoors/Other

What are your weight loss goals for the next year?

Why do you want surgical weight loss surgery?

Is there anything you would like to tell WLIA about yourself that was not asked in this questionnaire?