Peachtree Surgical & Bariatrics

Patient Information

FIRST Name: _____ MI _____ LAST Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ____ - ____ - _____ Cell Phone: ____ - ____ - _____ Work Phone: ____ - _____ - _____

Birth Date: _____ / _____ / _____ Sex: ☐ M ☐ F Height: _____ Weight: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Partner Social Security #: _____ - _____ - _____

Employer: _____ Phone: _____ - _____ - _____

Patient Email Address: _____

Ethnicity (check all that apply): ☐ Alaskan Native ☐ American Indian ☐ Asian ☐ Black or African ☐ Caucasian ☐ Hispanic or Latino ☐ Middle Eastern ☐ Pacific Islander ☐ Other: _____ ☐ Prefer not to answer

How did you hear about us? ☐ Family/Friend ☐ Physician ☐ Employee Referral ☐ TV / Radio ☐ Seminar – Peachtree Bariatric ☐ Trade Show/Health Fair/Expo ☐ Online/Social Other: _____

Emergency Contact

First Name: _____ Last Name: _____

Relationship to Patient: _____ Phone: _____ - _____ - _____

I understand and acknowledge that in some circumstances Peachtree Surgical and Bariatrics may file a claim with my health insurance as a courtesy to me and that I will be responsible for all billable services not covered by insurance. I am responsible for paying my co-pays at the time of service.

If I do not have benefits, I will be required to pay cash. If benefits are not determined, I understand that I may pay cash. In this case we will not file a health insurance claim for me, but may provide me with information to file the claim myself.

I have provided you with complete, current, and accurate information about all insurance coverage. Should any information regarding my insurance change, I agree to give notification immediately.

I agree to assign my health insurance benefits to Peachtree Surgical, Real Results, and Atlanta Aesthetic Surgery Center for the services rendered at this facility.

Name of patient or guardian: _____

Signed by: _____ Date: _____ /_____ /_____

Patient Name: _____ Date of Birth: _____ / _____ / _____

Pharmacy

Pharmacy: _____ Location:_____

Medications (please list ALL over-the-counter & prescribed medications you are currently taking)

Name of Medication	Dosage	Frequency	Start Date	Reason	Notes (for provider use only)

Vitamins & Supplements (please list ALL you are currently taking)

Name of Vitamin / Supplement	Dosage	Frequency	Start Date	Reason	Notes (for provider use only)

Doctors

Primary Care Physician: _____ Home Phone: ____ - _____ - _____

Fax: ____ - _____ - _____

OB-GYN: _____ Home Phone: ____ - _____ - _____

Fax: ____ - _____ - _____

Provider's Signature: _____ Date: _____ / _____ / _____

Patient Name: _____ **Date of Birth:** _____ / _____ / _____

Health History & Review of Systems (Please check all that apply)

Constitutional

Fatigue / Tiredness	
Fever	

Skin

Wounds that are slow to heal	
Skin Cancer	
Chronic rash	
Psoriasis / Eczema	

Respiratory

Asthma: Yr diagnosed _____	
Shortness of breath at rest / activity	
Flights of stairs you can climb _____	
COPD / Emphysema	
Snoring	
Difficulty sleeping flat	
Awakening at night	
Morning headaches	
Daytime drowsiness	
Observed apnea episodes	
Chronic insomnia	
Sleep Apnea: ☐CPAP ☐BiPAP Yr diagnosed _____	

Cardiovascular

Chest pain at rest / activity	
Heart attack (MI): Yr diagnosed _____	
Irregular heart beat: Yr diagnosed _____	
Heart Disease: Yr diagnosed _____	
Congestive Heart Failure: Yr diagnosed _____	
High Blood Pressure (HTN): Yr diagnosed _____	
Pregnancy Induced HTN	
Pacemaker / Defibrillator	
History of heart surgery	
High cholesterol / Triglycerides: Yr diagnosed _____	
Deep vein thrombosis (blood clot)	
Painful varicose veins	
History of Rheumatic Fever	

Other

Gastrointestinal

Heartburn / Reflux: Yr diagnosed _____	
Difficulty swallowing	
Painful swallowing	
Hoarseness	
Peptic Ulcer Disease	
Frequent nausea	
Frequent vomiting	
Chronic abdominal pain	
Chronic diarrhea	
Chronic constipation	
Blood in stool	
Painful Bowel Movements	
Change in stool size	
Irritable Bowel Syndrome	
Crohn's Disease	
Ulcerative Colitis	
Cirrhosis	
Fatty liver	
Elevated liver enzymes	
Hepatitis: ☐A ☐B ☐C ☐Not sure	
Hernia: ☐Hiatal ☐Inguinal ☐Umbilical ☐Ventral ☐Not sure Yr diagnosed _____	

Musculoskeletal

Swelling of legs / feet	
Osteo-Arthritis	
Rheumatoid Arthritis	
Lupus	
Scleroderma	
Herniated Disc	
Joint pain: ☐Limits ability to walk or exercise ☐Ankles ☐Knees ☐Feet ☐Hips ☐Back	

Hematologic/Lymphatic

Anemia: Type _____	
Blood clotting problem	
Sickle Cell Disease	
Blood transfusion: Year _____	
HIV: Yr diagnosed _____	

Endocrine

Hyperthyroidism (High)	
Hypothyroidism (Low)	
Goiter	
Diabetes: ☐Type 1 ☐Type 2 ☐Gestational Yr diagnosed _____	
Chronic steroid use	
Cushing's Disease	

Neurological

Seizures	
Light headedness	
Numbness	
Tremors	
Loss of consciousness	
Narcolepsy	
Stroke	
Migraine	
Fibromyalgia	
Multiple Sclerosis	

Psychological

Depression	
Anxiety Disorder	
Suicidal thoughts	
Suicide attempts	
Bi-Polar Disease	
Obsessive Compulsive Disorder	
Schizophrenia	
Anorexia	
Bulimia	
Binge eating	

Genitourinary

Frequent urination	
Urine leakage when coughing or laughing	
Kidney Disease	
Kidney Stones	
Blood in urine	
Painful urination	

Men's Health

Loss of erection	
Last Prostate exam (date) _____	
Prostate Cancer	
Enlarged breast tissue	

Women's Health

Polycystic Ovarian Syndrome	
Menopause	
Irregular periods	
Heavy periods	
Infertility	
Facial hair growth	
Breast Cancer	
Last Menstrual period (date) _____	

Provider's Signature: _____ **Date:** _____ / _____ / _____

Patient Name: _____ Date of Birth: _____ / _____ / _____

Allergies

Do you have any allergies: ☐ No ☐ Yes - Please describe _____

Allergic to any medications: ☐ No ☐ Yes - Please list _____

Allergic to latex: ☐ No ☐ Yes - Please describe the reaction _____

Have you or any of your family members had an adverse reaction to anesthesia? ☐ No ☐ Yes

Surgical History (Please list all minor and/or major surgical procedures & operations excluding weight loss surgery.)

Procedure	Date	Reason

Hospitalizations (Please list all hospitalizations)

Procedure	Date	Reason

Weight Loss History

How many years have you been overweight? _____

Have you had weight loss surgery? ☐ No ☐ Yes

Weight Loss Surgery (if you marked yes above, please list surgical procedures)

Weight Loss Surgery Procedure	Date	Surgeon	Weight Loss / Gain	
			☐ Loss _____ lbs	☐ Gain _____ lbs
			☐ Loss _____ lbs	☐ Gain _____ lbs
			☐ Loss _____ lbs	☐ Gain _____ lbs
			☐ Loss _____ lbs	☐ Gain _____ lbs

Provider's Signature: _____ Date: _____ / _____ / _____

Patient Name: _____ **Date of Birth:** _____ / _____ / _____

Diet Programs and Supplements (Please indicate which of the following diets or plans you have attempted.)

Program	Date: From / To	Was it Medically Supervised?	Weight Loss / Gain	
Atkins Diet		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs
Grapefruit Diet		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs
Herbalife		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs
Jenny Craig		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs
LA Weight Loss		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs
Low Carbohydrate		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs
Medifast		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs
Metabolife		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs
Nutri-System		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs
Optifast		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs
Protein		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs
Slim Fast		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs
South Beach		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs
TOPS		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs
Weight Watchers		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs
Other _____		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs

Weight Loss Medication History (Please indicate which of the following diets or plans you have attempted.)

Medication	Date: From / To	Was it Medically Supervised?	Weight Loss / Gain	
Amphetamines		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs
Phentermine (Adipex, Fastin, Pondimen)		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs
Phen-Fen		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs
Redux (Dexafenaflouramine)		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs
Xenical (Orlistat)		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs
Meridia (Sibutramine)		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs
Other _____		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs

Non-Dietary Therapies (Please indicate which of the following diets or plans you have attempted.)

Therapy	Date: From / To	Was it Medically Supervised?	Weight Loss / Gain	
Regular Exercise		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs
Hypnosis		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs
Behavior Modification		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs
Acupuncture		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs
Other _____		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs
Other _____		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs
Other _____		☐ No ☐ Yes	☐ Loss _____ lbs	☐ Gain _____ lbs

Provider's Signature: _____ **Date:** _____ / _____ / _____

Patient Name: _____ **Date of Birth:** _____ / _____ / _____

Family History (Please indicate family members diagnosed with the following illnesses)

	Mother	Father	Maternal G-mother	Maternal G-father	Paternal G-mother	Paternal G-father	Sibling 1	Sibling 2	Sibling 3
Obesity									
Cancer									
Diabetes									
Hypertension									
Heart Attack									
Heart Disease									
High Cholesterol									
Malignant Hyperthermia									
Stroke									
Unknown History									
Is this person living?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Age at death									
Cause of death									

Social History

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Partner

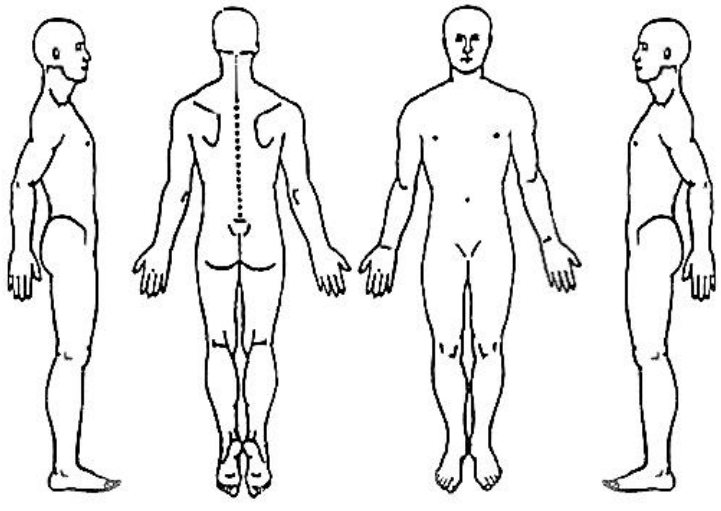
Number of children _____

Patient's Occupation: _____

Spouse / Partner Name: _____ Phone: ____ - _____ - _____

Smoking	☐ Current ☐ Past	Packs per day _____	# of years _____	Last used _____
Dipping	☐ Current ☐ Past	Dips per day _____	# of years _____	Last used _____
Alcohol	☐ Current ☐ Past	Drinks per day _____	# of years _____	Last used _____
Illicit / Illegal Drug Abuse	☐ Current ☐ Past	Substance _____	# of years _____	Last used _____
Illicit / Illegal Drug Abuse	☐ Current ☐ Past	Packs per day _____	# of years _____	Last used _____

Current Injuries (Please mark areas of current injuries and/or pain.)



Please rate your pain on a scale of 0 to 10
(0= no pain 10= worst pain)

Pain at rest: 0 1 2 3 4 5 6 7 8 9 10

Pain with activity: 0 1 2 3 4 5 6 7 8 9 10

What is duration of pain?
☐ Hardly ever ☐ Once in a while ☐ Comes and goes
☐ Most of the time ☐ Constant

Please describe your condition further if needed:

Provider's Signature: _____ **Date:** _____ / _____ / _____