

Obesity Surgery Center of Louisiana

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PATIENT APPLICATION:

Personal Data	
Today's Date:	
Full Name:	
Birth Date:	
Soc. Security #:	
Address:	
City, State: ZIP:	
Home Phone:	
Work Phone:	
E-mail Address:	
Occupation:	
Marital Status:	

Insurance Information

Insurance Company:	
Policy Holder's Name:	
SS # of Policy Holder:	
Policy Number:	
<input type="checkbox"/> Gastric Bypass <input type="checkbox"/> Lap Band	Why did you make this choice?

Family Physician Information

Family Physician:	
Address:	
City, State: ZIP:	
Office Phone:	
FAX number:	

Questionnaire: Section II

Body Size and Weight Information

<p>HEIGHT: _____</p> <p>WEIGHT: _____</p> <p>BMI: _____</p>

Previous Attempts at Weight Loss

Program:	Year:	Months:	Physician supervised?	Lbs lost:	Weight regained?

List any other diet attempts:	
List Medications Used to Lose Weight and Results:	

Describe any Family History of Obesity:	
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Questionnaire: Section III

Do you have a Psychiatrist?	Yes _____ No _____
If Yes:	
Psychiatrist's Name:	
Address:	
City, State: ZIP:	
Office Phone:	
Date Last Seen:	

Please List all Allergies:	
Please List all Medications Currently Taking and Dosages:	

List All Prior Abdominal Operations: (Indicate if done with laparoscope)	
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Briefly describe in your words how obesity is affecting your life and why you feel you would benefit from surgery:	
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Impact of Weight on Physical Functions

Please check the answer in the right column according to how well it describes you in the past 12 months:

Physical Function:	Always true	Usually true	Sometimes true	Rarely true	Never true
Because of my weight I have trouble picking up objects					
Because of my weight I have trouble tying my shoes					
Because of my weight I have difficulty getting up from chairs.					
Because of my weight I have trouble using stairs.					
Because of my weight I have difficulty putting on or taking off my clothing.					
Because of my weight I have trouble with mobility.					
Because of my weight I have trouble crossing my legs.					
I feel short of breath with only mild exertion.					
I am troubled by painful or stiff joints.					
My ankles and lower legs are swollen at the end of the day.					
I am worried about my health.					
Self-Esteem:					
Because of my weight I am self-conscious.					
Because of my weight my self-esteem is not what it could be.					
Because of my weight I feel unsure of myself.					
Because of my weight I don't like myself.					
Because of my weight I am afraid of being rejected.					
Because of my weight I avoid looking in mirrors or seeing myself in photographs.					
Because of my weight I am embarrassed to be seen in public places.					
Sexual Life:					
Because of my weight I do not enjoy sexual activity.					
Because of my weight I have little or no sexual desire.					
Because of my weight I have difficulty with sexual performance.					
Because of my weight I avoid sexual encounters whenever possible.					
Public Distress:					
Because of my weight I experience ridicule, teasing, or unwanted attention.					
Because of my weight I worry about fitting into seats in public places (e.g., movies, restaurants, cars, etc.)					
Because of my weight I worry about fitting through aisles or turnstiles.					
Because of my weight I worry about finding chairs that are strong enough to hold my weight.					
Because of my weight I experience discrimination by others.					
Work: (Note: If you are a homemaker or retired person, answer this section with respect to your daily activities.)					
Because of my weight I have trouble getting things accomplished or meeting my responsibilities.					
Because of my weight I am less productive than I could be.					
Because of my weight I don't receive appropriate raises, promotions, or recognition at work.					
Because of my weight I am afraid to go on job interviews.					

**Questionnaire: Section IV
Obesity and Selected Organ Function**

Check all that apply.

Cardiovascular

- Heart problems (*requiring medication*)
- Chest pains
- Racing heart/skipping
- High blood pressure (*requiring medication*)
- Chest tightness
- Shortness of breath (SOB)
- High cholesterol (*requiring medication*)
- High Triglycerides (*requiring medication*)
- Feel tired all the time

Diabetes

- Diabetes- Type I or II (*requiring medication*)
- Pre-Diabetic (abnormal glucose tolerance test)
- Gestational Diabetes ____ Age of diagnosis
- Hypoglycemia (low blood sugar)

Thyroid Problems

- Thyroid problems (*requiring medication*)

Gastrointestinal

- Gallbladder problems ____ removed? ____ Done laparoscopically?
- Stomach ulcers (*requiring medication*)
- Heartburn (GERD) ____ Daily? ____ Nightly?
- Regurgitation? ____ Requiring medication? What medication? _____
- Diarrhea or constipation

Respiratory

- Asthma Last attack? _____
- ? Bronchitis # of times in past 2 years ____ Is it recurring? Yes ____ No ____
- Pneumonia
- Blood clots in lungs
- Smoker Starting age? ____ When did you stop? ____
- Smokeless tobacco
- Sleep Apnea (If unsure, see self test at end of questionnaire)
- Snore
- Wake up gasping ____ With a smothered feeling?
- Using CPAP or BI-PAP

Musculoskeletal

Check all that apply.

	Mild	Moderate	Severe		
Hip Pain					Degenerative Joint Disease
Knee Pain					Using anti-inflammatory or pain medicine
Ankle Pain					Swelling in the legs
Feet Pain					Swelling in the feet
Back Pain					Swelling in the hands
Neck Pain					Varicose veins
Arthritis					Ulcers of the leg
					Problems with leg veins
					____ Pain ____ Inflamed ____ Red

For Females

<input type="checkbox"/>	Problems conceiving
<input type="checkbox"/>	Are you regular?
<input type="checkbox"/>	Any pain with period?
<input type="checkbox"/>	Loss of urine

Neuro-Psychiatric

<input type="checkbox"/>	Depression ____ because of obesity? ____ requiring medication?
<input type="checkbox"/>	Seizures ____ requiring medication?
<input type="checkbox"/>	Severe Headaches ____ requiring medication?
<input type="checkbox"/>	Visual problems
<input type="checkbox"/>	Been in counseling
<input type="checkbox"/>	History of alcohol abuse. How long have you been dry? _____
<input type="checkbox"/>	History of drug abuse. How long have you been clean? _____
<input type="checkbox"/>	Eating disorder. ____ Bulimia ____ Anorexia – Nervosa

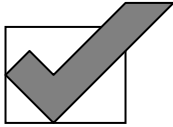
Family History (parents, grandparents, brothers, sisters)

	Parents	Grandparents	Brothers	Sisters	Other
Obesity					
Diabetes					
Heart Disease					
High Blood Pressure					
Cancer & Type					
Arthritis					
Early Death & Cause					

Sleep Apnea Self Test

	Yes	No
Do you snore?		
Have you been told that you hold you breath or stop breathing during sleep?		
Do you wake up gasping for breath?		
Do you awaken with headaches?		
Do you fall asleep frequently while reading?		
Have you fallen asleep while driving or stopped at a light?		
Do you have jerking movements while sleeping?		
Do you still feel exhausted after 8 hours of sleep?		

Total # of YES answers: _____



I WISH TO HAVE BARIATRIC SURGERY AND AUTHORIZE THE STAFF OF THE OBESITY SURGERY CENTER TO BEGIN THE PROCESS TO PREPARE ME FOR SUCH PROCEDURE.

Release of Information Authorization

I hereby authorize any Physicians who have treated me in the past 5 years to release any medical or other relevant information to Dr. Keith Chung and the Obesity Surgery Center, which may be necessary to prove necessity for Bariatric Surgery. I also authorize Dr. Keith Chung and the Obesity Surgery Center staff to release such information to my insurance company to obtain authorization for services.

Signature: _____

Date: _____

Consent for Information and Likeness Sharing

I hereby consent to the use of my likeness in photograph and the sharing of such likeness and other data associated with my outcome, with the hospital in which my procedure will be performed in order to ensure proper outcome analysis which is necessary for hospital funding of the hospitals. This information will be shared only between my surgeon and the facilities, and will not be used for patient education without my expressed written consent.

Signature: _____

Date: _____