David Thoman, M.D., FACS
520 West Junipero St.
Santa Barbara, CA 93105

Date:____________________

Patient Information:

Name: ____

Address: ____

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Home Phone: ____

Cell Phone: ____

Email: ____

Occupation: ____

Employer: ____

Address: ____

Phone: _____________________________________ Ext: ___________________

Date of Birth: ______________________________ Age ___________________

Social Security ____

Religion: ____

Referring Physician: ____

Health Insurance: ____

ID#: ____

Policy #: ________________________________ Group #:___________________

Principal Insurance Holder: ☐ Self ☐ Spouse ☐ _________________________

Insurance Phone:____

Emergency Contact:

Name: ____

Address: ____

Phone: ____

Relationship:____

Primary Care Physician Information:

Name: ____

Address: ____

Phone: ____

Weight Loss History:

Please check the appropriate boxes and add notes as needed. (Be specific)

My obesity started: ☐ in childhood ☐ in puberty ☐ as an adult ☐ after pregnancy
☐ after a traumatic event ☐ other ________________________

Additional notes regarding the onset of obesity: __________________________________

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Weight Loss Programs/Diets/Medications: (please check all that apply)

☐ Medifast ☐ Meridia ☐ Redux ☐ Phen-Fen ☐ Optifast ☐ Nutrasystem

☐ Jenny Craig ☐ Slim Fast ☐ Diet Center ☐ Metabolife ☐ Atkins Diet ☐ Sansum Wellness

☐ Cambridge ☐ Xenical ☐ Weight Watchers ☐ Medical weight management programs

☐ Other: ____

Additional physician/hospital supervised weight loss programs: ______________________

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Height: ______________________________ Current weight: ______________________

Highest adult weight: ___________________ Lowest adult weight: ___________________

Most weight lost in a program: ____

Taste preference: (check all that apply)

☐ Sweet ☐ Salty ☐ Fast Food ☐ Comfort foods ☐ Other: ________________

Eating habits: (check all that apply)

☐ Binge eater ☐ Stress ☐ Boredom ☐ Loneliness ☐ Other: ________________

Health Questionnaire:

Please list any **medications** to which you are **ALLERGIC:**

Medication:	Reaction:

Please list any **medications, vitamins, and/or herbal supplements** you are presently taking:

Medication:	Dosage:	Frequency:

Please list all previous **surgeries and hospitalizations**:

Procedure/Diagnosis:	Date:	Hospital Name/Location:

Family History: Please check which, if any of your family members had any of the following conditions:

Condition:	Sibling	Mother	Father	Grandparent	Aunt/Uncle	Comments:
Anemia						
Bleeding Problems						
Blood clots						
Cancer						
Diabetes						
Gallstones						
Gout						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Obesity						
Sleep Apnea						
Stroke						

Obesity related conditions: (check all conditions that apply)

- ☐ Belching of sour fluid
- ☐ Bulimia/Excessive vomiting
- ☐ Coughing or choking at night
- ☐ Daily headaches
- ☐ Daytime falling asleep
- ☐ Depression
- ☐ Diabetes mellitus
- ☐ Gallbladder disease
- ☐ Gout
- ☐ Hernia
- ☐ Heartburn/esophagitis
- ☐ Hiatal hernia
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Joint pain/Arthritis
- ☐ Leakage of urine
- ☐ Shortness of breath
- ☐ Rash/Dermatitis
- ☐ Sleep apnea syndrome
- ☐ Swollen ankles/feet

Habits:

Are you a smoker? ☐ No ☐ Yes Packs per day: ________________

Have you ever been a smoker? ☐ No ☐ Yes Age started: __________________

Age quit:_____________________

Do you consume alcohol? ☐ No ☐ Yes Drinks per day:________________

Do you use recreational drugs? ☐ No ☐ Yes Type/frequency: _______________

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Please check Yes or No if you have had <u>any</u> of the following **medical conditions** at <u>any</u> time:

Condition:	**Yes**	**No**	**Comments:**
Allergies			
Anemia			
Asthma			
Bladder / Kidney			
Blood Transfusions			
Cancer			
Colitis / Irritable Bowel Syndrome			
Easy Bruising			
Epilepsy / Seizures			
Excessive / Heavy Bleeding			
Fainting			
Frequent Nausea			
Heart attack			
Heart Failure			
Heart murmur			
Heart palpitations			
Heavy drinking			
Hemorrhoids			

Condition:	**Yes**	**No**	**Comments:**
Hepatitis			
Infections			
Kidney Stones			
Leg Cramping			
Liver Disease			
Lung Disease / Pneumonia			
Migraine / Severe Headaches			
Rheumatic Fever			
Stroke			
Thyroid Issues			
Tuberculosis			
Tumors			
Ulcers			
Varicose Veins			

Women only:

Date of your last menstrual cycle: ______________________________

Are your menses regular? ___________________________________

Are you using birth control? ____________________ If yes, what type? _______________________

Number of pregnancies: _______________________ Number of live births: _____________________

Other comments: ____

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Exercise:

Please describe your exercise routine. Include type of exercise, frequency, and physical limitations: ___________

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Other concerns:

Please write any other concerns that you have regarding your health or bariatric surgery: _________________

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____

Please do not write below this line:

OFFICE USE ONLY:

Surgeon Notes:

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QUESTIONS TO ASK YOUR

PPO INSURANCE

REGARDING BARIATRIC SURGERY

1) Do you have bariatric surgery (weight loss surgery) benefits?

2) Is Dr. David Thoman a preferred provider?

3) Is Santa Barbara Cottage Hospital a contracted facility?

4) Does your insurance have a COE (Center of Excellence) requirement?

5) Do you have to be on a Doctor Managed Weight Loss Program prior to starting the bariatric program?

6) What are your insurance company's requirements to be considered a candidate for weight loss surgery

Please answer all these questions is the space provided, sign and date at the bottom, and return with your questionnaire. This needs to be completed before your first appointment will be scheduled.

Name (print): ____

Signature: ____

Date: ____