ADVANCED BARIATRIC AND SURGICAL SPECIALISTS

Craig G. Chang, M.D., F.A.C.S

HEALTH QUESTIONNAIRE

Please complete the 3 page document and return or fax to the contact information below. Our office staff will review your information to determine eligibility for surgery. We will contact you to schedule your initial consultation.

Date_____

PATIENT NAME_____
FIRST MI LAST

MAILING ADDRESS _____ CITY _____ STATE_____ ZIP _____

HOME PHONE_____

CELL PHONE _____ MOBILE PHONE CARRIER_____

EMAIL ADDRESS_____

SOCIAL SECURITY #_____ BIRTHDATE _____ AGE_____ SEX____

MARITAL STATUS: Select [ ] SINGLE [ ] MARRIED [ ] DIVORCED [ ] SEPARATED [ ] DOMESTIC PARTNERSHIP

PREFERRED LANGUAGE: Select [ ] ENGLISH [ ] SPANISH

RACE: Select [ ] WHITE [ ] AFRICAN AMERICAN [ ] AMERICAN INDIAN [ ] PACIFIC ISLANDER [ ] HISPANIC [ ] ASIAN

ETHNICITY: Select [ ] NOT HISPANIC OR LATINO [ ] HISPANIC OR LATINO

PATIENT'S EMPLOYER_____ PHONE_____

ADDRESS_____CITY_____ STATE_____ ZIP_____

EMERGENCY CONTACT NAME_____

EMERGENCY CONTACT PHONE_____RELATIONSHIP_____

RESPONSIBLE PARTY_____ PHONE_____

INSURANCE INFORMATION

PRIMARY
Insurance Company_____
Address_____
City,St,Zip_____
Phone #_____
Policy Holder_____
Birthday_____
Social Security #_____
Group Number_____
Policy Number_____
Employer_____

SECONDARY
Insurance Company_____
Address_____
City,St,Zip_____
Phone #_____
Policy Holder_____
Birthday_____
Social Security #_____
Group Number_____
Policy Number_____
Employer_____

HEALTH QUESTIONNAIRE PATIENT NAME_____

AUTHORIZATION FOR CARE, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I the undersigned, by presenting for services, request and authorize evaluation, diagnosis and treatment by my physician and/or his/her designee. I further hereby authorize the release of any information relating to all claims for benefits submitted on my behalf. I further agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits without obtaining my signature on each and every claim.

AS A COURTESY TO YOU, we will file your insurance claim. It is your responsibility to see that your insurance pays on time. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. You may be asked to pay a portion of the charges prior to scheduling surgery. Failure to pay your bill could result in your account being turned over to a collection agency.

I hereby authorize my insurance benefits to be paid directly to Craig G. Chang, MD, PA and acknowledge that I am financially responsible for all charges as a result of services rendered to me.

Signature_____**Date**_____

MEDICAL HISTORY

Height_____feet_____inches

Weight_____lbs.

Are you overweight? Yes/No If yes, how many years have you been overweight?_____

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

YES	NO	
☐	☐	DIABETES MELLITUS HOW LONG?_____
☐	☐	HYPERTENSION (HIGH BLOOD PRESSURE)
☐	☐	JOINT PAIN (ARTHRITIS) IN FEET, KNEES OR HIPS
☐	☐	LOW BACK PAIN
☐	☐	SLEEP APNEA (STOP BREATHING DURING SLEEP)
☐	☐	GASTROESOPHAGEAL REFLUX (HEARTBURN)
☐	☐	URINARY STRESS INCONTINENCE
☐	☐	ASTHMA
☐	☐	CONGESTIVE HEART FAILURE
☐	☐	HEART ATTACK OR CORONARY DISEASE OR ANGINA
☐	☐	DEEP VEIN CLOTS (CLOTS IN LEGS OR LUNGS)
☐	☐	DEPRESSION
☐	☐	HEAVY PERIODS OR IRREGULAR PERIODS
☐	☐	INFERTILITY (FEMALES OF CHILD BEARING AGE)
☐	☐	HIGH CHOLESTEROL OR HIGH TRIGLYCERIDES
☐	☐	LOWER EXTREMITY SWELLING
☐	☐	SHORTNESS OF BREATH UPON EXERTION

Please list any other medical problems you have ever been diagnosed with_____

_____

_____

HEALTH QUESTIONNAIRE PATIENT NAME_____

YES NO

☐ ☐ Do you smoke tobacco? If yes, Packs Per Day_____ Age when first began smoking_____
If a previous smoker, when did you quit?_____

☐ ☐ Have you ever abused drugs or prescription medications?

☐ ☐ Do you exercise? How many times per week? _____

☐ ☐ Do you take medications? Please list all medications with dosage (or attach list).

_____
_____
_____
_____
_____
_____

☐ ☐ Are you **allergic** to any foods or medications? List Below (Please include over the counter medications)

_____
_____

☐ ☐ Have you ever had surgery? Please list type of surgery with approximate dates.

_____
_____
_____

☐ ☐ Have you ever had previous obesity surgery? What type?_____ When?_____
Name of surgeon or institution_____

☐ ☐ Have you received physician supervised treatment for obesity? List physicians and approximate dates.

_____
_____

☐ ☐ Have you ever taken medications for weight loss? Please circle which ones you've taken.
Phenteramine (Fastin, Adipex, Phen-fen) Xenical Meridia Other_____

How many meals do you eat per day (on average)_____ How many snacks do you eat per day_____
How many regular sodas do you drink per day?_____ How many diet sodas per day?_____
How many glasses of sweet tea do you drink per day (on average)?_____
How many cups of juice do you drink per day?_____
How many drinks of alcohol do you drink per: (day, week, month)?_____

Who is your Primary Doctor?
Name: _____
Address: _____
City / State / Zip: _____
Telephone: _____
Which other physicians do you see on a regular basis?_____

How did you hear about us (check all that apply)?

- ☐ Internet (search engine)
- ☐ www.drcraigchang.com
- ☐ www.gastricsleeves.org
- ☐ Other website _____
- ☐ Telephone Book
- ☐ Billboard
- ☐ Company health fair
- ☐ Postcard/Brochure
- ☐ Friend _____
- ☐ Newspaper Advertisement
- ☐ Physician Referral _____
- ☐ Support Group
- ☐ Facebook
- ☐ Television Commercial
- ☐ Other: _____