LONG ISLAND SURGERY, P.C.

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Supplemental History Form for Bariatric Patients

Please complete the following information to help us provide your insurance company with the basis for determining the medical necessity for bariatric (weight reduction) surgery. Please answer all the questions completely.

PATIENT NAME: _____ **DATE:** _____

Referred By: _____ Primary Care Provider: _____

Additional Treating Physicians: _____

_____

If necessary, which physician(s) do you think would write a letter of support to your insurance carrier? _____

_____

Age: _____ Height: _____ Weight: _____

How long have you been overweight? _____ Do you usually gain back more weight than you lost? ☐ Yes ☐ No

What was your biggest weight loss? _____ By what diet program? _____

Have you had weight loss surgery in the past? ☐ Yes ☐ No

If yes, please specify the type of surgery, date performed, location performed and physician's name: _____

_____

FAMILY HISTORY

Do you have a **FAMILY** history of:
Obesity: ☐ Yes ☐ No **High Blood Pressure**: ☐ Yes ☐ No **Heart Disease**: ☐ Yes ☐ No

Stroke: ☐ Yes ☐ No **Diabetes**: ☐ Yes ☐ No

Please indicate family members who have medical problems and specify the problem. If the family member is deceased, please specify cause of death and age if known.

Mother: _____

Father: _____

Siblings: _____

Maternal Grandparents: _____

Paternal Grandparents: _____

Maternal Aunts/Uncles: _____

Paternal Aunts/Uncles: _____

YOUR HISTORY

Do you have or have you ever had any of the following health problems:

Diabetes: ☐ Yes ☐ No How long: _____ Type of Control: ☐ Diet ☐ Tablets ☐ Insulin Dependent

High Blood Pressure: ☐ Yes ☐ No Angina (Chest Pain): ☐ Yes ☐ No **Heart Attack**: ☐ Yes ☐ No # of attacks _____

Coronary Artery Disease: ☐ Yes ☐ No **Congestive Heart Failure**: ☐ Yes ☐ No

Cardiac Medications: _____

High Cholesterol: ☐ Yes ☐ No Sleep Problems ☐ Yes (please list) ☐ No _____

Arthritis: ☐ Yes ☐ No If yes, list type (Rheumatoid/Osteoarthritis) and Medications: _____

_____

Muscle and Joint Pain: ☐ Yes ☐ No If yes, please specify: ☐ Hip ☐ Foot/Ankle ☐ Knee ☐ Back ☐ Other: _____

_____

Breathing Problems: ☐ Yes ☐ No If yes, please specify: ☐ Asthma ☐ Shortness of Breath ☐ Other: _____

_____

Gastroesophageal Reflux Disease (GERD): ☐ Yes ☐ No Medications: _____

Depression: ☐ Yes ☐ No If yes, please list treating physician and any medications: _____

_____

Cancer: ☐ Yes ☐ No If yes, please list type, current treatments, physician and current status: _____

_____

_____

Venous Insufficiency (varicose veins, swollen legs): ☐ Yes ☐ No **Thrombophlebitis (blood clots)**: ☐ Yes ☐ No

Gallbladder Disease: ☐ Yes ☐ No If yes, please list any treatment and physician: _____

_____

Gynecological Problems: ☐ Yes ☐ No ☐ Not Applicable

If yes, please answer the following:

Difficulty Achieving Pregnancy: ☐ Yes ☐ No

Ovarian Cyst(s) ☐ Yes ☐ No

Fibroids (uterine tumors): ☐ Yes ☐ No

Menstrual Irregularities: ☐ Yes ☐ No Please specify: _____

Other Problems: _____

Please list any other medical conditions not previously listed: _____

_____

_____

_____

Please list any medications not previously listed: _____

_____

_____

_____

Please give us more information about how your weight affects your life:

Physically: _____

Financially: _____

Socially: _____

Other Limitations: _____

_____

Have you participated in commercial weight loss programs? ☐ Yes ☐ No If yes, please fill in the information below.

PROGRAM	DURATION OF PROGRAM	WEIGHT LOSS	HOW LONG DID YOU MAINTAIN THE WEIGHT LOSS?
Optifast			
Weight Watchers			
Tops			
Richard Simmons			
Physician Supervised			
Slimfast			
Jenny Craig			
Susan Pouter			
Health Spas			
Exercise Program			
L.A. Weight Loss			
Atkins			
Nutrisystem			
Other:			

Have you tried calorie or fat reduction diets, "fad" diets, or diets which required the purchase of books and tapes?

☐ Yes ☐ No If yes, please list: _____

_____

Have you had psychological or psychiatric counseling for weight loss or problems associated with weight loss?

☐ Yes ☐ No If yes, please describe: _____

_____

Have you been on medically supervised weight loss programs? ☐ Yes ☐ No If yes, please fill out the following:

Doctor: _____ Duration: _____ Weight Loss: _____

Doctor: _____ Duration: _____ Weight Loss: _____

Nutritionist: _____ Duration: _____ Weight Loss: _____

Were any medications used as part of the program(s)? ☐ Yes ☐ No If yes, please fill out the following:

MEDICATION	DURATION OF USE	WEIGHT LOSS	HOW LONG DID YOU MAINTAIN THE WEIGHT LOSS?	REASON FOR STOPPING?

Primary Insurance Information

Insurance Company: _____ ID #: _____ Group: _____

Address: _____ City/State/Zip: _____ Phone: _____

Insured Name: _____ Relationship to Patient: _____Date of Birth: _____

Secondary Insurance Company: _____ ID #: _____ Group: _____

Address: _____ City/State/Zip: _____ Phone: _____

Insured Name: _____ Relationship to Patient: _____Date of Birth: _____