



Edmund Chute, MD
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Procedure of choice:

- Laparoscopic Roux-en-Y Gastric Bypass
- Sleeve Gastrectomy
- Adjustable Gastric Band
- Unsure

Personal Information:

First Name: _____ Middle Initial _____ Last Name _____
 Date of Birth: _____ Social Security: _____ - _____ - _____
 Gender: M F Race _____ Marital Status: _____ Spouse's/partner's name: _____

Home Information:

Street Address: _____
 City: _____ State: _____ Zip Code: _____
 Home Phone: _____ - _____ - _____ Cell Phone: _____ - _____ - _____
 Email Address: _____ @ _____

Work Information:

Business Name: _____ Occupation: _____
 Street Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone Number: _____ - _____ - _____ Fax: _____ - _____ - _____
 Email Address: _____ @ _____

Insurance Information:

Primary Insurance

Company: _____ Subscriber: _____
 Street Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone Number: _____ - _____ - _____
 ID Number: _____ Group Number: _____

Secondary Insurance

Company: _____ Subscriber: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ - _____ - _____

ID Number: _____ Group Number: _____

Primary Doctor:

First name: _____ Last Name: _____ Degree: _____

Specialty: _____ Organization/clinic: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ - _____ - _____ Fax: _____ - _____ - _____

How long have you been going to this doctor? _____

Doctor/Specialist:

First name: _____ Last Name: _____ Degree: _____

Specialty: _____ Organization/clinic: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ - _____ - _____ Fax: _____ - _____ - _____

How long have you been going to this doctor? _____

Psychologist/Psychiatrist: (if you are seeing one)

First name: _____ Last Name: _____ Degree: _____

Specialty: _____ Organization/clinic: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ - _____ - _____ Fax: _____ - _____ - _____

How long have you been going to this doctor? _____

Emergency Contact Information: (must list two)

EMERGENCY CONTACT #1: Relationship: _____

First name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ - _____ - _____ Cell: _____ - _____ - _____

Email Address: _____ @ _____

EMERGENCY CONTACT #2: Relationship: _____

First name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ - _____ - _____ Cell: _____ - _____ - _____

Email Address: _____ @ _____

Personal Weight History:

Height: _____ feet _____ inches Present Weight: _____ (Office use) BMI _____
Age you 1st became overweight: _____ Age you became 100 lbs. overweight: _____
Weight at age 18: _____ Five years ago: _____ Highest weight in five years: _____ Lowest weight in five years: _____

Previous dietary weight loss efforts:

<u>Name of program or Doctor</u>	<u>Start Date (M/Y)</u>	<u>End Date (M/Y)</u>	<u>Starting Weight</u>	<u>Ending Weight</u>
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____

Health Information: How is your health in general? good fair poor

Central Nervous System/Psychological:

Have you been depressed? yes no

Hospitalized for depression? yes no

Have you been suicidal? yes no

Are you taking medications for depression? yes no

Do you have or have you had any other mental health problems? yes no

Please describe. _____

Do you have a history of substance or alcohol abuse? yes no

Please describe. _____

Average # alcoholic drinks per week: _____ OR per month: _____

Do you have idiopathic intracranial hypertension (high fluid pressure in the brain)? yes no

Cardiovascular:

Do you have hypertension (high blood pressure)? yes no

If so, how many years? _____

Do you have heart disease? yes no

If so, please describe. _____

Have you taken phen-fen? yes no

When? _____ For how long? _____ # pounds lost on it _____

Pulmonary:

Do you have lung problems? yes no

Please describe. _____

Do you smoke? yes no

Have you quit? yes no When? _____

Do you have asthma? yes no

Do you have sleep apnea? yes no

Do you use CPAP (continuous positive airway pressure)? yes no

Does your family say you have loud and irregular snoring? yes no

What is the chance that you would doze off when you are:

Sitting and reading?	<input type="checkbox"/> never	<input type="checkbox"/> slight	<input type="checkbox"/> moderate	<input type="checkbox"/> high	_____
Watching television?	<input type="checkbox"/> never	<input type="checkbox"/> slight	<input type="checkbox"/> moderate	<input type="checkbox"/> high	_____
Sitting inactive in a public place, like in a theater or meeting?	<input type="checkbox"/> never	<input type="checkbox"/> slight	<input type="checkbox"/> moderate	<input type="checkbox"/> high	_____
A passenger in a car?	<input type="checkbox"/> never	<input type="checkbox"/> slight	<input type="checkbox"/> moderate	<input type="checkbox"/> high	_____
Lying down to rest in the afternoon?	<input type="checkbox"/> never	<input type="checkbox"/> slight	<input type="checkbox"/> moderate	<input type="checkbox"/> high	_____
Sitting quietly after lunch (when you have not had alcohol)?	<input type="checkbox"/> never	<input type="checkbox"/> slight	<input type="checkbox"/> moderate	<input type="checkbox"/> high	_____
In a car, stopped in traffic?	<input type="checkbox"/> never	<input type="checkbox"/> slight	<input type="checkbox"/> moderate	<input type="checkbox"/> high	_____
	0	1	2	3	

Office use only: _____/24

Gastrointestinal:

Do you have frequent heartburn? yes no

Do you take antacids or other medication for heartburn? yes no

Do you have gastroesophageal reflux disease (GERD)? yes no

Are you taking medication for GERD? How many years? _____ yes no

Have you had an upper endoscopy (gastroscopy)? yes no

When? _____ Where was it done? _____

Do you have a history of jaundice or hepatitis? yes no

Have you had an ulcer? yes no

Genitourinary:

Do you have kidney problems? yes no

Do you sometimes lose your urine with coughing or sneezing? yes no

If so, how often? _____

Have you been diagnosed with urinary stress incontinence? yes no

Are you infertile? yes no

Have you seen a doctor about this? yes no

If yes, what is the diagnosis? _____ yes no

For women: # of pregnancies _____ # of babies _____ When was your last period? _____

Musculoskeletal:

Do you have bone, joint or muscle problems? yes no

Which joints? Spine hips knees ankle other

Is there a diagnosis yes no Diagnosis: _____

Do you have lower leg venous stasis ulcers? yes no

Do you have fibromyalgia? yes no

Hematology/Oncology?

Do you have a history of abnormal bleeding or clotting? yes no

Do you or have you had anemia (low hemoglobin)? yes no

Are you HIV positive? yes no

Ever been MRSA+? yes no

VRE+ yes no

Have you had a cancer or any other tumor? yes no

When? _____ Where was the cancer? _____

Metabolic:

Do you have elevated cholesterol or triglycerides or lipids? yes no

Do you have diabetes mellitus ("sugar diabetes")? When diagnosed? _____ yes no

Do you take pills for this? yes no Do you take insulin for this? yes no

Family History:

Have any of your family members had any of these illnesses? (even if deceased):

Relative	Weight	Diabetes	Heart problems or attack	High blood pressure	Sleep apnea	High cholesterol	Joint problems	Stroke or blood clots
Father								
Mother								
Brother 1								
Brother 2								
Brother 3								
Brother 4								
Sister 1								
Sister 2								
Sister 3								
Sister 4								

Medications: Please list all medications, including non-prescription medications and supplements.

Name of Medication/Supplement: Dose: How often do you take it? Purpose of the medication:

Attach additional pages if necessary.

Allergies: Please list any allergy to foods or medications and the reactions that you have to them.

Food/Medication:

What was the reaction?

When did you have a reaction?

Surgeries: Please list any previous surgeries that you have had.

_____	Date: _____
_____	Date: _____
_____	Date: _____
_____	Date: _____
_____	Date: _____
_____	Date: _____

Review of Unrelated Medical Systems: Please mark all that you have now or that you have had in the past:

Excessive fatigue	Ear drainage	Frequent infections	Can't sleep lying down
Shortness of breath	Abnormal heart valve	Blood clot in leg	Kidney stones
Frequent urination	Frequent cough	Trouble swallowing	ringing in ears
Wake at night unable to breathe	Stroke	Lump in neck	Leg cramping
Urgency to urinate	Muscle weakness	Trouble speaking	Frequent runny nose
Double vision	Numbness	Vomiting	Muscular dystrophy
Blood in urine	Lumps in nose	Constipation	Phlegm production
Change in vision	"Pins & needles" feeling	Diarrhea	Seizures
Leg/foot swelling	Growths in mouth	Intolerant of cold	Sores in mouth
Hearing loss	Sinus infections	Lump in breast	Easy bruising
Heart attack	Excessive urination	Pancreas problem	Frequent nausea
Prostate problems	Pneumonia	Intolerant of heat	Stiff neck
Fluttering in chest	Emphysema	Gallstones	Blood in stool
Muscle problems	Spinal cord/brain injury	Chest pain	Abnormal immune system
Frequent ear infections	Blood clot in lungs	Thyroid problem	Lump in armpit
Nose bleeds	Abnormal bleeding	Crohn's disease	Lump in groin
	Tuberculosis	Blurry vision	

Please tell us anything else that you would like us to know to help us provide you with the best possible care.

Authorization to release information: I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims.

_____ Date _____
Signature

Authorization to pay benefits to physician: I understand that as a courtesy to me Ridgeview Bariatric & Weight Loss Center will file insurance claims on my behalf. I understand, however, that I am responsible for payment of services that I have received. I hereby authorize payment directly to the physician of the Surgical or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing that I am responsible to pay non-covered services.

_____ Date _____
Signature

Medicare patients:

We are participating physicians in the Medicare program and accept assignment of benefits from Medicare, however, you are still responsible for your deductible and co-insurance amounts after Medicare has paid. Your signature below will serve as the authorization for payment from Medicare to Ridgeview Bariatric & Weight Loss Center.

_____ Date _____
Signature

ALL PATIENTS and PROSPECTIVE PATIENTS MUST READ AND SIGN BELOW:

*****IMPORTANT*****

Although I understand that Ridgeview's Insurance Specialists will call my insurance company on my behalf to verify coverage for Bariatric Surgery, I understand that it is ultimately my responsibility to know whether or not Bariatric Surgery and the Pre and Post Op Required Appointments are a covered benefit.

I will not hold Ridgeview Medical Center, Ridgeview Bariatric and Weight Loss Clinic, its staff or supporting staff responsible for insurance misinformation, insurance changes, coverage changes or plan changes. It is my responsibility to inform Ridgeview Bariatric and Weight Loss Clinic in writing (Mail or Email) of any changes to insurance plans or coverage.

_____ Date _____
Signature