



LAP BAND New Patient Questionnaire

Date of Visit: ___ / ___ / ___	Last Name:	First:	Middle Initial:
	Birthday: ___ / ___ / ___	Age:	<input type="checkbox"/> Female <input type="checkbox"/> Male
	Height (ft):	Weight (lbs):	BMI:
	Referring Physician:	Family Physician:	
How did you hear about our program?	<input type="checkbox"/> TV <input type="checkbox"/> Newspaper <input type="checkbox"/> Internet <input type="checkbox"/> Friend/Family <input type="checkbox"/> Physician <input type="checkbox"/> Other:		
What weight-loss programs have you tried before?	<input type="checkbox"/> Atkins <input type="checkbox"/> Weight Watchers <input type="checkbox"/> Jenny Craig <input type="checkbox"/> Herbalife <input type="checkbox"/> South Beach <input type="checkbox"/> Others: <input type="checkbox"/> What medications? _____		
Do you take any medications?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, I take: <input type="checkbox"/> Aspirin/Blood Thinners 1. _____ 3. _____ 5. _____ 2. _____ 4. _____ 6. _____	
Are you allergic to any drugs?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, I'm allergic to:	
Have you ever had an eating disorder?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, I have or had at some time: <input type="checkbox"/> Anorexia <input type="checkbox"/> Binge Eating <input type="checkbox"/> Bulimia <input type="checkbox"/> Other _____	
Have you ever had surgery?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, I had (please include year): 1. _____ 3. _____ 5. _____ 2. _____ 4. _____ 6. _____	
Social Habits	Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	
	Exercise	<input type="checkbox"/> Never <input type="checkbox"/> Several times/week <input type="checkbox"/> Daily	
	Tobacco Use	<input type="checkbox"/> Never <input type="checkbox"/> I smoke ___ pack(s)/day for ___ years <input type="checkbox"/> Year Quit _____	
	Alcohol Use	<input type="checkbox"/> Never <input type="checkbox"/> Rare <input type="checkbox"/> Once/week <input type="checkbox"/> Daily	
	Other Drugs	<input type="checkbox"/> Never <input type="checkbox"/> I use/have used:	
Are there any major illness (such as heart disease, diabetes, or cancers) or bleeding disorders in your family?			
<input type="checkbox"/> No	<input type="checkbox"/> Yes, my	Mother has/had: _____ Father has/had: _____ Siblings have/had: _____ Grandparents have/had: _____	
Patient Statement: To the best of my knowledge, the above information is accurate and complete.			
Patient Signature:	Date: / /	Reviewed by Physician:	



Patient History Questionnaire: Review of Systems

Last Name:		First:		Middle Initial:	
Please check the boxes below next to any illness or problems that you may have or had at one time.					
General			Musculoskeletal		
<input type="checkbox"/> None	<input type="checkbox"/> Fevers <input type="checkbox"/> Generalized Weakness <input type="checkbox"/> Recent travel abroad or sick contacts <input type="checkbox"/> Car accidents <input type="checkbox"/> Cancer		<input type="checkbox"/> None	<input type="checkbox"/> Scleroderma/Connective Tissue Disease <input type="checkbox"/> Arthritis <input type="checkbox"/> Joint pain or swelling <input type="checkbox"/> Back pain or spine disease How far can you walk without having pain or being tired? _____ blocks	
Neurologic			Endocrine		
<input type="checkbox"/> None	<input type="checkbox"/> Strokes, Mini-Stroke or TIA <input type="checkbox"/> Brain Tumor or Aneurysm <input type="checkbox"/> Slurred speech <input type="checkbox"/> Paralysis or Seizures		<input type="checkbox"/> None	<input type="checkbox"/> Diabetes <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Cushing's or Adrenal Disease	
Head/Neck			Genitourinary		
<input type="checkbox"/> None	<input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Masses or swelling in throat or neck <input type="checkbox"/> Exposure to neck radiation <input type="checkbox"/> Trouble with vision		<input type="checkbox"/> None	<input type="checkbox"/> Trouble urinating <input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney stones <input type="checkbox"/> Kidney failure/dialysis	
Heart			Gastrointestinal		
<input type="checkbox"/> None	<input type="checkbox"/> Heart Attack <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Chest pain or angina <input type="checkbox"/> Heart Failure <input type="checkbox"/> Murmur <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Pacemaker <input type="checkbox"/> Heart Catheterization (Year _____) <input type="checkbox"/> Heart surgery (Year _____) <input type="checkbox"/> Last stress test was: ___/___/___		<input type="checkbox"/> None	<input type="checkbox"/> Inflammatory bowel disease (Crohns/UC) <input type="checkbox"/> Reflux (GERD) <input type="checkbox"/> Jaundice (skin/eyes turn yellow) <input type="checkbox"/> Nausea or Vomiting <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Constipation or Diarrhea <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Hepatitis <input type="checkbox"/> Last colonoscopy was ___/___/___	
Lungs			Vascular		
<input type="checkbox"/> None	<input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Cough or Shortness of breath <input type="checkbox"/> Pneumonia <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema/COPD		<input type="checkbox"/> None	<input type="checkbox"/> Blood clots/DVT <input type="checkbox"/> Leg pain when walking or at rest <input type="checkbox"/> Aneurysms <input type="checkbox"/> Leg/foot ulcers or wounds	
Women			Men		
<ul style="list-style-type: none"> • Age of first menses: _____ • Number of pregnancies: ____/ Abortions: _____ • Age of first pregnancy: _____ • Last menstrual period: ___/___/_____ • Last mammogram was: ___/___/_____ 			<input type="checkbox"/> None <input type="checkbox"/> Prostate problems <input type="checkbox"/> Erectile dysfunction <input type="checkbox"/> Testicular pain or swelling <input type="checkbox"/> Hernias or Previous Hernia Surgery <input type="checkbox"/> Sexually transmitted diseases		
<input type="checkbox"/> None	<input type="checkbox"/> Polycystic Ovarian Syndrome <input type="checkbox"/> Female/Pelvic Surgery <input type="checkbox"/> Breast mass or cancer <input type="checkbox"/> Sexually transmitted diseases				
Patient Statement: To the best of my knowledge, the above information is accurate and complete.					
Patient Signature:		Date: / /		Reviewed by Physician:	



Patient Registration Form

Last Name:		First Name:		Middle Initial:	
Birthday: __ __ / __ __ / __ __ __ __		Social Security #:		<input type="checkbox"/> Female <input type="checkbox"/> Male	
Local Address					
	Street		City		State Zip
	Home Phone #		Cell Phone #		E-mail Address
Permanent Address (If Different from Above)					
	Street		City		State Zip
	Home Phone #		Cell Phone #		E-mail Address
Emergency Contact Person:			Phone #:	Relationship:	
Primary Insurance					
	Insurance Company		Name of Insured Subscriber		
	Subscriber's Birth Date		Subscriber's Social Security		Employer
Secondary Insurance					
	Insurance Company		Name of Insured Subscriber		
	Subscriber's Birth Date		Subscriber's Social Security		Employer
<p>Financial Policy:</p> <p>We are committed to providing you with the best care and we will be happy to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship.</p> <ul style="list-style-type: none"> ● All patients must complete our "Patient Registration" form and present insurance cards BEFORE seeing the physician. ● We will be happy to file insurance claims as a courtesy to you as our patient. ● Payment for services NOT COVERED by insurance is to be paid at the time of service. ● We accept Cash, Checks, and VISA & MASTERCARD. We can also make payment arrangements if necessary. ● Any account over 90 days without payment is subject to being forwarded to a collection agency and therefore subject to collection fees, attorney fees, and court costs. 					
<p>Patient Statement: I understand that I am ultimately responsible for any services NOT COVERED by my insurance company. I authorize my insurance company to pay Bradenton Surgical Group, P.A. (Dr. Gary M. Bunch) directly for services rendered by him or his office.</p>					
Patient /Legal Guardian Signature:				Date: / /	