



Your Journey to Healthy Living



PRELIMINARY APPLICATION

PLEASE COMPLETE AND BRING TO INFORMATION SESSION

General Information

Date _____ Name _____ email _____

Address _____

Phone Home (____) _____ Work (____) _____ Cell (____) _____

Sex _____ Age _____ Current Weight or Best Estimate _____ Current Height _____ft _____in

How did you hear of this program? TV Radio Newspaper LRGH.org WINH.org

My Doctor _____ Another Patient Other _____

Your Primary Choice Choose more than one if you're unsure.

Surgical Programs Gastric Bypass Gastric Sleeve

Hospitalizations List all inpatient hospitalizations, including any for psychiatric and substance abuse treatment.

Table with 3 columns: Date, Diagnosis, Hospital

Medical and Psychiatric History Check each of the following conditions that you are experiencing now, or have experienced in the past. List any additional conditions.

Medical

- Diabetes, Hypertension/high blood pressure, Sleep apnea / C-PAP, High cholesterol or triglycerides, Heart Disease, Pulmonary Disease, Ulcerative Colitis/Crohn's, Kidney Disease, Liver Disease, Prior Abdominal Surgery, Currently smoking, Past history of smoking, Other

Do you need a walking aid Yes No How far can you walk _____

Psychiatric Depression Bipolar disorder Eating disorder Anorexia Bulimia Other _____

Present Medications (Including Psychiatric) _____

Insurance Information

Insurance Co. Name _____ ID # _____

Name of insured _____

Relationship to patient Self Spouse Child Other _____

I have carefully read this assessment and have answered the questions as truthfully as possible.

Signature _____ Date _____