Live Healthy MD

New Patient Information Profile

LIVE HEALTHY MD

Have you ever been a patient in this office for any doctor: ❑ Yes ❑ No

Patient's Full Name: _____
(please print) (First) (Middle) (Last) (name called)

Mailing Address: _____
(Street/apt #) (City) (State) (Zip)

(Date of Birth) (Age) (Sex) (Ethnicity)

(Area Code) (Phone #) (Cell #) (Work #)

(Social Security #) (Employer)

(Email Address) (Pharmacy/Pharmacy Phone #)

(Marital Status) (Spouse's Name)

(Spouse's Date of Birth) (Spouse's SS#)

Please state reason for seeing doctor today: _____

Dr. that referred you here: _____ **Primary Care Physician:** _____

Emergency Contact Name: _____ Phone: _____

Relationship to Patient: _____ 2nd ph #: _____

Primary Insurance Co: _____ Insured: _____

Secondary Insurance Co: _____ Insured: _____

Payment Information: *You will receive statements for balances due which are payable upon receipt. We are happy to assist you with account issues. If your account becomes delinquent & is referred to a 3rd party for collections, you are responsible for all collection and/or attorney fees. Per your insurance contract, all co-pays are due at the time of office visits. Thank you for giving us the opportunity to serve you. Please refer to our payment policy for further information.*

HEALTH HISTORY QUESTIONNAIRE

The following information is very important to your health. Please take time to fully and completely fill out this information. We are counting on you to provide accurate health history information.

Name:	Age:	DOB:
Current Height:	Current Weight:	

Allergies:

❑ Problems with anesthesia ❑ Latex or tape allergy

❑ Food; Please specify: _____

❑ Medication(s); Please specify: _____

_____

History **(please do not write in this space):**

CURRENT MEDICATIONS

Medication		Dose	
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			

PAST MEDICAL HISTORY

Past/Current Medical History (Check all that apply):	❑ Heart Attack	❑ Heart Failure	❑ Atrial Fibrillation	❑ High Blood Pressure
	❑ Diabetes	❑ Elevated Cholesterol	❑ Cancer	❑ Hepatitis/Liver Ds
	❑ Stroke	❑ COPD or Emphysema	❑ Kidney Failure	❑ Reflux Disease
	❑ Blood Clots	❑ Sleep Apnea	❑ Vascular Disease	❑ Hypothyroid
	❑ Asthma	❑ Arthritis	❑ Thyroid problems	❑ Knee/Joint Pain

Have you ever had a colonoscopy? ❑ Yes ❑ No If yes, when? _____

Please list any other medical conditions:

PAST SURGICAL HISTORY

Surgical History and type:	Date of Surgery:
❑ None	
❑ Chest Surgery	
❑ Abdominal Surgery	
❑ Hernia Repair	
❑ Breast Surgery	
❑ Heart Surgery	
❑ Hysterectomy	
❑ Weight Loss Surgery	
❑ Other	

FAMILY MEDICAL HISTORY

Do you have any siblings? ❑ Yes ❑ No If yes, How many sisters? _____ brothers? _____
half-sisters? _____ half-brothers? _____ stepsisters? _____ stepbrothers? _____
Your Birth Order/Position in family: _____

Family History:	Family Relationship:
❑ Colon Cancer	
❑ Breast Cancer	
❑ High Blood Pressure	
❑ Diabetes	
❑ Heart Attack	
❑ Stroke	
❑ Aneurysms	
❑ Obesity	❑ Mother ❑ Father ❑ Grandparent(s) ❑ Sibling(s)

The information from the following question may not be included in your report to the doctor, but is important for the psychologist to know: Have you ever been physically, sexually, verbally, or emotionally abused? If yes, explain: _____

SOCIAL HISTORY

Education:	Highest degree completed: ❑ GED ❑ High School ❑ College ❑ Masters ❑ PhD ❑ MD ❑ Other: ________________
Occupation:	❑ Employed Full Time ❑ Employed Part Time ❑ Disabled ❑ Unemployed ❑ Full Time Student ❑ Part Time Student Current Position: ____
Current Marital Status:	❑ Married ❑ Separated ❑ Single ❑ Widowed ❑ Divorced ❑ Partnered # number of times married _____
Pregnancies	Number of pregnancies _______ Number of miscarriages/abortions _____ /_____ Current ages of biological children ____ Number of males _______ Number of females _______ How many of your children are overweight or obese? _______ Current ages of step-children ____ How many of your step-children are overweight or obese? ______
Tobacco Use:	❑ Never ❑ Previously, but quit ❑ Currently (list packs/day and # of years) Year you quit _____ ___________________________________
Substance History:	❑ Never ❑ Rarely (less than once a month) ❑ Occasionally (less than once a week) ❑ Moderately (one or more times weekly) ❑ Daily ❑ I quit drinking (year _____) Quit due to a problem with alcohol? ❑ Yes ❑ No Have you ever gone on drinking binges where you feel that you may not be able to stop (drinking much more than most people would drink under the same circumstances? ❑ Yes ❑ No If yes, how often during the worst week? ________________________________ Have you ever used marijuana? ❑ Yes ❑ No ❑ Never ❑ Rarely (less than once a month) ❑ Occasionally (less than once a week) ❑ Moderately (one or more times weekly) ❑ Daily ❑ I quit (year _____) Quit due to a problem with marijuana? ❑ Yes ❑ No Have you ever had a DUI? ❑ Yes ❑ No If so, when? (If more than one, include all dates) ____________________________
Behavioral Addiction(s):	Have you ever been in treatment for alcohol or drug addiction? ❑ Yes ❑ No Have you ever abused or been addicted to prescription medication(s)? ❑ Yes ❑ No If so, what medication(s) and when? ____ What other drugs are you currently using or have you used in the past? Name of Drug / Current? How often? / Past? What year(s)? ___________________________ ____________________ __________________ ___________________________ ____________________ __________________
Behavioral	Please indicate any of the following that you currently struggle with or have struggled

Addiction(s) continued:	with in the past: Current? How long? Past? What year(s)? Gambling _____ _____ Shopping _____ _____ Pornography/Sex _____ _____ Other _____ _____ _____ Are there addiction problems in your immediate and/or extended family? ❑ Yes ❑ No If yes, please note which addiction(s): ❑ Gambling ❑ Shopping ❑ Pornography/Sex ❑ Other _____ Who? _____ _____
Mental Health	Are you currently, or have you ever been in counseling with a professional therapist or a psychiatrist for a mental *health problem* (such as: Anxiety, Depression, or Family Conflict, Alcohol/Drugs, Anger, ?) ❑ Yes ❑ No If yes, when, why and where? _____ _____ Have you ever had suicidal thoughts? ❑ Yes ❑ No If yes, when? _____ Have you ever attempted suicide? ❑ Yes ❑ No If yes, describe: _____ Have you ever felt homicidal? ❑ Yes ❑ No If yes, when/how recently? _____ Have you ever attempted to end someone else's life? ❑ Yes ❑ No If yes, describe: _____

REVIEW OF SYSTEMS	
Check the boxes that apply to YOU.	
Constitutional:	❑ Weight gain ❑ Weight Loss
Eyes:	❑ Double vision ❑ Blurred vision
Cardiovascular:	❑ Heart attack or chest pain ❑ Pain in legs with walking
ENT:	❑ Hearing Loss ❑ Sore throat
Respiratory:	❑ Excessive shortness of breath ❑ Chronic/Persistent cough
Gastrointestinal:	❑ Recent blood in stool ❑ Heart Burn
Genitourinary:	❑ Difficulty with urination ❑ Incontinence
Musculoskeletal:	❑ Leg cramps ❑ Joint pain
Skin/Breast:	❑ Breast mass ❑ Nipple discharge
Neurological:	❑ Seizures ❑ Stroke
Psychiatric:	❑ Depression ❑ Anxiety Disorder ❑ Bipolar Disorder ❑ Other: _____
Endocrine:	❑ Hot/Cold episodes ❑ History of thyroid disease
Hematology/Lymphatic	❑ Abnormal bleeding ❑ History of blood clots

WEIGHT HISTORY

Please indicate your weight at the following times during your life. Note significant life events that contributed to weight gain during the given age ranges (EG: divorce, child born, abuse, death of loved ones, injuries, etc.)

Age	Weight	Significant Life Events at that Age
0 – 5		
6 – 12		
12 – 18		
20-30		
30-40		
40-50		
50-60		
60-70		

PATIENT READINESS

Readiness

For how long have you been seriously trying to lose weight? _____ years

Rate the following on a scale from 0 – 10:

Your seriousness at dieting attempts: _____

How desperately you want to lose weight: _____

Your level of frustration with medical weight loss programs: _____

What are you willing to do to lose and maintain a significant amount of weight loss?

_____

_____

Are you willing to attend individual counseling if it is recommended prior to your having weight loss surgery?

❑ Yes ❑ No (If not, why? _____)Are you willing and able to attend Live Healthy Support Group meetings before and after your weight loss surgery?

❑ Yes ❑ No (If not, why? _____)

Diet History

What is the most weight you have ever lost with dieting? _____ lbs

Your age at the time _____

What did you do to lose this weight? _____

How long did it take to lose this weight? _____

How long did it take to regain the weight? _____

And how much did you regain? _____

Which of the following have you tried at some time?

Diet	Your Age at the Time of Diet	Amount of Weight Lost	Length of time you kept weight off
❑ Adkins			
❑ South Beach			
❑ Grapefruit			
❑ Cabbage			
❑ Jenny Craig			
❑ Weight Watchers			
❑ PHC			
❑ Nutrisystem			
❑ Diet Pills			
❑ Very Low Cal Diet			
❑ Other:			
❑ Other:			

Professional advice

Which of the following professionals have you worked with to lose weight?

Professional	Your Age at the Time of Diet	Amount of Weight Lost	Length of time you kept w ight off
❑ Family Doctor			
❑ Weight Loss Specialist/ MD			
❑ Dietician			
❑ Psychologist			
❑ Overeaters Anonymous			
❑ Weight Watchers			
❑ Other			

Preparation for surgery	What is the most important reason you are interested in weight loss surgery: _____ What are your weight loss goals: _____ What do you believe is a healthy weight for you? _____ How confident are you that you can/will lose the amount of weight you expect to following surgery? ❑ Extremely ❑ Somewhat ❑ Not at all ❑ Unsure How confident are you that you will MAINTAIN your weight loss over time? ❑ Extremely ❑ Somewhat ❑ Not at all ❑ Unsure How does your family feel about you pursuing weight loss surgery? ❑ Supportive ❑ Skeptical ❑ Unsupportive ❑ Think you're crazy What have you done to research the option of weight loss surgery? ❑ Internet Research ❑ Informational Session ❑ Books ❑ Other Patients ❑ Other Sources: _____ What weight loss operation are you considering? ❑ Gastric Bypass ❑ Gastric Banding ❑ Sleeve Gastrectomy ❑ Duodenal Switch ❑ Not Sure What side affects are you aware of in terms of bariatric surgery? _____ _____ Will anyone attempt to sabotage your weight loss? _____ Who? _____ To what extent do you enjoy physical activity? ❑ Not at all ❑ Slightly ❑ Moderately ❑ Greatly Do you currently exercise? ❑ Yes ❑ No If so, what do you do and how often? _____ _____ Are you aware of the guidelines for how much time is suggested for exercise in order to keep weight off after losing weight? ❑ No, I'm not aware. ❑ Yes, they are: _____

Preparation for surgery continued:	***How do you SPECIFICALLY plan to meet the exercise requirements?*** _____ _____ ***What SPECIFIC healthy eating and exercise behaviors are you willing to implement between now and the time you have the surgery AND that you will continue following your surgery in order to lose weight and maintain the weight loss?*** _____ _____ _____ _____ What positive coping skills do you use on a regular basis to help you get through difficult situations? (A positive coping skill is a behavioral tool which may be used to help in difficult situations, such as deep breathing, journaling, etc.) If none then state none. _____ _____ How do you think that stress in your life affects your eating – in terms of food selections, eating habits (such as eating too quickly, eating while watching TV, etc.)? _____ _____ Given that weight loss surgery does NOTHING to change your thinking patterns, does NOTHING to prevent you from going fast food restaurants or from going to a buffet, does NOTHING to keep holidays from coming and people serving wonderful "bad" foods, does NOTHING to change your old eating habits (times you eat, eating in front of the TV, snacking at work, etc.) what makes you think you will be successful LONG TERM in keeping your weight off because you are having surgery? _____ _____

PHYSICAL EFFECTS OF OBESITY

From which of these physical limitations do you suffer because of your weight?	❑ Get short of breath easily.	❑ Frequently tired and lethargic.
	❑ Unable to participate in family outdoor activities.	❑ Have difficulty with personal hygiene.
	❑ Have difficulty buying clothes.	❑ Cannot cut your toenails/tie shoes.
	❑ Difficulty sitting in chairs with arms.	❑ Travel, especially in planes, is difficult.

What is the most difficult limitation your weight presents in your life: _____
_____

List any other particular difficulties that your weight is currently causing in your life: _____
_____

SOCIAL EFFECTS OF OBESITY

Which of these statements are true about you?	❑ I'm embarrassed about my appearance.	❑ I feel like I'm discriminated against.
	❑ I avoid social activities if possible.	❑ I feel like I've been passed over in the work place due to your weight

Looking in the mirror, would you describe your appearance as: *(Place an "X along the scale 0-10)*

0----------5----------10

Upsetting OK I like my appearance

How important is your physical appearance in your decision to consider surgery?

0----------5----------10

Not important Important Very important

Are you worried about how your weight will have on your future health and your life expectancy?

❑ Yes ❑ No

How important is your future health in your decision to consider surgery?

0----------5----------10

Not important Important Very important

Which of the following have you done in the past 6 months?	❑ Gone on eating binges where you feel that you may not be able to stop (eating much more than most people would eat under the same circumstances? If yes, how often during the worst week? _____ ❑ Ever made yourself sick (vomited) to control your weight or shape? If yes, how often during the worst week? _____ ❑ Ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape? If yes, how often during the worst week? _____ ❑ Ever been treated for an eating disorder? If yes, when and where? _____ If so, was this after an eating binge? _____ ❑ Did you ever eat during the night when most others are sleeping? If so, how often does that happen? _____ ❑ Did you eat when you get upset/angry/worried/bored? If yes, please explain: _____

Eating Attitudes Test (EAT – 26)

For each of the statements below, please choose one of the following six responses:

Always = 3 Usually = 2 Often = 1 Sometimes = 0 Rarely = 0 Never = 0

Questions	**Score**
1. I am terrified about being overweight.	_____
2. I avoid eating when I am hungry.	_____
3. I find myself preoccupied with food.	_____
4. I have gone on eating binges where I feel that I may not be able to stop.	_____
5. I cut my food into small pieces.	_____
6. I am aware of the calorie content of foods that I eat.	_____
7. I particularly avoid food with a high carbohydrate content (i.,e., bread, rice, potatoes, etc.).	_____
8. I feel that others would prefer if I ate more.	_____
9. I vomit after I have eaten.	_____
10. I feel extremely guilty after eating.	_____
11. I am preoccupied with a desire to be thinner.	_____
12. I think about burning up calories when I exercise.	_____
13. Other people think that I am too thin.	_____
14. I am preoccupied with the thought of having fat on my body.	_____
15. I take longer than others to eat my meals.	_____
16. I avoid foods with sugar in them.	_____
17. I eat diet foods.	_____
18. I feel that food controls my life.	_____
19. I display self-control around food.	_____
20. I feel that others pressure me to eat.	_____
21. I give too much time and thought to food.	_____
22. I feel uncomfortable after eating sweets.	_____
23. I engage in dieting behavior.	_____
24. I like my stomach to be empty.	_____
25. I have the impulse to vomit after meals.	_____
26. I enjoy trying new rich foods.	_____
TOTAL SCORE	_____

NUTRITION ASSESSMENT

Allergies

List any food allergies or intolerances.

Food	Allergy/Intolerance Symptoms
_____	_____
_____	_____
_____	_____

Food choices

Please answer each question with a number.

How many times per week do you eat fast food? _____
How many times per week do you dine out? _____
How many times per week do you eat fried foods? _____
How many times per week do you eat sweets? _____
How many times per week do you drink alcohol? _____

Beverages

Check the beverages you drink and how much/how often:

Beverage	Serving size (ounces)	Servings per week
❑ Soda		
❑ Diet Soda		
❑ Juice		
❑ Milk		
❑ Tea		
❑ Sweet Tea		
❑ Coffee ❑ Cream ❑ Sugar		
❑ Fruit Drinks		
❑ Water		
❑ Beer		
❑ Wine		
❑ Liquor		
❑ Other		

Check the foods you crave the most (if any):	❑ Pasta	❑ Rice	❑ Potatoes	❑ Bread
	❑ Cereal	❑ Sweets	❑ Chips	

Check the protein rich foods you enjoy most:	❑ Beef	❑ Chicken	❑ Turkey	❑ Fish
	❑ Eggs	❑ Tofu	❑ Wild Game	❑ Nuts

Do you eat at least one of these foods every day? _____

Do you eat breakfast every day? ❑ Yes ❑ No
If so, what do you eat? _____

Do you regularly skip meals? ❑ Yes ❑ No
If so, what meal do you skip? _____

What do you perceive as your biggest weakness in your diet? (check all that apply)	❑ Portion Control	❑ Light Night Eating	❑ Emotional Eating
	❑ Grazing	❑ Binge Eating	❑ Meal Skipping
	❑ Sweets	❑ Sugared Beverages	❑ Other: _____

3-Day Food Diary

Please use this form to keep a record of everything you eat and drink for the next 3 days. Please write everything you eat and drink down and approximate amounts. This will help me determine what changes you need to make after your surgery. Please be honest. This will in no way determine whether or not you are a good candidate for weight loss surgery.

Day 1	Day 2	Day 3
Breakfast	Breakfast	Breakfast
Lunch	Lunch	Lunch
Dinner	Dinner	Dinner
Snacks	Snacks	Snacks

PATIENT ACKNOWLEDGMENT FORM

Patient's Name: _____ SSN: _____ DOB:_____

I understand that the patient's health information is private and confidential. I understand that Live Healthy MD works very hard to protect the patient's privacy and preserve confidentiality of the patient's personal health information.

I understand that Live Healthy MD may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. I understand that the nutritionist(s) and mental health practitioner(s) who contract with Live Healthy MD and the program director will have access to my medical file. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

Live Healthy MD has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and contains a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses and communications; and receiving an accounting of disclosures as required by law.

Live Healthy MD may update this Acknowledgment and "Notice of Privacy Practices". If I ask, Midtown Surgical Specialists/Live Healthy MD will provide me with the most current "Notice of Privacy Practices".

Live Healthy MD has established procedures which help them meet their obligations to patients. These procedures may include signature requirements, written acknowledgments/authorizations; reasonable time frames for requests, charges for copies and non-routine information needs; etc. I will assist Live Healthy MD by following these procedures if I exercise any rights described in the "Notice of Privacy Practices".

I have received a copy of Live Healthy MD "Notice of Privacy Practices".

Signature: _____ Date: _____

_____

Relationship to patient if signed by anyone other than patient (parent, legal guardian, person representative, etc.)

PATIENT ACKNOWLEDGMENT FORM CONTINUED

With this consent, Live Healthy MD may call my home or other alternative location and leave a message, to include return call messages, on voice mail or with any person who answers in reference to any items that assist the practice in carrying out treatment, payment, and operations such as appointment reminders, insurance items and calls pertaining to my clinical care, including test results, notification regarding surgery among others. This would apply to mailed information and e-mail also. I further authorize Live Healthy MD to release my protected health information to my family members both verbally and written, and to mail prescription, disability forms, etc. to me or my family members as needed.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

The above information on all of these pages has been completed by me and is true and correct to the best of my knowledge.

Signature: _____ Date: _____

_____

Relationship to patient if signed by anyone other than patient (parent, legal guardian, person representative, etc.)

Printed name of Patient and/or Personal Representative: _____

LIVE HEALTHY MD
SURGICAL AND MEDICAL WEIGHT LOSS

Patient Acknowledgment of Payment Policy

1. Payment of insurance co-payment prior to routine scheduled office visits is expected. This is required by your insurance company contract. If co-payment cannot be made at the time of service your appointment may be rescheduled to the next available time.
2. We will bill your insurance company for services rendered. Once insurance payment has been made and credited to your account, you will then receive a statement for any outstanding portion of the account to include deductibles. We appreciate payment in full by the billing due date. If payment cannot be made in full within 30 days of the first statement then we would appreciate you making arrangements with our billing office to set up a payment plan. A payment plan may be established with the office through the use of:
    a. Recurring payment with a credit/debit card
    b. Establishing monthly payment contract with our office
    c. Extension of a line of credit through a medical services credit company
3. Statements will be mailed to you monthly for our outstanding balances. If the account is not paid in full or no payment has been received by the fourth statement then the account balance may be forwarded for collections in accordance with laws established by the State of Georgia. Monthly finances charges may be applied to all out standing balances over 30 days.
4. **Prior to elective surgery we will confirm benefits, and calculate balances on deductibles with your insurance company. For your convenience, this will allow us to determine your portion of the bill prior to the procedure. We expect payment of this balance prior to the procedure, or establishing a payment plan prior to the procedure in order to avoid billing concerns after the rendered services.**
5. **Questions or concerns regarding your bills should be addressed directly with the midtown billing staff and not your physician at (706) 738-3359.**
6. We take pride in our relationship with you and appreciate you giving us the unique opportunity to care for you and your family. We understand that medical care can be costly. We are willing to work with you in any way possible to minimize the financial stress associated with having surgery and being ill. However, we can only do this if you communicate your concerns with our billing office and allow us to assist you in this matter. We cannot help you if we do not know what the problem is regarding making payment.
7. I give my permission for the staff and physicians at Midtown Surgical and Live Healthy MD to contact me with automated reminders by the above methods. I understand that patient specific medical information will not be left, but information about appointment dates, times, doctors and locations and instructions will be communicated. We cannot guarantee that someone else other than the intended patient will not receive the call/message.

_____ _____ _____

PRINTED NAME SIGNATURE DATE

Automated Message Consent

In our office we have an automated system that will allow us to communicate with you better. The system will allow us to send you automated appointment reminders and other messages by:

1. voice message (land and cell lines): **Home #**_____

Cell #_____

Work #_____

2. text message (must have text capability) **Cell #:** _____

3. **email address:** _____

1. Can we contact you by this system (we will not leave medically sensitive information):

❑ YES ❑ No

2. If YES, then please answer the following questions:

1. How do you want to be contacted:

❑ Voice ❑ Text ❑ Both

2. If voice message, then what number do you prefer us to call:

❑ Home ❑ Cell ❑ Work

3. When do you want to get these messages

❑ Morning ❑ Afternoon ❑ Evening