LiveNew

Patient Information
#001 rev. 10/17

PATIENT INFORMATION

Full Name: _____ SSN: _____

Sex: ☐ M ☐ F DOB: ____/____/_____ Preferred Name: _____

Address: _____

City _____ State _____ Zip Code _____

Mailing Address: ☐ Check if same as above

_____

City _____ State _____ Zip Code _____

Home Phone: (_____) - _____ - _____ Cell Phone: (_____) - _____ - _____

Email: _____

Marital Status: ☐ Divorced ☐ Legally Separated ☐ Married ☐ Significant Other ☐ Single ☐ Widowed

Preferred Language: ☐ English ☐ Other (please specify) _____ Written Language_____

Religion: _____ ☐ Declined Birthplace: _____

Ethnicity: Do you consider yourself to be Hispanic or Latino? ☐ Yes ☐ No ☐ Declined

Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ White
☐ Black or African American ☐ Asian ☐ Declined

EMPLOYMENT

Name _____ Employer Phone: (_____) - _____ - _____ Occupation _____

Status: ☐ Part-time ☐ Full-time ☐ Self-Employed ☐ Retired ☐ Active Military ☐ Disabled ☐ Student
☐ Unemployed

PHARMACY

Name of Pharmacy _____ Address _____

City _____ State _____ Zip Code _____

CARE TEAM

Primary Care Provider: _____ Phone Number (_____) - _____ - _____

Specialist Name: _____ Specialty: _____ Phone #: (_____) - _____ - _____

Specialist Name: _____ Specialty: _____ Phone #: (_____) - _____ - _____

EMERGENCY CONTACT

Name: _____ Relation to Patient: _____

Address: _____

Phone: (_____) - _____ - _____

Name: _____ Relation to Patient: _____

Address: _____

Phone: (_____) - _____ - _____

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PARTY RESPONSIBLE FOR PAYMENT

Name: _____ DOB: _____/_____/_____

Address: _____

City _____ State _____ Zip Code _____

Phone: (_____) - _____ - _____

SSN: _____ Relation to Patient: _____

Employer: _____

ADVANCE DIRECTIVES

Do you have a Living Will / DNR? ☐ Yes ☐ No

Do you have a Durable Power of Attorney? ☐ Yes ☐ No

If yes, (Print Name) _____ (Phone Number) (_____) - _____ - _____

If no, would you like information regarding Advance Directive? ☐ Yes ☐ No

ALLERGIES ☐ No Known Drug Allergies

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Other (latex, adhesive, food, environment): _____

Other (latex, adhesive, food, environment): _____

Other (latex, adhesive, food, environment): _____

MEDICATIONS ☐ None

Please list any medications you are taking (including aspirin, vitamins, supplements or any other over the counter medication).

Name of Medication	Dose	How often do you take	Reason for taking

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PATIENT INFORMATION

Name: _____ DOB: _____/_____/_____

PERSONAL MEDICAL HISTORY

Please check all diagnoses that apply to you and add notes as needed.

AIDS	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	High Triglycerides	☐ Yes	☐ No
Arrhythmia/Palpitations	☐ Yes	☐ No	HIV	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Hypertension (High blood pressure)	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Inflammatory Bowel Disease (e.g. Crohn's)	☐ Yes	☐ No
Atrial Fibrillation	☐ Yes	☐ No	Irritable Bowel Syndrome (IBS)	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	Kidney Disease/Failure	☐ Yes	☐ No
Bipolar Disorder	☐ Yes	☐ No	Kidney Stones	☐ Yes	☐ No
Bleeding disorder/ tendency	☐ Yes	☐ No	Long-Term Steroid Use	☐ Yes	☐ No
Blood Clots	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Macular Degeneration	☐ Yes	☐ No
Bone Loss - DEXA: _____	☐ Yes	☐ No	Motor Vehicle Accident	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Oxygen Use	☐ Yes	☐ No
Chronic Fatigue	☐ Yes	☐ No	Peripheral Artery Disease	☐ Yes	☐ No
Chronic Kidney Disease	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No
Chronic Pain	☐ Yes	☐ No	Pseudotumor Cerebri		
Connective Tissue Disorder	☐ Yes	☐ No	(Normal Pressure Hydrocephalus)	☐ Yes	☐ No
COPD/Emphysema	☐ Yes	☐ No	Restless Leg Syndrome	☐ Yes	☐ No
CVA/Stroke	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Sciatica	☐ Yes	☐ No
Diabetes - Type: _____	☐ Yes	☐ No	Scoliosis	☐ Yes	☐ No
Dialysis (hemodialysis or peritoneal)	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Disabilities: _____	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Diverticulitis	☐ Yes	☐ No	Sinusitis, recurrent	☐ Yes	☐ No
Ear Infection, recurrent	☐ Yes	☐ No	Sleep Apnea	☐ Yes	☐ No
Eating Disorder	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Genetic/Congenital Condition:	☐ Yes	☐ No	Urinary Incontinence	☐ Yes	☐ No
GERD (Heartburn)	☐ Yes	☐ No	UTI (Bladder infections)	☐ Yes	☐ No
GI Bleeding	☐ Yes	☐ No	Vertigo	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Other Conditions: _____		
Gunshot Wound	☐ Yes	☐ No	_____		
Head Injury/Concussion	☐ Yes	☐ No	**HEALTH SCREENING**		
Hearing Deficit	☐ Yes	☐ No	**Date of last colonoscopy** _____/_____/_____		
Heart Disease (e.g. Heart attack or CAD)	☐ Yes	☐ No	Doctor: _____		
Hepatitis - Type: _____	☐ Yes	☐ No	History of colon polyps	☐ Yes	☐ No
Hiatal Hernia	☐ Yes	☐ No	**Date of last prostate exam** _____/_____/_____		

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Name: _____ DOB: _____/_____/_____

SURGICAL HISTORY

Please list surgeries/procedures and add notes as needed

Year	Surgery/Procedure	Hospital/Location	Complications/Additional Notes

Have you ever had a reaction to general anesthesia? ☐ Yes ☐ No

Additional Personal Medical History

_____

_____

_____

FEMALE PATIENTS ONLY

☐ Abnormal Pap Smear

Form of Contraception (if any) _____

Planning Pregnancy? ☐ Yes ☐ No

Age of first menstrual period: _____/_____/_____Last Mammogram: _____/_____/_____

Date of last menstrual period: _____/_____/_____ Last Pap Smear: _____/_____/_____

Number of pregnancies: _____ Number of Deliveries: _____ Number of Elective abortions: _____

Number of Miscarriages: _____

Currently Pregnant? ☐ Yes ☐ No Currently Breastfeeding? ☐ Yes ☐ No

Age of menopause: _____

Sexual Activity: ☐ Not active ☐ Active

Number of lifetime sexual partners: _____ ☐ Men ☐ Women ☐ Both

Do you have a caregiver? ☐ Yes ☐ No

(If yes) Name: _____ Relationship: _____

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REVIEW OF SYMPTOMS

Please check any symptoms you've experienced over the **LAST ONE TO TWO WEEKS:**

General Constitution
- ☐ Activity Change
- ☐ Appetite Change
- ☐ Chills
- ☐ Diaphoresis (Sweating)
- ☐ Fatigue
- ☐ Fever
- ☐ Irritability
- ☐ Unexpected Weight Change

Ear, Nose, & Throat
- ☐ Congestion
- ☐ Dental Problems
- ☐ Drooling
- ☐ Ear Discharge
- ☐ Ear Pain
- ☐ Facial Swelling
- ☐ Hearing Loss
- ☐ Mouth Sores
- ☐ Nosebleeds
- ☐ Postnasal Drip
- ☐ Rhinorrhea (Runny Nose)
- ☐ Sinus Pressure
- ☐ Sneezing
- ☐ Sore Throat
- ☐ Tinnitus (Ringing in the Ears)
- ☐ Trouble Swallowing
- ☐ Voice Change

Eyes
- ☐ Eye Discharge
- ☐ Eye Itching
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Photophobia (Sensitivity to Light)
- ☐ Visual Disturbance (Blurred Vision)

Respiratory
- ☐ Apnea
- ☐ Chest Tightness
- ☐ Choking
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Stridor (Airway Obstruction)
- ☐ Wheezing

Cardiovascular
- ☐ Chest Pain
- ☐ Leg Swelling
- ☐ Palpitations (Irregular Heart Beat)

Gastrointestinal
- ☐ Abdominal Distention (Bloating)
- ☐ Abdominal Pain
- ☐ Anal Bleeding
- ☐ Blood in Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Rectal Pain
- ☐ Vomiting

Endocrine
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Polydipsia (Abnormal Thirst)
- ☐ Polyphagia (Abnormal Hunger)
- ☐ Polyuria (Abnormal Urination)

Genitourinary
- ☐ Difficulty Urinating
- ☐ Dysuria (Painful Urination)
- ☐ Enuresis (Involuntary Urination)
- ☐ Flank Pain (Low Back Pain)
- ☐ Frequency Change (Urinary)
- ☐ Genital Sores
- ☐ Hematuria (Blood in Urine)
- ☐ Menstrual Problems
- ☐ Pelvic Pain
- ☐ Penile Discharge
- ☐ Penile Pain
- ☐ Penile Swelling
- ☐ Scrotal Swelling
- ☐ Testicular Pain
- ☐ Urinary Urgency
- ☐ Changes in Urine Stream
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge
- ☐ Vaginal Pain

Musculoskeletal
- ☐ Arthralgias (Joint Pain)
- ☐ Back Pain
- ☐ Gait Problems
- ☐ Joint Swelling
- ☐ Myalgias (Muscle Pain)
- ☐ Neck Pain
- ☐ Neck Stiffness

Skin
- ☐ Color Change
- ☐ Pallor (Paleness)
- ☐ Rash
- ☐ Wounds

Allergy/Immunologic
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Immunocompromised

Neurologic
- ☐ Dizziness
- ☐ Facial Asymmetry
- ☐ Headache(s)
- ☐ Light Headedness
- ☐ Numbness
- ☐ Seizures
- ☐ Speech Difficulty
- ☐ Syncope (Loss of Consciousness)
- ☐ Tremors
- ☐ Weakness

Hematologic
- ☐ Adenopathy (Swollen Glands)
- ☐ Bruising Tendency
- ☐ Bleeding Tendency

Behavioral
- ☐ Agitation
- ☐ Behavioral Problems
- ☐ Confusion
- ☐ Decreased Concentration
- ☐ Dysphoric Mood (Mood Changes)
- ☐ Hallucinations
- ☐ Hyperactive
- ☐ Nervousness
- ☐ Anxiety
- ☐ Self Injury
- ☐ Sleep Disturbances
- ☐ Suicidal Thoughts

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FAMILY HISTORY

In this section, please complete this chart to the best of your knowledge. If you are adopted and have no history of your biological family, please place an X in the box: ☐ Adopted

What illnesses/conditions/diagnoses are in your family? Indicate the age of diagnosis in the boxes, if known.

Relationship	Name	Status	Blood Clots	High Blood Pressure	High Cholesterol	Colon Cancer/Polyps	Inflammatory Bowel Disease (e.g. Crohn's)	Obesity	Liver Disease or Hepatitis	Cancer	Gallbladder Disease	Anxiety or Depression	Substance Abuse	Diabetes	Coronary Artery Disease
Mother		☐ Alive ☐ Deceased													
Father		☐ Alive ☐ Deceased													
Sibling 1		☐ Alive ☐ Deceased													
Sibling 2		☐ Alive ☐ Deceased													
Sibling 3		☐ Alive ☐ Deceased													
Sibling 4		☐ Alive ☐ Deceased													
Child 1		☐ Alive ☐ Deceased													
Child 2		☐ Alive ☐ Deceased													
Child 3		☐ Alive ☐ Deceased													
Child 4		☐ Alive ☐ Deceased													
Maternal Grandmother		☐ Alive ☐ Deceased													
Maternal Grandfather		☐ Alive ☐ Deceased													
Paternal Grandmother		☐ Alive ☐ Deceased													
Paternal Grandfather		☐ Alive ☐ Deceased													

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INITIAL EVALUATION FORM FOR WEIGHT LOSS SURGERY

Name _____ Date of Birth ___/____/_____ Age _____
Insurance Company _____
Primary Phone (_____) - _____ - _____
Height _____ Current Weight _____
Address _____
Email Address _____ Marital Status: S M D W

PRIMARY CARE DOCTOR/PROVIDER

Name of Physician _____
Address _____
Phone (_____) - _____ - _____ Fax (_____) - _____ - _____
Please list any other physicians/specialists you see:
Name of Physician _____ Specialty _____
Address _____
Phone (_____) - _____ - _____ Fax (_____) - _____ - _____
Name of Physician _____ Specialty _____
Address _____
Phone (_____) - _____ - _____ Fax (_____) - _____ - _____

Record below major diets that resulted in a weight loss of 10 pounds or more (use additional pages as needed)

Year	Length of Diet	Starting Weight	# of lbs lost	Length of time weight stayed off	Type of diet program

At what age did you develop a significant weight problem? _____
Are there events that are related to your weight gain? If so, what are they? _____
_____
_____

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Medical Health Information

Please indicate if any of the following conditions have ever been significant problems for you. Please specify the year diagnosed and the physician who currently manages the problem.

BLOOD DISORDERS

Do you have or have you had any abnormalities with bleeding or clotting? ☐ YES ☐ NO

If yes, explain: _____

OTHER MEDICAL DISORDERS

_____

_____

_____

_____

SMOKING/DRUG/ALCOHOL HISTORY

Do you currently use tobacco? ☐ YES ☐ NO Have you ever used tobacco? ☐ YES ☐ NO

If you answered yes to the above questions:

a. What type of tobacco do/did you use? ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chew/Snuff
b. What age did you start tobacco use? _____
c. How many years have you used tobacco? _____
d. How much do/did you usually smoke per day?
   ☐ ½ pack or less ☐ between 1 to 1½ packs ☐ between 1½ to 2 packs ☐ 2½ packs or more
e. If applicable, what age did you quit smoking? _____

Do you currently drink alcohol? ☐ YES ☐ NO

If you answered yes to the above question:

a. Type of alcohol ☐ Wine ☐ Beer ☐ Mixed Drinks ☐ Other _____
b. Please indicate how many drinks you currently drink: ☐ 1-2 a month ☐ 3-4 a month
   ☐ 5-6 a month ☐ 7-9 a month ☐ 10 a month ☐ Other _____
c. Have you been treated for alcohol problems? ☐ YES ☐ NO

Have you ever used any illicit drugs? (e.g. marijuana, cocaine, heroin, amphetamine, etc.) ☐ YES ☐ NO

a. If yes, please indicate _____
b. How long ago? ☐ 6 months or less ☐ 6 months to 1 year ☐ more than 1 year

Do you use caffeine? ☐ YES ☐ NO

Do you use NSAIDS? (e.g. Aspirin, Ibuprofen, Naproxen, Mobic/Meloxicam) ☐ YES ☐ NO

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BARIATRIC QUESTIONAIRE

Are you receiving any medical or psychological services at this time?
(i.e., repeated doctor visits for the same problems) ☐ YES ☐ NO
Are you currently being treated or have you ever been treated for depression? ☐ YES ☐ NO
Do you have or have you been treated for an eating disorder?
(anorexia, bulimia, binge-eating disorder, compulsive overeating) ☐ YES ☐ NO
Counseling services (type of program) _____
Name of psychiatrist or mental health provider _____
Do you snore? ☐ YES ☐ NO
Do you ever wake at night gasping for breath? ☐ YES ☐ NO
Has anyone ever told you that you stop breathing while asleep? ☐ YES ☐ NO
Do you exercise regularly? ☐ YES ☐ NO
If so, what type of exercise do you perform? _____
How many times a week do you exercise? _____
How long do you exercise each time? _____

In your opinion, which of the following contribute to your excess weight (check all that apply):

☐ Portion sizes ☐ Eating too much fat/sugar ☐ Nervous eating
☐ Emotional eating ☐ Compulsive eating ☐ Stress
☐ Lack of exercise ☐ Lack of knowledge about healthful eating and exercise

---

Have you or one of your relatives/spouse ever
had bariatric surgery or weight reduction surgery? ☐ YES ☐ NO

If yes, answer the following questions:

What relationship are they to you?

☐ Self ☐ Mother ☐ Father ☐ Spouse ☐ Brother ☐ Sister ☐ Other _____

What type of procedure was performed?

☐ Gastric Banding ☐ Roux-en-Y Gastric Bypass ☐ Distal Bypass ☐ Don't Know
☐ Other _____

PREVIOUS DIAGNOSTIC PROCEDURES

Please check any laboratory diagnostic procedures done within the **LAST YEAR**. Please indicate what month they were performed.

☐ EKG _____ ☐ Echocardiogram _____ ☐ Stress Test _____
☐ Heart Catheterization _____ ☐ Upper GI _____ ☐ Lower GI _____
☐ Upper Endoscopy _____ ☐ Abdominal Sonogram _____ ☐ Colonoscopy _____
☐ Sleep Study _____ ☐ Pulmonary Function Test _____ ☐ Chest X-ray _____
☐ CT Scan (body area) _____ ☐ Other _____

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REFERRAL INFORMATION

Please tell us **ALL** the ways that you heard about us in as much detail as possible:

☐ Seminar (which location and date) _____

☐ Website/Internet (which website) _____

☐ Radio (which station) _____

☐ Word-of-Mouth Referral (name) _____

☐ Insurance (name) _____

☐ Hospital (which hospital) _____

☐ Doctor Referral (name) _____

☐ Print Ad (name) _____

☐ Digital Ad (name) _____

☐ Social Media (which application) _____

☐ Mail

☐ Other (please specify) _____

QUESTIONS

Please list any specific question(s) that you may have about your surgical procedure in order that our providers may become aware of your concerns prior to your appointment.

_____

_____

_____

_____

_____

This information is very important. It helps us to give you the best possible medical/surgical care. Thank you for taking the time and energy to complete this worksheet for your bariatric surgery.

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Patient Authorization to Disclose Protected Health Information
#001 rev. 10/17

Patient Authorization to Disclose Protected Health Information

Patient Name	Date of Birth	Last 4 of Social Security Number
Address	**City, State, Zip Code**	**Telephone Number**

I hereby authorize the LiveNew facility listed below to disclose/release the Protected Health Information specified in this request to the organization, agency, or patient named.

Release from: _____	Release to: _____
Facility Name	Facility Name
_____	_____
Address	Address
_____	_____
City, State, Zip Code	City, State, Zip Code

Treatment Date(s): _____
Purpose: ☐ Further Medical Care ☐Workers' Comp
☐ Personal Use ☐ Insurance ☐Legal
☐ Marketing/Fundraising
☐ Other: _____

Type of Disclosure Authorized & Delivery Instructions:
☐ Provide copies of records to organization/agency/individual
☐ Mail records directly to address above
☐ Call to pick-up records: _____
☐ Fax records to: _____

Pertinent Protected Health Information Allowed to be Included:

☐ Discharge summary	☐ Radiology	☐ Special Studies	☐ Entire Medical Record
☐ History & Physical/Consult	☐ Outpt Record	☐ Medication Records	
☐ Operative Report	☐ Progress Notes	☐ Psych Health Records	
☐ Labs	☐ Physician Orders	☐ Other (specify): _____	

Authorization: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by submitting my request in writing to the designated Health Information Management / Medical Records department. If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be as valid as the original.

I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee may be charged for copies of my medical record. I understand the facility will provide me a copy of the signed authorization form. If I have questions about disclosure of my health information, I can contact the designated Corporate Responsibility and Privacy Officer.

Expiration: Without my express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event, will expire 90 days from the date hereof, unless a different date is specified here: _____

Acknowledgement: I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses (HIV), also known as acquired immune deficiency syndrome (AIDS).

For Marketing/Fundraising Purposes Only, if Applicable: I understand that LiveNew ☐ will ☐ will not receive remuneration, either direct or indirect, as a result of the marketing that I hereby authorize.

SIGNATURE: _____DATE: _____
Patient (Parent or Legal Guardian)

Minor's signature is required for release of any records for treatment which the minor may authorize under Colorado Law.
Relationship (if other than patient): _____ ☐ Power of Attorney ☐ Death Certificate
Name of individual signing on behalf of patient: _____
Verification: ☐ Driver's License # _____ ☐ Other Appropriate ID #: _____

OFFICE USE ONLY: Attach copies of required identification.
Number of pages released: _____ Completion date: _____ Delivery method: _____
Name of individual who received request: _____ Date received: _____
Patient Medical Record Number / Account Number: _____/_____