MATTHEW ST. LAURENT, MD, FACS
BOARD CERTIFIED GENERAL SURGEON

PATIENT INFORMATION

Legal Name-Last: ________________________ First: ________________________________ M.I. ____
Birthdate: _______-_______-________ Age: _____ Home Phone: (_____) ________-________
Address: _____________________________ City: _____________ State: _______ Zip Code: _______
Social Security: _______-_______-_______ Drivers License # ___________ Sex: M F
Marital Status: Single Married Divorced Widow Widower
Employer: __________________________ Occupation: __________________________________
Work Phone: (_______) _______-_______
Employer Address: ________________________ City: ___________ State: _____ Zip Code: _______

PRIMARY INSURED/SUBSCRIBER INFORMATION

Legal Name-Last: ________________________ First: ________________________________ M.I. ____
Birthdate: _______-_______-________ Age: _____ Home Phone: (_____) ________-________
Address: _____________________________ City: _____________ State: _______ Zip Code: _______
Social Security: _______-_______-_______ Relationship to patient: ______________________
Employer: __________________________ Employer Address: __________________________
Work Phone: (_______) _______-_______ Occupation: __________________________________

SPOUSE INFORMATION

Spouse's Name: ___________________________ Work Phone: (_______) _______-________

NEAREST RELATIVE NOT LIVING WITH YOU

Name: ___________________________ Relationship: _________________________________
Home Phone: (_______) ________: ________

RESPONSIBLE PARTY STATEMENT

As the responsible party, I agree that all charges that are not directly paid by my Insurance will be my Responsibility.

Responsible Party Signature: _________________________________ Date: ______________________

INSURANCE INFORMATION (Please complete unless self-pay)

Primary Insurance Co. Name: ____
Policy/Certification Number: ____
Group Number: ____
Phone Number: (_______) _______-_______
Secondary Insurance Co. Name: ____
Policy/Certification Number: ____
Group Number: ____
Phone Number: (_______) _______-_______
How did you FIRST hear about us?: (circle) TV NEWSPAPER RADIO other____________________
How did you discover lapbandsolutions.com?: (circle) TV NEWSPAPER RADIO other_____________
Primary Dr.'s Name: _______________________________ Phone Number: (___) _______-__________

ALL INFORMATION MUST BE COMPLETED

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LAP BAND QUESTIONNAIRE

PATIENT WEIGHT LOSS AND MEDICAL HISTORY QUESTIONNAIRE

Name: ____
Weight: ______________ Height: ____________ Date of Birth: ____________
Allergies to medications: ______________________________
Primary care physician: ______________________________
Primary care physician's office number: ________________________

MEDICATIONS: PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

NAME	DOSAGE	FREQUENCY	INDICATIONS

PAST SURGICAL HISTORY: PLEASE LIST SURGICAL OPERATIONS

PROCEDURE	DATE	HOSPITAL	INDICATIONS

FAMILY HISTORY: PLEASE INDICATE FAMILY MEMBERS HAVING ANY OF THE FOLLOWING ILLNESSES

	MOTHER	FATHER	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	SIBLINGS
OBESITY							
DIABETES							
HIGH BLOOD PRESSURE							
HEART DISEASE							
CANCER							
SEIZURES							
BREATHING PROBLEMS							
KIDNEY DISEASE							
ARTHRITIS							
EARLY DEATH & CAUSE							
OTHER							

Patient name: ____

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How many years have you been overweight? ________________________________

PREVIOUS WEIGHT LOSS SURGERY? NO _______ YES ________

SURGERY TYPE	DATE	SURGEON	WEIGHT LOSS

DIET PROGRAMS AND SUPPLEMENTS: **PLEASE INDICATE THE DIETS OR PLANS THAT APPLY**

PROGRAM	DATES	DURATION	MD SUPERVISED?	WEIGHT LOSS
Weight Watchers				
Jenny Craig				
Metabolife				
Medifast				
Nutri/System				
Atkins Diet				
Herbalife				
Slim Fast				
Grapefruit Diet				
Liquid Diets				
Pritikin Diet				
Optifast				
TOPS				
Other				

WEIGHT LOSS MEDICATION HISTORY: **PLEASE INDICATE THE MEDICATIONS THAT APPLY**

MEDICATION	DATES	DURATION	MD SUPERVISED?	WEIGHT LOSS
Amphetamines				
Phentermine (Adipex, Fastin, Pondimen)				
Phen-Fen				
Redux (Dexfenfluramine)				
Xenical (Orlistat)				
Meridia (Sibutramine)				
Other Diet Medication				

NON DIETARY THERAPIES: **PLEASE INDICATE THE WEIGHT LOSS THERAPIES THAT APPLY**

THERAPY	DATES	DURATION	MD SUPERVISED?	WEIGHT LOSS
Exercise				
Hypnosis				
Behavior Modification				
Acupuncture				

Patient name: ____

SOCIAL HISTORY

Do you use tobacco? **YES** **NO**
Number of packs per day _____
Years of tobacco? _____

Do you use alcohol? **YES** **NO**
Amount and frequency _____

Have you ever been treated for depression? **YES** **NO**
Are you currently in treatment? **YES** **NO**
If yes, please indicate the name of you physician or therapist

____

Have you ever been hospitalized for mental illness? **YES** **NO**

SYSTEM REVIEW: PLEASE CIRCLE ALL THAT APPLY

Constitutional
Fatigue
Tiredness
Recent Weight Loss
Fever
Night Sweats
Abnormal Bleeding

Head and Neck
Blurred vision
Double vision
Loss of vision
Loss of hearing
Vertigo Sinus Congestion
Runny Nose
Sneezing
Loss of smell
Sinus infection
Sore throat
Difficulty Swallowing
Hoarseness
Lump in neck
Pain swallowing

Cardiovascular
Chest pain
Pain in arm/neck
Heart attack
Palpitations
Heart pounding
Stroke
Heart murmur
Pain in legs
Cold feet
Loss of pulses
Low blood pressure
High blood pressure
Abnormal heart beats

Respiratory
Shortness of breath
Asthma
Wheezing
Cough
Bloody Sputum
Emphysema
Pneumonia
Bronchitis
Difficulty sleeping flat
Waking at night short of breath

Gastrointestinal
Jaundice
Hepatitis
Cirrhosis
Vomiting
Nausea
Heartburn
Abdominal pain
Diarrhea
Constipation
Pain with bowel movements
Blood in stool
Hemorrhoids
Change in stool size
Irritable bowel
Colitis

Genitourinary
Blood in urine
Frequent urination
Leakage of urination
Pain with urine
Trouble starting urine
Kidney stones
Bladder infection

Men
Discharge from penis
Loss of erection

Women
Vaginal Discharge
Abnormal Vaginal bleeding
Irregular Periods
Hysterectomy
Pap exam w/in last year

Musculoskeletal
Pain in joints
Muscular aches
Swelling of joints
Arthritis
Pain in hips
Pain in knees
Pain in ankles
Pain in feet
Lower back pain
Herniated disk
Sciatica
Numbness in feet or legs
Abnormal lumps or masses

Endocrine
Hyperthyroid
Hypothyroid
Goiter
Previous radiation
Diabetes
Adrenal gland tumor
Previous steroid use
Swollen glands

Skin/Breast
Skin Cancer
Abnormal Moles
Burns
Rash
Breast Mass
Nipple Discharge
Mammogram w/in
in last year

Neurological
Seizures
Convulsions
Fainting
Vertigo
Light Headedness
Falling
Muscle weakness
Numbness
Tremors
Stroke
Loss of
consciousness

Psychological
Depression
Nervousness
Anxiety
Suicidal thoughts
Suicide attempts
Schizophrenia
Anorexia
Bulimia
Binge eating
Counseling
Hospitalization for
emotional problem

Patient name: ____

OBESITY RELATED MEDICAL HISTORY

Do you have or have you had any of the following illnesses or symptoms?

Heart disease	Yes	No	Year of diagnosis ______________
Angina	Yes	No	Year of diagnosis ______________
MI (Heart attack)	Yes	No	Year of diagnosis ______________
Coronary bypass surgery	Yes	No	Year of surgery ______________
Palpitations (abnormal heart beat)	Yes	No	Year of diagnosis ______________
Congestive heart failure	Yes	No	Year of diagnosis ______________
High blood pressure	Yes	No	Year of diagnosis ______________
Elevated Cholesterol	Yes	No	Year of diagnosis ______________
Elevated triglycerides	Yes	No	Year of diagnosis ______________
Asthma	Yes	No	Year of diagnosis ______________
Reflux	Yes	No	Year of diagnosis ______________
Heartburn	Yes	No	Year of diagnosis ______________
Esophagitis	Yes	No	Year of diagnosis ______________
Hiatel Hernia	Yes	No	Year of diagnosis ______________

Shortness of breath	Yes	No	
How many blocks can you walk?	__________		
Flights of stairs?	__________		

Sleep Apnea	Yes	No	Year of diagnosis _____________
Do you use CPAP/BiPAP	Yes	No	

Sleep difficulties

Snoring	Yes	No
Awakening at night	Yes	No
Daytime drowsiness	Yes	No
Observed apnea spells	Yes	No
Morning headaches	Yes	No

Venous Stasis	Yes	No
Leg or ankle edema	Yes	No
Leg ulceration	Yes	No

Pain of Arthritis	Yes	No
In ankles	Yes	No
In knees	Yes	No
In hips	Yes	No
Limits ability to walk	Yes	No
Limits ability to exercise	Yes	No

Low back pain/Sciatica	Yes	No
Limits ability to walk	Yes	No
Limits ability to exercise	Yes	No

Patient name: ____

Diabetes	Yes	No	Year of diagnosis _______________
Juvenile onset			
Gestational (pregnancy)			
Adult onset			
Diet controlled	Yes	No	
Oral medications	Yes	No	
Insulin	Yes	No	

Urinary Incontinence	Yes	No
Leaking urine with cough	Yes	No
Leaking urine with sneezing	Yes	No
Leaking urine with straining	Yes	No

Migraine	Yes	No
Frequency _______________		

Deep Venous Thrombosis	Yes	No	Year of diagnosis _______________
Pulmonary embolism	Yes	No	

Abdominal wall hernia	Yes	No
Incisional	Yes	No
Umbilical	Yes	No
Number of hernia repairs ____________		

Have you ever had/been:

Blood transfusions	Yes	No
Hepatitis	Yes	No
Exposed to HIV/AIDS	Yes	No
Abused intravenous drugs	Yes	No

PAST MEDICAL HISTORY

Please list all other medical conditions, illnesses or important information not previously mentioned:

____
____
____
____
____
____

Patient signature: ______________________________________ Date: ______________________