



Patient Profile

Patient Information

First Name: _____ M.I.: _____ Last Name: _____
Birth Date: ____/____/____ Sex: M F Social Security Number: _____-_____-_____
Email Address: _____
Street Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: (____) ____-____ Work Phone: (____) ____-____ Cell Phone: (____) ____-____
Employer: _____ Phone (____) ____-_____

Are you covered by Medicare or Tricare/CHAMPVA or employed by a federal agency?

Yes – please see receptionist No

Primary Insurance (Please provide all requested information)

Insurance Company: _____ Benefits Phone Number: (____) ____-_____
Plan Type: PPO HMO EPO POS Other: _____
Group #: _____ Member #: _____
Whose insurance is this? Self – Skip to secondary insurance Other – Complete this section
Relationship to patient: Spouse Parent Other: _____ Social Security #: _____-_____-_____
First Name: _____ M.I.: _____ Last Name: _____
Street Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: (____) ____-____ Work Phone: (____) ____-____ Cell Phone: (____) ____-____
Employer: _____ Phone (____) ____-_____

Secondary Insurance (Please provide all requested information)

Insurance Company: _____ Benefits Phone Number: (____) ____-_____
Plan Type: PPO HMO EPO POS Other: _____
Group #: _____ Member #: _____
Whose insurance is this? Self – Skip to secondary insurance Other – Complete this section
Relationship to patient: Spouse Parent Other: _____ Social Security #: _____-_____-_____
First Name: _____ M.I.: _____ Last Name: _____
Street Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: (____) ____-____ Work Phone: (____) ____-____ Cell Phone: (____) ____-____
Employer: _____ Phone (____) ____-_____

Emergency Contact

Name: _____

Relationship to Patient: _____ Phone: (____) ____ - _____

Please tell us how you heard about us?

- Family/Friend Seminar – Peachtree Bariatric Seminar – Real Results Newspaper Physician
- Radio Employee Referral Trade Show/Expo/Health Fair Web/Online Other:

I understand and acknowledge that in some circumstances Real Results may file a claim with my health insurance as a courtesy to me and that I will be responsible for all billable services not covered by insurance. I am responsible for paying my co-pays at the time of service.

If I do not have benefits, I will be required to pay cash. If benefits are not determined, I understand that I may pay cash. In this case, Real Results will not file a health insurance claim for me, but may provide me with information to file the claim myself.

I have provided you with complete, current, and accurate information about all insurance coverage. Should any information regarding my insurance change, I agree to notify Real Results immediately.

I agree to assign my health insurance benefits to Real Results for the services rendered at this Real Results facility.

Name of patient or guardian: _____

Signed by: _____ Date: ____/____/_____

Patient Name: _____ Date of Birth: ____/____/____

Health History and Review of Systems (Please check all that apply)

Constitutional

Fatigue / Tiredness	
Fever	
Skin	
Wounds that are slow to heal	
Skin Cancer	
Chronic rash	
Psoriasis / Eczema	

Respiratory

Asthma – Yr diagnosed ____	
Shortness of breath at rest / activity	
Flights of stairs you can climb ____	
COPD / Emphysema	
Snoring	
Difficulty sleeping flat	
Awakening at night	
Morning headaches	
Daytime drowsiness	
Observed apnea episodes	
Chronic insomnia	
Sleep Apnea – Yr diagnosed ____	
<input type="checkbox"/> CPAP <input type="checkbox"/> BiPAP	

Cardiovascular

Chest pain at rest / activity	
Heart attack (MI) – Yr diagnosed ____	
Irregular heart beat – Yr diagnosed ____	
Heart Disease – Yr diagnosed ____	
Congestive Heart Failure – Yr diagnosed ____	
High Blood Pressure (HTN) – Yr diagnosed ____	
Pregnancy Induced HTN	
Pacemaker / Defibrillator	
History of heart surgery	
High cholesterol / Triglycerides – Yr diagnosed ____	
Deep vein thrombosis (blood clot)	
Painful varicose veins	
History of Rheumatic Fever	

Other

Gastrointestinal

Heartburn / Reflux – Yr. diagnosed ____	
Difficulty swallowing	
Painful swallowing	
Hoarseness	
Peptic Ulcer Disease	
Frequent nausea	
Frequent vomiting	
Chronic abdominal pain	
Chronic diarrhea	
Chronic constipation	
Blood in stool	
Painful Bowel Movements	
Change in stool size	
Irritable Bowel Syndrome	
Crohn's Disease	
Ulcerative Colitis	
Cirrhosis	
Fatty liver	
Elevated liver enzymes	
Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> Not sure	
Hernia – Yr diagnosed ____	
<input type="checkbox"/> Hiatal <input type="checkbox"/> Inguinal <input type="checkbox"/> Umbilical <input type="checkbox"/> Ventral	
<input type="checkbox"/> Not sure	

Musculoskeletal

Swelling of legs /feet	
Osteo-Arthritis	
Rheumatoid Arthritis	
Lupus	
Scleroderma	
Joint pain <input type="checkbox"/> Limits ability to walk or exercise	
<input type="checkbox"/> Ankles <input type="checkbox"/> Knees <input type="checkbox"/> Feet <input type="checkbox"/> Hips <input type="checkbox"/> Back	
Herniated Disc	

Hematologic/Lymphatic

Anemia, Type _____	
Blood clotting problem	
Sickle Cell Disease	
Blood transfusion – Year _____	
HIV – Yr diagnosed _____	

Endocrine

Hyperthyroidism (High)	
Hypothyroidism (Low)	
Goiter	
Diabetes – Yr diagnosed _____	
<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Gestational	
Chronic steroid use	
Cushing's Disease	

Neurological

Seizures	
Light headedness	
Numbness	
Tremors	
Loss of consciousness	
Narcolepsy	
Stroke	
Migraine	
Fibromyalgia	
Multiple Sclerosis	

Psychological

Depression	
Anxiety Disorder	
Suicidal thoughts	
Suicide attempts	
Bi-Polar Disease	
Obsessive Compulsive Disorder	
Schizophrenia	
Anorexia	
Bulimia	
Binge eating	

Genitourinary

Frequent urination	
Urine leakage when coughing or laughing	
Kidney Disease	
Kidney Stones	
Blood in urine	
Painful urination	

Men's Health

Loss of erection	
Last Prostate exam (date) _____	
Prostate Cancer	
Enlarged breast tissue	

Women's Health

Polycystic Ovarian Syndrome	
Menopause	
Irregular periods	
Heavy periods	
Infertility	
Facial hair growth	
Breast Cancer	
Last Menstrual period (date)	

Provider's Signature: _____ Date: ____/____/____

Patient Name: _____ Date of Birth: ____/____/____

Weight Loss History

How many years have you been overweight? _____ Have you had weight loss surgery? Yes (describe below) No

Weight Loss Surgery Type	Date	Surgeon	Weight Loss / Gain	
			<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs
			<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs

Diet Programs and Supplements (Please indicate which of the following diets or plans you have attempted.)

Program	Dates From / To	Was it Medically Supervised?	Weight Loss / Gain	
Atkins Diet		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs
Grapefruit Diet		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs
Herbalife		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs
Jenny Craig		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs
LA Weight Loss		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs
Liquid Diets		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs
Low Carbohydrate		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs
Medifast		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs
Metabolife		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs
Nutri-System		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs
Optifast		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs
Protein		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs
Slim Fast		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs
South Beach		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs
TOPS		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs
Weight Watchers		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs
Other _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs

Weight Loss Medication History (Please indicate which of the following diets or plans you have attempted.)

Medication	Dates From / To	Was it Medically Supervised?	Weight Loss / Gain	
Amphetamines		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs
Phentermine (Adipex, Fastin, Pondimin)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs
Phen-Fen		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs
Redux (Dexafenflouramine)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs
Xenical (Orlistat)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs
Meridia (Sibutramine)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs
Other _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs

Non-Dietary Therapies (Please indicate which of the following diets or plans you have attempted.)

Therapy	Dates From / To	Was it Medically Supervised?	Weight Loss / Gain	
Regular Exercise		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs
Hypnosis		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs
Behavior Modification		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs
Acupuncture		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs
Other _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Loss _____ lbs	<input type="checkbox"/> Gain _____ lbs

Provider's Signature: _____ Date: ____/____/____

Patient Name: _____ Date of Birth: ____/____/____

Family / Social / Surgical History

Surgical History (Please list all minor and/or major surgical procedures and operations excluding weight loss surgery.)

Procedure	Date	Reasons

Family History (Please indicate family members diagnosed with the following illnesses)

	Mother	Father	Maternal G-mother	Maternal G-father	Paternal G-mother	Paternal G-father	Sibling 1	Sibling 2	Sibling 3
Is this person living?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Age at death									
Cause of death									
Obesity									
Cancer									
Diabetes									
Hypertension									
Heart Attack									
Heart Disease									
High Cholesterol									
Malignant Hyperthermia									
Stroke									
Unknown History									

Social History

Marital Status: Single Married Divorced Widowed Partner Number of Children: _____

Spouse / Partner Name: _____ Phone Number: (____) _____-_____

Patient's Occupation: _____

Smoking	Dipping	Alcohol	Illicit / Illegal Drug Abuse
<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> Current <input type="checkbox"/> Past
Packs per day _____	Dips per day _____	Drinks per day _____	Substance _____
# of years _____	# of years _____	# of years _____	# of years _____
Last used _____	Last used _____	Last used _____	Last used _____

Provider's Signature: _____ Date: ____/____/____

Patient Name: _____ Date of Birth: ____/____/____

Current Medications

Medications, Vitamins, and Supplements

Please list all medications (over the counter and prescribed), vitamins and supplements you are currently taking.

Name of Medication	Dosage	Frequency	Start Date	Reason		Notes (for provider use only)

Name of Vitamin / Supplement	Dosage	Frequency	Start Date	Reason		Notes (for provider use only)

Primary Care Physician: _____ Phone: (____) ____ - ____ Fax: (____) ____ - ____

Ob /Gyn: _____ Phone: (____) ____ - ____ Fax: (____) ____ - ____

Allergies:

Do you have any allergies? No Yes Please describe _____

Allergic to any medications? No Yes Please list _____

Allergic to Latex? No Yes Please describe reaction _____

Have you or any of your family members had an adverse reaction to anesthesia? Yes No



Provider Use Only

(Do Not Write Below This Line)

Information Reviewed By:

Provider Signature	Date

Provider Signature	Date

Provider Signature	Date

Patient Name: _____ Date of Birth: ____/____/____

Eating / Exercise Behaviors Initial Visit

Are you currently on a diet? No Yes – Which One? _____

Eating Behaviors: # of Meals / day: _____ # of Snacks / day: _____

Type of Liquids: _____ # of oz. / day: _____

Describe Your Typical Menu:

Morning:

Midday:

Evening:

Night:

How often do you eat out? 1-5 meals /week 6-10 meals /week 10+ meals /week

Typically are you experiencing any of the following? (Check all that Apply)

- Late Night Snacking Constantly Snacking Eating Quickly
 Frequently Eating Fast Food Large Bites Large Portions

Please describe your racial background: African American American Indian Asian Pacific Islander
 White (Hispanic) White (non-Hispanic) Other _____

Exercise: Are You Currently Exercising?

Yes What Do You Do for Exercise?

- Walking / Jogging Pilates / Yoga Strength Training Swimming Tennis Biking
 Aerobics / Elliptical Other _____ How often? _____ Duration? _____

No What Keeps You from Exercising? Joint Pain Fatigue Lack of Time No Motivation
 Other: _____