*LAPAROSCOPIC ASSOCIATES OF SAN FRANCISCO*[SM]
*2100 Webster St., Suite 110 San Francisco, CA 94115*
*Tel:(415)561-1310 Fax: (415)561-1713*

*DEMOREG 2008*
*Gregg H Jossart, MD*
*Paul T Cirangle, MD*

## DEMOGRAPHICS

TODAY'S DATE: ____/____/2008 SS#:_____-____-_____ DATE OF BIRTH: ____/____/____

AGE:_____ HEIGHT:_____ WEIGHT:_____ BMI:_____MAXWT:_____

PATIENT'S NAME: _____ _____ _____
(Last) (First) (Middle Initial)

HOME ADDRESS: _____
(Number and Street)
_____
(City) (State) (Zip Code)

HOME PHONE: (_____)_____-_____ FAX: (_____)_____-_____

MOBILE PHONE: (_____)_____-_____ Email:_____

WORK PHONE: (_____)_____-_____ INSURANCE CO:_____

EMPLOYER: _____ OCCUPATION:_____

PHARMACY: _____( )____-_____ REFFERRED BY:_____

## CURRENT PRIMARY CARE PHYSICIAN INFORMATION

NAME: _____

ADDRESS: _____
(Number and Street)
_____
(City) (State) (Zip Code)

PHONE: (_____)_____-_____ FAX: (_____)_____-_____

## EMERGENCY CONTACT INFORMATION

NAME: _____ Relationship to patient: _____

HOME PHONE: (_____)_____-_____ WORK PHONE: (_____)_____-_____

MOBILE PHONE: (_____)_____-_____ Email:_____

**Patient Authorization:** I hereby authorize Laparoscopic Associates of San Francisco[SM] to release information acquired during the course of my examination and treatment to the Health Care Financing Administration and its agents or any other third party carrier as necessary to secure payment of any benefits due me. I hereby assign payment of said benefits to include MEDICARE BENEFITS directly to Laparoscopic Associates of San Francisco Incorporated. I understand that I am responsible for all charges regardless of insurance status as well as any associated costs for collection should such action become necessary. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. A photocopy of this agreement shall be considered as valid as the original. I have read the above and fully understand the terms thereof.

**SIGNATURE**_____**DATE**_____

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## ALLERGIES/REACTIONS/PROBLEMS WITH ANESTHESIA OR NARCOTICS

**Please write the name of the medication or substance and the type of reaction you had.**

| Name of Medication/Substance | Circle below | Reaction it Causes |
|---|---|---|
| 1. Anesthesia | Yes No Never Had | |
| 2. Narcotic: | Yes No Never Had | |
| 3. Other | | |
| 4. Other | | |

## MEDICATIONS/SUPPLEMENTS/VITAMINS/HERBS

| Name of Medication | Strength | Dose | Reason for Taking |
|---|---|---|---|
| *Example: Atenolol* | *100mg* | *1 daily* | *High Blood Pressure* |
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |

## PAST SURGICAL HISTORY(Circle or write)

| | | | | | | |
|---|---|---|---|---|---|---|
| Appendix | Gallbladder | Hernia | Ovary | Tubal Ligation | Hysterectomy (Vaginal) | Hysterectomy (Abdominal) |
| Breast | Cesarean Section | Tonsillectomy | Prior Weight Loss Surgery | Prostate | Knee | Back |
| OTHER: | | | | | | |

## FAMILY HISTORY(Circle for Mother, Check for Father)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Obesity | Kidney Disease | Heart Disease | Diabetes Mellitus | High Blood Pressure | Alcoholism | Liver Problems | Lung Problems |
| Bleeding Disorder | Gallstones | Mental Illness | Cancer | Malignant Hyperthermia | Lung Problems | Other: | |
| Mother | Alive or Deceased | | Age of Death: | | Cause of Death | | |
| Father | Alive or Deceased | | Age of Death: | | Cause of Death | | |

**SIGNATURE**_____**DATE**_____

**MAIL, FAX OR BRING THIS WITH YOU TO YOUR APPOINTMENT**

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## WEIGHT LOSS HISTORY(Circle Answer)

| | |
|---|---|
| How long have you been obese? | Young adult 5 years 10 years 15 years 20 years |
| How much is your weight increasing each year? | Stable 5 lbs 10 lbs 20 lbs >20 lbs |
| Best weight loss with a diet? | 10lbs 20lbs 30lbs 40lbs 50lbs 60lbs >70lbs |

## GYNECOLOGICAL(For Women Only)(Circle answer)

| | | | |
|---|---|---|---|
| Do you have regular periods? | Yes No | #of Pregnancies | 0 1 2 3 4 5 |
| Fertility Problems? | Yes No | #of Children | 0 1 2 3 4 5 |
| Age of children: | | # of miscarriages/abortions | 0 1 2 3 4 5 |

## SOCIAL HISTORY/HABITS(circle Answer)

| | |
|---|---|
| How many cups of caffeine-containing beverages do you have each day? | 0 1 2 3 4 >5 |
| How many carbonated beverages(Sodas) do you have per day? | 0 1 2 3 4 >5 |
| How many cigarettes do you smoke per day? | 0 10 20 >20 |
| How many years have you smoked? | 0 5 10 20 >20 |
| Alcohol use? None Occasional Daily | |
| Who will help you after surgery? | |

## REVIEW OF SYSTEMS
## (Circle if you have any of the following)

| | | | | |
|---|---|---|---|---|
| Fever | Chills | Sweats | Weakness | Fatigue |
| Decreased activity | Chest pain | Cough | Short of breath | Wheezing |
| Pounding heart | Ankle swelling | Passing out | Nausea | Vomiting |
| Heartburn | Diarrhea | Constipation | Vomiting Blood | Urinary problems |
| Frequent Urination | Easy Bruising | Low Platelets | Blood Transfusion: YES NO | |
| How many blocks can you walk?: 1 2 >3 | | How many flights of stairs can you climb?: 1 >2 | | |

## PAST MEDICAL HISTORY/ACTIVE PROBLEMS & DIAGNOSIS
**Please circle if you have any of the following**

| | | | |
|---|---|---|---|
| Diabetes | High Blood Pressure | High Cholesterol | High Triglycerides |
| Slee Apnea CPAP | Snoring | Multiple joint pains | Heartburn |
| Hiatal Hernia/ GERD | Ankle Swelling | Fatty Liver | Gallstones |
| Gout | Urinary Stress Overflow | Varicose Veins | Blood Clots(DVT or PE) |
| Asthma | Polycystic Ovaries | Depression | Anxiety |
| Kidney Stone | Hypothyroidism | Low Back Pain | Enlarged Prostate |
| Other: | Other: | Other: | Other: |
| MD comments | | | |
| MD comments | | | |

**SIGNATURE**_____**DATE**_____

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