Affiliated Surgical Associates / Southwest Weightloss
9377 E Bell Road, Suite 207 Scottsdale, AZ 85260
Main : 480-500-5080 Fax : 480-500-5081
www.southwestweightloss.com

How did you learn about us?	
Last Name :	First Name
Preferred Phone Number :	Alternate Phone Number:
Social Security Number :	Date of Birth
Gender :	Marital Status :
Address:	Address :
City:	State , Zip
Email Address:	Alternate Email:

Employment/Doctor Information

Employer :	Employer Number :
Emergency Contact:	Emergency Contact Phone:
PCP Doctor Name :	Doctor Phone Number:

Insurance Information

Primary Insurance:	Address:	City	State	Zip
Insurance Phone Number:				
If the policy holder is different than the patient, please complete: Name, Relationship, DOB, & SSN				
Policy ID Number:	**Group Number**			
Secondary Insurance:	Address:	City	State	Zip
Insurance Phone Number:				
If the policy holder is different than the patient, please complete: Name, Relationship, DOB, & SSN				
Policy ID Number:	**Group Number**			
If patient is under the age of 18 please complete the sections below:				
Name:	Relationship:	Phone Number:		
Employer:	Number:	Position:		
Signature:				
Date:				

MEDICATION / DRUG LIST:

MEDICATION NAME	DOSE	FREQUENCY	NEED FOR MEDICATION

ARE YOU CURRENTLY TAKING ANY BLOOD THINNER INCLUDING THE FOLLOWING: WARRARIN , COUMADIN, LOVENOX, HEPARIN

_____

Allergy List:

MEDICATION / ALLERY	REACTION

Medical Information:

Heart Disease	Yes	No	Fatigue	Yes	No	Lupus	Yes	No
High Cholesterol	Yes	No	Keloid Formation	Yes	No	Chrohn's Disease	Yes	No
High Blood Pressure	Yes	No	Nosebleed (Epistaxis)	Yes	No	Ulcerative Colitis	Yes	No
Type II Diabetes	Yes	No	Painful Urination	Yes	No	Emphysema	Yes	No
Shortness of Breath	Yes	No	Kidney Disease	Yes	No	Heart Palpitations	Yes	No
Peptic Ulcer	Yes	No	Infertility	Yes	No	Myocardial Infraction	Yes	No
Recent Wheezing	Yes	No	Daytime Drowsiness	Yes	No	Difficulty Breathing	Yes	No
Coughing at Night	Yes	No	Skin Cancer	Yes	No	Restless Sleep	Yes	No
Acid Reflux	Yes	No	Breast Cancer	Yes	No	Loud Snoring	Yes	No
Gallstones	Yes	No	Colon Cancer	Yes	No	Urinary Incontinence	Yes	No
Hip Pain	Yes	No	Knee Pain	Yes	No	Ankle Pain	Yes	No
Swelling of the legs	Yes	No	Thyroid Disease	Yes	No	Back Pain	Yes	No
PE	Yes	No	DVT	Yes	No	Migraine Headaches	Yes	No
Hepatitis A/B/C	Yes	No	HIV	Yes	No	Other	Yes	No
Other	Yes	No		Yes	No		Yes	No

Past Surgical History:

PROCEDURE	OPEN / LAPARSCOPIC	DATE OF SURGERY

Family Medical History:

Has any family member had the following conditions:	Yes	No	Family Member
Congestive Heart Failure / Coronary Disease			
Colon Cancer			
Thyroid Cancer or Disease			
Adrenal Problem			
Obesity			
Breast Cancer			
Arthritis – Type			
Digestive Disease			

Do you have sensitivity to adhesives?

_____

Do you have an allergy to LATEX?

_____

Have you ever been diagnosed with Sleep Apnea? _____

If so, when? _____

Do you use a CPAP or a BiPAP Machine? _____

Settings _____

Do you Smoke? _____

How Often?_____

Do you Drink? _____

How Often? _____

Do you use Illegal Substance(s)? _____

How Often? _____

What substances? _____

_____