

RICHARD E. COLLIER, M.D.
PATIENT INFORMATION FORM

Name: _____ Date of Birth: _____ Age: _____ Sex: M F

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

E-MAIL Address: (optional) _____

Social Security No. _____ Driver's License No. _____

Single () Married () Divorced () Widowed () Name of Referring Doctor: _____

Patient's Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Do you authorize any significant other to discuss and/or receive information regarding your care? _____
If so, please complete and sign below:

Name of person authorized to receive your medical information: _____

How is this person related to you? (spouse/daughter/son, parent, etc.). _____

In addition, I give my permission to leave messages on my cell phone or answering machine regarding my medical care. () Yes () No

Patient Signature: _____ Date: _____

INSURANCE INFORMATION

Primary Insurance: _____

Secondary Insurance: _____

Name of Primary Insured: _____ Relationship to you: _____

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST SO THAT A COPY CAN BE MADE FOR YOUR FILE.

I hereby authorize Richard E. Collier, Jr., M.D., P.A. to furnish information to my insurance carrier concerning my illness and treatment. I understand that payment of co-pays or co-insurance amounts are due at the time of service. I hereby assign to Richard E. Collier, M.D., P.A. all payments for medical services rendered to me. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE.

Signature of Patient

Date

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PATIENT WEIGHT LOSS AND MEDICAL HISTORY QUESTIONNAIRE

Name: _____
 Height: _____ Weight: _____ How long have you been overweight? _____
 Allergies to medications: _____
 Latex allergy? _____ Adhesive tape? _____ Any other allergies? _____
 Primary care physician: _____
 Primary care physician's office number: _____

MEDICATIONS: LIST ALL THE MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING HERBAL AND NON-PRESCRIPTION

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 (list type)							
SEIZURES							
BREATHING PROBLEMS							
KIDNEY DISEASE							
ARTHRITIS							
Death/Cause							
OTHER							

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HAVE YOU HAD PREVIOUS WEIGHT LOSS SURGERY? _____

SURGERY TYPE	DATE	SURGEON	WEIGHT LOSS

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

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

WEIGHT LOSS MEDICATION HISTORY: PLEASE INDICATE THE MEDICATIONS THAT APPLY

MEDICATION	DATES	DURATION	MD SUPERVISED	WEIGHT LOSS
Amphetamines				
Phentermine (Adipex, Fastin)				
Phen-Fen				
Redux (Dexfenfluramine)				
Xenical (orlistat)				
Meridia (Sibutramine)				
Other				

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

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

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SOCIAL HISTORY:

Do you currently use tobacco? YES NO

If so, number of packs per day _____ How many years? _____

Prior smoker? Number of years: _____ Quit when: ? _____

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 list the name of your physician or therapist: _____

Have you ever been hospitalized for mental illness? YES NO

GENERAL SYSTEM REVIEW: PLEASE CIRCLE ALL THAT APPLY

CONSTITUTIONAL

Fatigue
Tiredness
Recent Weight Loss
Fever
Night Sweats
Abnormal Bleeding

HEAD/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 heartbeat

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
Colitis

GENITOURINARY

Blood in urine
Frequent urination
Leakage of urine
Pain with urination
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

Hyperthyroidism
Hypothyroidism
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 last year

NEUROLOGICAL

Seizure
Convulsions
Fainting
Vertigo
Light headedness
Falling
Muscle weakness
Numbness
Tremors
Stroke
Loss of consciousness

PSYCHOLOGICAL

Depression
Nervousness
Anxiety
Suicidal thoughts
Suicidal attempts
Schizophrenia
Anorexia
Bulimia
Binge eating
Counseling
Hospitalization for emotional problems

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Diabetes

Juvenile onset	Yes	No
Gestational (pregnancy)	Yes	No
Adult onset	Yes	No
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

Frequency?	Yes	No
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Deep venous thrombosis	Yes	No
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

FEMALE PATIENTS: Is there a chance you may be pregnant? _____ Date of last period: _____

PAST MEDICAL HISTORY

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

Why do you want weight loss surgery?

To the best of my knowledge, the above information is accurate and complete:

Patient signature: _____ Date: _____