

BARIATRIC NEW PATIENT INFORMATION

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Date of visit: _____ Male Female

Patient Name: _____ Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ SSN #: _____

Home Phone: _____ Cell/Work Phone: _____

Emergency Contact Name: _____

Phone Number: _____

Family Physician: _____ Phone: _____



How did you hear about our weight loss program?

- 1) Referred by: _____
- 2) Current patient: Yes No
- 3) Other: _____



I understand that this is NOT a covered benefit by my insurance plan and that I am financially responsible for all charges presented to me, which are to be PAID IN FULL at the time services are provided (cost of diet programs vary depending on each individuals need).

Signed: _____ Date: _____

Medical History Form

Present Status:

Are you in good health at the present time to the best of your knowledge?
Yes/No

Are you under a doctor's care at the present time? **Yes/No**
If Yes, for what? _____

Are you taking any medications at the present time? **Yes/No**

Name of Medication: _____ Taken for: _____
Name of Medication: _____ Taken for: _____
Name of Medication: _____ Taken for: _____
Name of Medication: _____ Taken for: _____

Do you have any allergies to any medications? **Yes/No**
If yes, what? _____

Do you have a history of:

High Blood Pressure **Yes/No**

Diabetes (what age?____) **Yes/No**

Heart Attack **Yes/No**

Chest Pain **Yes/No**

Swelling of Feet or Hands **Yes/No**

Frequent Headaches **Yes/No**

Do you take medication for headaches? _____

If yes, what? _____

Migraines **Yes/No**

Constipation **Yes/No**

Glaucoma **Yes/No**

Gynecologic History:

Pregnancies (Number _____ Dates: _____)

Natural Delivery or C-Section (specify) _____

Menstrual Cycle: Age of Onset _____ Duration (days) _____

Are they regular? **Yes/No**

Pain Associated? **Yes/No**

Last Menstrual Period: _____

Hormone Replacement Therapy: **Yes/No**

What: _____

Birth Control Pills: Yes/No
Type: _____

Last Check Up: _____

Serious Injuries

Yes/No

Specify: _____ Date: _____
Specify: _____ Date: _____
Specify: _____ Date: _____

Surgeries

Yes/No

Specify: _____ Date: _____
Specify: _____ Date: _____
Specify: _____ Date: _____

Family History:

Fathers Age _____ Good Health Yes/No
Mothers Age _____ Good Health Yes/No

Does your father, mother, sisters, or brothers suffer from any of the following:

Heart Disease? Yes/No
High Cholesterol? Yes/No
Diabetes? Yes/No
Cancer? Yes/No
Obesity? Yes/No

Has any **blood relative** had any of the following:

Glaucoma?	Yes/No	Who? _____
Asthma?	Yes/No	Who? _____
Epilepsy?	Yes/No	Who? _____
High Blood Pressure?	Yes/No	Who? _____
Kidney Disease?	Yes/No	Who? _____
Diabetes?	Yes/No	Who? _____
Tuberculosis?	Yes/No	Who? _____
Psychiatric Disorder?	Yes/No	Who? _____
Heart Disease/Stroke	Yes/No	Who? _____
HIV/Hepatitis	Yes/No	Who? _____

Past Medical History: (check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Polio | <input type="checkbox"/> Measles | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Mumps | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Kidneys | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Nervous Breakdown |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Gout | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Gallbladder Disorder | | <input type="checkbox"/> Psychiatric Illness |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Alcohol Abuse |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Malaria | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Cholera | <input type="checkbox"/> Cancer | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other: _____ |

Nutrition Evaluation:

Present Weight _____ Height: _____ Desired Weight: _____

In what time frame would you like to be at your desired weight? _____

Birth Weight: _____ Weight at 20 years of age: _____

Weight one year ago: _____

What is the main reason for your decision to lose weight?

When did you begin gaining excess weight? (If known, give reasons):

What has been your maximum lifetime weight (non-pregnant) and when? _____

Previous diets you have followed:

Give dates and results of weight loss:

Is your spouse, fiance', or partner overweight? Yes/No
By how much is he/she overweight? _____
How often do you eat out? _____
What restaurants do you frequent? _____
How often do you eat "fast foods"? _____
Who plans meals? _____ Cooks? _____ Shops? _____
Do you use a shopping list? Yes/No
What day of the week and time of the day do you generally shop for groceries?

Food Allergies: _____
Food dislikes: _____
Food you crave: _____
Is there any specific time of day or month that you crave food? _____
Do you drink coffee or tea? Yes/No How much daily? _____
Do you drink cola drinks? Yes/No How much daily? _____
Do you drink alcohol? Yes/No
What? _____ How much? _____ Frequency? _____
Do you use sugar substitute? _____ Butter? _____ Margarine? _____
Do you awaken hungry during the night? Yes/No
What do you do? _____
What are your worst food habits? _____

Snack Habits:

What? _____ How much? _____ When? _____
What? _____ How much? _____ When? _____

When you are under a stressful situation at work or family related, do you tend to overeat? Yes/No Explain: _____

Do you think you are currently undergoing a stressful situation or an emotional upset? Yes/No Explain: _____

Smoking Habits: (answer only one)

- _____ You have never smoked cigarettes, cigars, or a pipe
- _____ You quit smoking _____ years ago and have not smoked since
- _____ You have quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke
- _____ You smoke 20 cigarettes per day (1 pack)
- _____ You smoke 30 cigarettes per day (1 1/2 packs)
- _____ You smoke 40 cigarettes per day (2 packs)

Typical Breakfast:

Time eaten: _____

Where: _____

With whom: _____

Typical Lunch:

Time eaten: _____

Where: _____

With whom: _____

Typical Dinner:

Time eaten: _____

Where: _____

With whom: _____

Describe your usual energy level: (1=low, 10=high) _____

Activity level: (answer only one)

_____ **Inactive** = no regular physical activity with sit-down job

_____ **Light Activity** = no organized physical activity during leisure time

_____ **Moderate Activity** = occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling

_____ **Heavy Activity** = consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling, or active sports at least three times per week.

_____ **Vigorous Activity** = participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

Behavior Style: (answer only one)

_____ You are always calm and easygoing

_____ You are usually calm and easygoing

_____ You are seldom calm and persistently driving for advancement

_____ You are never calm and have overwhelming ambition

_____ You are hard-driving and can never relax

Please describe your general health goals and improvements you wish to make:

This information will assist us in assessing your particular problem areas and establishing your medical weight loss and management. Thank you for your time and patience in completing this form.

WEIGHT-LOSS CONSUMER BILL OF RIGHTS

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WARNING: Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1 ½ pounds to 2 pounds per week, or weight loss of more than 1 percent of body weight per week after second week of participation in a weight-loss program. Only permanent lifestyle changes, such as making healthful food choices and increasing physical activity, promote long-term weight loss. Qualifications of this provider are available upon request. The patient is under no obligation whatsoever, to purchase medication and supplements from Dr. Bryman. Supplements for meal replacements such as Nutrimed or Protimax, as well as medications, are sold for profit.

You as the patient have the right to:

Ask questions about the potential health risks of this program and its nutritional content, psychological support, and educational components; receive an itemized statement of the actual or estimated price of the weight-loss program, including extra products, services, supplements, examinations, and laboratory tests; know the actual or estimated duration of the program; know the name, address, qualifications of the dietician or nutritionist who has reviewed and approved the weight-loss program.

I have read and understand the above:

Patient's Signature

Date