

Thank you for choosing Guthrie Weight Loss Center. If you are considering weight loss surgery and wish to make an appointment in the clinic, this packet is to be filled out in its entirety. You may return it to the Guthrie Weight Loss Center by mail or in person, and we will then contact you to schedule an appointment.

STEPS IN THE PROCESS:

1. Attend one of our free public informational seminars. A schedule of upcoming seminars can be found at www.guthrieweightlosscenter.org or by calling (570) 887-3920.
2. Complete and return this patient profile packet, in person or by mail. If you want, you may bring it with you to give to us at one of our seminars. Be sure to include a copy, front and back, of your insurance card. Our mailing address is:

**Guthrie Weight Loss Center
Guthrie Clinic
One Guthrie Square
Sayre, PA 18840**

- Most insurance carriers require a letter of support from your Primary Care Provider (PCP). It is best to make this request early on, so that your PCP has time to discuss it with you and write an appropriate letter.
 - Most insurance carriers also require documentation of past weight loss attempts. There will be a place for you to list these attempts in this packet, but you should also submit supporting copies of any office visits, attendance or enrollment cards, weight charts, etc.
3. We will call and confirm the details of your insurance coverage for weight loss surgery. You may wish to do this on your own before submitting the packet, especially if you are unsure of your level of coverage. If your insurance unfortunately does not provide a bariatric surgery benefit, we will contact you to inform you, and give you information about our medical weight loss programs.
 4. We will contact you to schedule a clinic consultation with the surgeon. Note that this does not commit you to anything, but is rather a chance for you to explore on a personal level whether bariatric surgery is right for you in your unique situation. *If you did not already submit the letter of support from your PCP or other supporting documentation, you should bring these with you to this visit.*

Thank you for your patience in this process. Although it is a life-changing journey you're starting, it does not happen overnight.

At Guthrie, we don't just take your weight loss seriously, we take it personally.

Patient Information		Name	Date of Birth	Gender (circle one) Male - Female
Address / City / State / ZIP				
Home Phone		Cell Phone		Work Phone
E-mail address			Marital Status Single - Married - Divorced - Widow - Other	
Employer			Spouse's Employer (if applicable)	
Emergency Contact (Name and relation)			Emergency Contact Phone	
Referral Source (circle one) Family/friend - Physician - Website - Web ad - Radio/TV ad - Print ad - Insurance company - Other: _____				

Physician Information		Referring Physician / PCP (Name)		
Location (city, state)		Date of last visit	Date of next visit	
Preferred Pharmacy			Phone	

Insurance Information		Policyholder Name (if other than patient)		
Primary Insurance (i.e. BC/BS, Aetna, etc.)			Primary Insurance Phone #	
ID / Policy Number		Group Number		
Secondary Insurance Policyholder Name (if other than patient)				
Secondary Insurance (if applicable)			Secondary Insurance Phone #	
ID / Policy Number		Group Number		

The information provided is correct to the best of my knowledge. *My signature below authorizes Guthrie Weight Loss Center to communicate with me via email, phone, or other means indicated.

Signature*: _____ Date: _____

Obesity History	1. How long have you been obese?	2. Highest adult weight (lbs.)	3. Lowest adult weight (lbs.)	
4. How does your weight limit you?				
Weight Management History	LENGTH OF TIME (MONTHS)	YEAR	WEIGHT LOST (lbs)	WEIGHT RE-GAINED (lbs)
<i>Example: Low calorie diet</i>	<i>10 months</i>	<i>2002</i>	<i>30 lbs.</i>	<i>15 lbs.</i>
Low calorie diet				
Low fat diet				
Atkins diet				
Optifast [®] / Medifast [®]				
Phen-Fen				
Other prescription meds (Name: _____)				
Diet shots (B12, etc.) (Name: _____)				
Non-prescription diet pills (Name: _____)				
Doctor-supervised diet				
Registered Dietician (RD)				
Exercise program				
Nutrisystem [®]				
T.O.P.S. [®]				
Weight Watchers [®]				
Jenny Craig [®]				
Other:				
Other:				

The entire weight management history must be filled out, to the best of your knowledge. Do not write "All my life" or "Years" but be specific, as close as you can recall.

Medical History		You may not be familiar with some terms, but mark all that apply.	
CONDITION	MANAGEMENT (Check all that apply)	CONDITION	MANAGEMENT (Check all that apply)
<input type="checkbox"/> Type 2 Diabetes	<input type="checkbox"/> Diet controlled <input type="checkbox"/> Oral Medication <input type="checkbox"/> Insulin	<input type="checkbox"/> Congestive Heart Failure (CHF)	<input type="checkbox"/> Medication <input type="checkbox"/> Hospitalization
<input type="checkbox"/> Hypertension (High Blood Pressure)	<input type="checkbox"/> Diet controlled <input type="checkbox"/> Medication Usual reading: _____ / _____	<input type="checkbox"/> Coronary Disease (Heart Attack, Angina)	<input type="checkbox"/> Medication <input type="checkbox"/> Stents: _____ <input type="checkbox"/> Bypass surgery
<input type="checkbox"/> High cholesterol (Hyperlipidemia)	<input type="checkbox"/> Diet controlled <input type="checkbox"/> Medication	<input type="checkbox"/> Liver Disease (List type: _____)	
<input type="checkbox"/> Obstructive Sleep Apnea	<input type="checkbox"/> Using CPAP <input type="checkbox"/> CPAP prescribed, not used <input type="checkbox"/> Using mouth spacer	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Medication <input type="checkbox"/> Dialysis Creatinine: _____
<input type="checkbox"/> Gastroesophageal Reflux (GERD, heartburn)	<input type="checkbox"/> Diet controlled <input type="checkbox"/> Medication	<input type="checkbox"/> Venous Insufficiency	<input type="checkbox"/> Swelling <input type="checkbox"/> Compression hose <input type="checkbox"/> Ulcers
<input type="checkbox"/> Arthritis / Joint Pain	<input type="checkbox"/> Physical therapy <input type="checkbox"/> Prior surgery	<input type="checkbox"/> COPD (Emphysema or Chronic Bronchitis)	<input type="checkbox"/> Medication <input type="checkbox"/> Oxygen
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Chiropractor / PT <input type="checkbox"/> Medication <input type="checkbox"/> Other: _____	<input type="checkbox"/> Asthma	<input type="checkbox"/> Medication <input type="checkbox"/> Frequency of inhaler use: _____
<input type="checkbox"/> Depression	<input type="checkbox"/> Therapy / counseling <input type="checkbox"/> Medication	<input type="checkbox"/> Gallstones	
<input type="checkbox"/> Infertility / Polycystic Ovaries		<input type="checkbox"/> Blood Clots in Leg / Lung (DVT/PE)	<input type="checkbox"/> Blood thinner – current <input type="checkbox"/> Blood thinner – past <input type="checkbox"/> IVC filter
<input type="checkbox"/> Irregular Menstrual Cycles		<input type="checkbox"/> Cancer (Type: _____)	
<input type="checkbox"/> Stress Urinary Incontinence (leakage)	<input type="checkbox"/> Using pads <input type="checkbox"/> Medication Leakage frequency: _____	<input type="checkbox"/> Other:	
<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Medication <input type="checkbox"/> Prior thyroid surgery	<input type="checkbox"/> Other:	

Surgical History		You may not be familiar with some terms, but mark all that apply. Add anything not listed.	
SURGERY TYPE	APPROACH	YEAR	
<input type="checkbox"/> Appendix (appendectomy)	<input type="checkbox"/> Laparoscopic <input type="checkbox"/> Open <input type="checkbox"/> I don't know		
<input type="checkbox"/> Gallbladder (cholecystectomy)	<input type="checkbox"/> Laparoscopic <input type="checkbox"/> Open <input type="checkbox"/> I don't know		
<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Laparoscopic <input type="checkbox"/> I don't know <input type="checkbox"/> Open <input type="checkbox"/> Vaginal		
<input type="checkbox"/> Previous bariatric surgery <i>List type:</i>	<input type="checkbox"/> Laparoscopic <input type="checkbox"/> Open	<i>Hospital:</i>	

Medications		List all current medications.		
MEDICATION	DOSE	SCHEDULE	PURPOSE	
Example: <i>Metformin</i>	<i>500mg</i>	<i>1 pill twice a day</i>	<i>diabetes</i>	

Allergies	
List all medication/food allergies, or indicate: <input type="checkbox"/> <i>I have no known allergies.</i>	
MEDICATION NAME	REACTION

Social History	
Fill out everything to the best of your knowledge.	
TOBACCO USE	Do you smoke? YES - NO Did you ever used to smoke? YES - NO I quit in _____ (yr) Packs/day: _____ Years: _____ Willing to quit? YES - NO
ALCOHOL USE	Do you drink? YES - NO _____ drinks per week of (circle) beer / wine / liquor
SUBSTANCE USE	Do you use any of the following: <input type="checkbox"/> Marijuana <input type="checkbox"/> Ecstasy <input type="checkbox"/> Heroin <input type="checkbox"/> Meth(amphetamines) <input type="checkbox"/> Cocaine <input type="checkbox"/> Other: _____
FITNESS HISTORY	Has a physician ever told you NOT to participate in a fitness or exercise program? YES - NO REASON: _____
	Is there anything that will prevent you from participating in a fitness program? YES - NO REASON: _____

Demographics	
Have you attended a Guthrie Weight Loss Center seminar? YES - NO Date: _____ Location: _____	
RACE: <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Caucasian or White <input type="checkbox"/> Native American <input type="checkbox"/> Hawaiian or Pacific Islander <input type="checkbox"/> I choose not to identify	
ETHNICITY: <input type="checkbox"/> Latino or Hispanic <input type="checkbox"/> Not Latino or Hispanic	LANGUAGES SPOKEN: First: _____ Other: _____

Review of Body Systems		You may not be familiar with some terms, but mark all symptoms that you are <i>currently</i> experiencing.	
GENERAL	<input type="checkbox"/> Fevers or chills <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Excessive sweating	URINARY	<input type="checkbox"/> Pain with urination <input type="checkbox"/> Kidney stones <input type="checkbox"/> Trouble starting/stopping stream <input type="checkbox"/> Leakage (incontinence)
EYES	<input type="checkbox"/> Burning / irritation <input type="checkbox"/> Change in vision <input type="checkbox"/> Double vision	SKIN / BREAST	<input type="checkbox"/> Skin lesion (new) <input type="checkbox"/> Rash <input type="checkbox"/> Changing mole <input type="checkbox"/> Breast lump (new)
EARS / NOSE / THROAT	<input type="checkbox"/> Earaches <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Cough <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Sore throat	HEMATOLOGIC	<input type="checkbox"/> Easy bruising <input type="checkbox"/> Prolonged bleeding <input type="checkbox"/> Swollen glands
RESPIRATORY	<input type="checkbox"/> Wheezing <input type="checkbox"/> Pneumonia <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Asthma	MUSCULOSKELETAL	<input type="checkbox"/> Back or neck pain <input type="checkbox"/> Painful joints: _____ <input type="checkbox"/> Muscle aches <input type="checkbox"/> Muscle weakness
CARDIOVASCULAR	<input type="checkbox"/> Chest pain <input type="checkbox"/> Chest pressure <input type="checkbox"/> Palpitations / irregular heartbeats	NEUROLOGICAL	<input type="checkbox"/> Numbness or tingling <input type="checkbox"/> Seizures <input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness / vertigo
GASTROINTESTINAL	<input type="checkbox"/> Nausea / vomiting <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Abdominal pain	SLEEP	<input type="checkbox"/> Snoring loudly (according to partner) <input type="checkbox"/> Fatigue during daytime / nodding off

Upon completion, submit this information packet either *in person* or *by mail* to:

**Guthrie Weight Loss Center
 Guthrie Clinic
 One Guthrie Square
 Sayre, PA 18840**

We want to safeguard your personal information as best we can. Please do not email or fax this packet.

Thank you and best of luck as you begin this journey!



AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

(Read Entire Document Before Signing)

Patient Name: _____ Maiden/Previous Name: _____
Date of Birth: _____ Social Security #: _____ Medical Record #: _____
Address: _____
(Street) (City) (State) (Zip)

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:

Name: _____
Address: _____
(Street) (City) (State) (Zip)

3. Description of information to be used or disclosed:

Clinic Notes – From: _____ To: _____ Immunization Records – From: _____ To: _____
 Other *(Please specify records and dates)* _____

4. This information may be disclosed to and used by the following individual or organization:

Name: _____ Telephone: _____
Address: _____
(Street) (City) (State) (Zip)

5. Purpose of disclosure:

_____ My personal records
_____ For other healthcare providers
_____ For my attorney – Attorney's Name _____
_____ Other (please describe) _____

6. I understand that:

- 1) I may refuse to sign this authorization and that it is strictly voluntary.
- 2) My refusal to sign this authorization will not affect my ability to obtain treatment, except when health services are solely for the purpose of reporting to a third party.
- 3) I may revoke this authorization at any time in writing, but if I do, it will not apply to any disclosure already made in response to this authorization. The revocation will not apply to my insurance company when the law provides my insurer with rights to contest a claim under my policy.
- 4) Once the information listed above has been disclosed, it may be redisclosed by the recipient and the information may not be protected by Federal privacy laws or regulations.
- 5) I may see and obtain a copy of the information described on this form, for a reasonable copy fee.

7. This authorization will expire six months from the date of signature unless you request an earlier date or event.

Expiration Date: _____ Event: _____

8. **Specially protected information** (please check all that apply):

- I understand that the information to be disclosed may include information relating to AIDS or HIV.
- I understand that the information to be disclosed may include information relating to psychiatric or other mental health treatment.
- I understand that the information to be disclosed may include information about treatment for drug, alcohol, or substance abuse.

I have read and understand this authorization and authorize the use and/or disclosure of the protected health information as described in this authorization.

Signature of Patient/Guardian: _____ **Date:** _____

Photo ID required for records to be picked up.

Witness to ID: _____ **Relationship to Patient:** _____