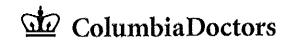


New Patient Intake Form

Patient Information		
Last Name:	First Name:	DOB:
Preferred Phone:	Email:	Gender:
Emergency Contact:	Rela	itionship:
Emergency Contact Phone:	Pati	ent Marital Status:
Occupation:	Emp	oloyer:
Primary Care Provider (PCP):PCP Address:		PCP Phone:
Preferred Pharmacy:		Pharm Phone:
Preferred Pharmacy Address:		
Collection of the following information is monitor and improve the quality of care Ethnicity: Race: Decline Response Decline Hispanic or Latino America Not Hispanic or Latino Asian Preferred Language: Patient Signature:	provided to all patients. Response n-Indian or Alaska Nativ	☐ Black or African American ve ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Decline Response
financially responsible and make full pay authorize my insurance benefits be paid	ents and deductibles are ment for all charges not directly to ColumbiaDo elease pertinent medica	
Patient or Guarantor Name (Print): Patient or Guarantor Signature:		Date:
·	copy of the ColumbiaD	octors Notice of Privacy Practices (NOPP).
Patient Name (Print): Patient Signature:		
If completed by a patient's personal repre	sentative, please print an	nd sign below.
Representative (Print):		Relationship:
Representative Signature:		Date:
myColumbiaDoctors Patient Portal Sig Access your personal records securely, 2	•	ortphone, or iPad. See brochure for details.

Send me an invitation to join myColumbiaDoctors.
 Look for an email invite from noreply@followmyhealth.org and click the Registration link.



Reason for today's vis	sit:					
General Medical Que Have you EVER had a						
Asthma/Breathing Pr	oblems a Y	οN	Heart Dise	ase/Disorder	🗆 Y	ΠN
Arthritis	order	0 N 0 N 0 N 0 N 0 N 0 N 0 N 5 and p	Liver Disea Neurologic Psychiatric Pulmonary Stroke Seizure or Thyroid Di Urinary/Kic rovide detai	ase cal Disorder/Chro c Disorder/Illness c Embolism/DVT Epilepsy sorder	□ Y onic Headaches □ Y □ Y □ Y □ Y □ Y □ Y □ Y □ Y above conditions.	- N - N - N - N - N - N - N
	es you have had and the approcedure		Date	C	omplications	
•						
Please indicate any m	ajor conditions/illnesses tha	t vour i	immediate f	amily members	have had:	
Relative	Condition and			Living?	If deceased, at what	age?
Mother				oy oN		
Father				OY ON		
Sibling				OY ON		
Other:				OY ON		
Do you use other toba	ke? □Y □N If no, previo	Con	sume alcoho	ol? 🗆 Y 🗆 N If	Packs/day yes, drinks/week:	
Do you have any aller If yes, please list aller	gies to medications or other gies and reactions (including	substa rash, h	nces?	Y □N swelling, anaph	ylaxis).	



Please list ALL previous physicians who have treated you relevant to your visit (i.e. pulmonologist, oncologist, internist, cardiologist, gastroenterologist, etc...)

Doctor's Name:			
Address:			
Phone Number:		Fax Number:	
Specialty:			
Doctor's Name:			
Address:			
Phone Number:		rax Number:	
Specialty:			
Doctor's Name:			
Address:			
Phone Number:		Fax Number:	
Specialty:			
Doctor's Name:			
Address:			
Phone Number:		Fax Number:	
Specialty:			
Doctor's Name:			
Address:			
Phone Number:		Fax Number:	
Specialty:			
Please list ALL of your current med	dications, including	over the counter medications, suppler	nents, and herbs:
Medication Name	Dose	Medication Name	Dose
,			
Provider Signature:		Date:	



Review of Systems

Please indicate ALL that you have experienced within the past 6 – 12 months.

General	□ None□ Feeling Tired	□ Fever □ Weight Gain	□ Chills□ Feeling Poorly□ Weight Loss
Eyes	□ None □ Dry Eyes	□ Eye Pain □ Itchy Eyes	□ Vision Changes □ Eyesight Problems
Ear/Nose/Throat	□ None □ Sinus problems	□ Earache □ Sore throat	□ Loss of hearing □ Nose bleeds □ Hoarseness
Heart	□ None □ Slow heart rate	□ Chest pain□ Leg swelling	☐ Palpitations ☐ Fast heart rate ☐ Leg pain, discomfort, fatigue during walking
Lungs/Breathing	□ None □ Trouble breathin	□ Cough ng with exertion	☐ Wheezing ☐ Shortness of breath ☐ Trouble breathing when lying flat
Gastrointestinal	□ None □ Heartburn	□ Abdominal pain□ Nausea	☐ Constipation ☐ Diarrhea ☐ Vomiting ☐ Blood in stool
Bladder	□ None □ Pelvic pain	☐ Incontinence ☐ Painful period	□ Discolored urine □ Painful urination □ Vaginal Discharge
Skin	□ None□ Skin lesions	☐ Acne☐ Skin wound	□ Itching □ Change in a mole □ Breast pain □ Breast lump
Neurological	□ None □ Limb weakness	□ Confused□ Loss of memory	☐ Convulsions ☐ Dizziness ☐ Difficulty walking
Psychiatric	□ None □ Suicidal	☐ Anxiety☐ Disturbed sleep	☐ Depression ☐ Change in personality ☐ Emotional problems
Endocrine	□ None □ Hair loss	□ Weak muscles□ Hot flashes	□ Feeling weak □ Deepening of voice
Hem/Lymph	□ None	□ Easy bleeding	□ Easy bruising □ Swollen glands

Version 1.4b Updated: 11/30/2015



Additional Bariatric Information

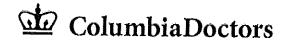
Please circle the appropriate answer or fill in the blank for the following que	stions:
---	---------

1)	Do you snore?	Yes	No	Don't know	w If Ye	s: Nigh	tly?	Loud	Yylk			
2)	Has anyone eve	er told	you t	that you st	op breathing	g, struge	gle to bre	athe (or gasp	in your	sleep? Yes	N
3)	Do you ever wa	ke up	short	t of breath	or gasping?	No	Rarely	Occ	casiona	lly Fre	quently	
4)	Do you have tro	ouble f	alling	g asleep me	ore than one	e a wee	ek?	Yes	No			
5)	How many time	es do y	ou us	sually wake	e up during t	he nigh	t?	0-1	1-2	2-3	3 or more	
6)	How many time	es do y	ou us	sually urina	ate during th	e night	?	0-1	1-2	2-3	3 or more	
7)	What time do y	ou usu	ally :	get into be	d at night (r	ange is	OK)?		_AM	PM (Cire	cle one)	
8)	What time do y	ou usu	ally	et out of l	ed to start	your da	y (range	s OK)	?	AM	PM (Circle o	ne
9)	How many hou	rs of to	tal s	leep do yo	u average ea	ch nigh	it?	Но	urs			
	Are you refresh									No		
	Do you nap <u>on</u>	-										
	Never I	Rarely	(<1/r	no)	Sometimes	(1/wk)	Freque	ently (2 or m	ore/wk)	Daily	
12)	Epworth Sleeping contrast to just done some of the choose the most situation:	feeling he thin	g tire gs re	d? This ref ecently, try	ers to your (to imagine	isual wa now the	ay of life i ey would	n rec	ent tim : you. L	es. Even Ise the fo	if you have n ollowing scale	ot e to
0= '	Would never doze		1= SII	ight chance	of dozing	2= M	oderate ch	ance o	of dozinį	g 3=Hig	h chance of do	zing

SITUATION	CHANCE OF DOZING
Sitting and reading	
Watching TV	
Sitting inactive in public (i.e. at a meeting or in a theater)	a a shirinda da Tara a sa
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after a lunch without any alcohol	
In a car, while stopped for a few minutes in traffic or when you are taking mass transit	

13) Please write in any other information about your sleep that you think might be important.

Version 1.1 Updated: 11/30/2015



Most insurance companies are requesting a diet history before approving surgery. For each weight loss method, please indicate if you have tried it, the number of times you have tried that method, for how long, and the amount of weight lost.

	# of times tried:	<u>From</u> :	<u>To</u> :	Amt. WT. Lost:
Weight Loss Programs:				
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Comprohensive Weight				
Comprehensive Weight				
Loss Programs:				
				
				
D. .				
<u>Diets</u> :				
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Madiantinus		· · · · · · · · · · · · · · · · · · ·		
Medications:				
				•
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Weight Loss Aides:				
resigne 2033 Alacs.				
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14hou 14/olaht !				
Other Weight Loss				
<u>lethods</u> :				
		·	<u></u>	

NewYork-Presbyterian The University Hospital of Columbia and Cornell

Center for Metabolic and Weight Loss Surgory 161 foil Washington Avenue New York, NY 10032 III 212 305 4000 IAX 212 342 1996 WAY LOBERT TO THE BOOK WAY LOBERT TO THE BOOK AND THE BOOK AND

(Patlent signature)
cla,MS,RD,CDN for the following services provided during my
tient Name) agree to enter into a private payment arrangemer
ne and address, phone II)