415 US Hwy. 377 South | Suite 102 | Argyle, TX 76226
940.464.2263 | Fax 940.464.3538

630 N. Coit Road | Suite 2200 | Richardson, TX 75080
940.464.2263 | Fax 940.464.3538

John M. Marsden, M.D., FACS

www.metroplexlapband.com

Patient Information

Name: ______________________________ Birth Date: ______________
Last First M.I. MM/DD/YY

Age: ________ Height: ________ Weight: ________ Sex: M F

Street Address: ______________________________ Apt/Unit: ________

City: ________________ State: ________ Zip Code: ________

Social Security Number: ______-______-______ E-mail Address: ______________

Home Phone: (____)________ Work Phone: (____)________ Alt. Phone: (____)________

Employer: ______________________ Occupation: ______________________

Employer Address: ____

Level of Education: ____

Marital Status: ☐ married ☐ single ☐ divorced ☐ widowed Number of Children: ________

Who can we thank for referring you to us? ______________________ Phone: (____)________

Primary Insured Information (if different than patient)

Name: ______________________________ Birth Date: ______________
Last First M.I. MM/DD/YY

Relationship to Patient: ______________

Street Address: ______________________________ Apt/Unit: ________

City: ________________ State: ________ Zip Code: ________

Social Security Number: ______-______-______

Home Phone: (____)________ Work Phone: (____)________ Alt. Phone: (____)________

Employer: ______________________ Occupation: ______________________

Employer Address: ____

Spouse Information

Name: ______________________ Work Phone: (____)________

Emergency Contact

Name: ______________________ Relationship: ______________________

Contact Phone: (____)________

Insurance Information

Primary Insurance Company: ____

Type of Plan: (circle one) PPO HMO EPO POS Other

Secondary Insurance Company: ____

Type of Plan: (circle one) PPO HMO EPO POS Other

Patient Medical and Weight Loss History

Patient Name: ______________________ **DOB:** ______________

Allergies to Medications/Other: ______________________

Primary Care Physician: ______________________ **Phone:** ______________

Medications (please list all medications you are currently taking)

Name of Medication	Dosage	Frequency	Indication

Past Surgical History (please list all surgical procedures and operations)

Procedure	Date	Location	Indications

Family History (please indicate family members diagnosed with the following illnesses)

	Mother	Father	Maternal G-mother	Maternal G-father	Paternal G-mother	Paternal G-father	Siblings	Children
Obesity								
Diabetes								
Hypertension								
Heart Disease								
High Cholesterol								
Stroke								
Cancer								
Seizures								
Asthma								
Arthritis								
Kidney Disease								
Early Death								

Patient Name: ______________________ DOB: ______________

How many years have you been overweight? ______________

Have you had previous weight loss surgery? ☐ NO ☐ YES (if yes, please indicate below)

Weight Loss Surgery Type	Date	Surgeon	Weight Loss

Diet Programs and Supplements (please indicate which of the following diets or plans you have attempted)

Program	Dates	Duration	MD Supervised	Weight Loss
Atkins Diet				
Grapefruit Diet				
Herbalife				
Jenny Craig				
Liquid Diets				
Medifast				
Metabolife				
Nutri-System				
Optifast				
Pritikin Diet				
Slim Fast				
TOPS				
Weight Watchers				
Other				

Weight Loss Medication History (please indicate which of the following medications you have taken)

Medication	Dates	Dosage	MD Supervised	Weight Loss
Amphetamines				
Phentermine (Adipex, Fastin, Pondimen)				
Phen-Fen				
Redux (Dexafenaflouramine)				
Xenical (Orlistat)				
Meridia (Sibutramine)				
Other Diet Medication				

Non-Dietary Therapies (please indicate if you have attempted any of the following weight loss treatments)

Therapy	Dates	Duration	MD Supervised	Weight Loss
Regular Exercise				
Hypnosis				
Behavior Modification				
Acupuncture				

Patient Name: ______________________________ DOB: ____________________

Social History

Do you use tobacco? **YES** **NO**
Number of packs per day: ________
Number of years smoking: ________
Do you use alcohol? **YES** **NO**
Amount and Frequency: ____________________
Do you or have you ever used intravenous drugs? **YES** **NO**
Do you use recreational drugs? **YES** **NO**
If yes, name of substance and date of last usage: ____________
Do you have a history of drug addiction? **YES** **NO**
Do you have any tattoos?
If yes, where? ______________________________
Do you have any piercings?
If yes, where? ______________________________

Systems Review (please circle all that apply)

Constitutional:
Fatigue/Tiredness
Fever
Night sweats

Head and Neck:
Recent change in vision
Do you wear glasses? Y N
contacts? Y N
Do you wear a hearing aide? Y N
Ringing in ears
Vertigo
Loss of Smell
Difficulty Swallowing
Painful Swallowing
Hoarseness

Cardiovascular:
Chest Pain: At rest/Activity
History of a heart attack
Heart surgery
Pacemaker
Heart murmur
High blood pressure
Irregular heart beat
Painful varicose veins
High cholesterol
Year diagnosed ________
High triglycerides
Year diagnosed ________
Anemia
Blood clot in leg (DVT)
Blood transfusion - year ________
Year ________
Known exposure to HIV
Rheumatic fever

Respiratory
Asthma
Emphysema
Chronic Bronchitis
Shortness of Breath:
At rest
With activity
How many flights of stairs can you climb? ________
Difficulty Sleeping Flat
Snoring*
Awakening at night*
Morning headaches *
Daytime drowsiness*
Observed apnea episodes*
Chronic Insomnia
Sleep apnea
Year diagnosed ________
CPAP BiPAP

Gastrointestinal:
Hepatitis: Which type?
□ A □ B □ C □ not sure
Cirrhosis
Elevated liver enzymes
Frequent nausea & Vomiting
Heartburn/reflux
Chronic Abdominal Pain
Chronic Diarrhea
Chronic Constipation
Irritable Bowel syndrome
Ulcerative Colitis
Crohn's disease
Fatty Liver

Genitourinary:
Frequent Urination
Leak urine with straining
Frequent bladder infections
Interstitial cystitis
Kidney disease

Musculoskeletal:
Painful Joints
Swelling of legs/feet
Rheumatoid Arthritis
Chronic pain in:
Hips Knees Feet
____ Limits ability to walk
____ Limits ability to exercise
Chronic Low Back Pain
Herniated Disk
Where? ________
Numbness of Legs/Feet
Joint replacement:
Hip Knee
Hernia
Type or location ________
Year repaired ________

Neurological:
Seizures
Muscle Weakness
Tremors
Narcolepsy
Stroke
Migraines - Freq____
Fibromyalgia
Muscular Dystrophy
Multiple Sclerosis

Psychological:
Depression
Anxiety disorder
Suicidal Thoughts
Suicide Attempts
Bi-polar disease
Schizophrenia
Anorexia
Bulimia

Endocrine:
Hyperthyroid (high)
Hypothyroid (low)
Diabetes:
____ Insulin dependent
____ Oral medicine
____ Diet controlled
Chronic Steroid Use
Cushing's disease

Skin:
Wounds that don't heal
Skin Cancer
Abnormal Moles
Chronic Rash
Psoriasis/Eczema
Lupus
Scleroderma

Men:
Loss of Erection
Last prostate exam ________
Enlarged breast tissue

Women:
Sexually active Y N
Method of Birth control:
____
Hysterectomy
Ovaries removed
Menopause
Last menstrual period ____
Irregular Periods
Heavy periods
Polycystic ovarian disease
Infertility
Facial hair growth
Last pap smear ________
Breast cancer
Last mammogram ________

Patient Name: ______________________________ **DOB:** ______________

Have you ever had a Chest X-Ray? **YES** **NO**
If yes, when? __________

Have you ever had an EKG? **YES** **NO**
If yes, when? __________

Have you ever had a Cardiac Stress Test? **YES** **NO**
If yes, when? __________

Have you had any blood work in the last 12 months **YES** **NO**
If yes, when? __________

Past Medical History

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

____
____
____
____
____
____
____
____

PLEASE SIGN (By signing below you are acknowledging that the information you have provided above is correct to the best of your ability and knowledge.)

Patient Signature: ______________________________ **Date:** ______________

Legal Guardian/Representative: ______________________________ **Date:** ______________