



**Weight Loss Institute of Arizona**  
**Dr. John DeBarros and Dr. Michael Orris**

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How did you hear about WLIA?		
Last Name		Doctor's Name
First Name		Date of Birth
Home Phone	Cell Phone	Work Phone
Previous Name		Sex
Address Line 1		Marital Status
Address Line 2		SSN
City		Employer
State		Zip
Employment Status		Student Status

Name of Insurance Company	Address of Insurance Company	City	State	Zip
Insurance Company Phone Number for Providers				
<i>If policy holder is different than patient, please list his or her Name, Relationship, DOB, and SSN.</i>				
ID Policy Number	Group Number	Insurance Company Number		
Secondary Insurance Company, Address, City, State, Zip				
Name of Company	Address	City	State	Zip
Secondary ID Policy Number	Secondary Group Number	Secondary Insurance Company Number		
<i>If patient is under 18, please provide the Responsible Party Information.</i>				
Name	Relationship	Contact Number		
Employer Company	Work Number	Position		

I hereby authorize my insurance company to pay directly any and all claims submitted to the Weight Loss Institute of Arizona, L.L.C. I accept responsibility for any unpaid balance following insurance reimbursement or should insurance deny coverage for services for any reason and will pay the balance in a timely manner. My signature on this document and my initials on each page thereafter permit W.L.I.A. to communicate with me through e-mail. My signature also allows W.L.I.A. to request copies of all medical records from any source pertinent to my medical care. A copy of your insurance card(s) and identification will be requested to accompany this application.

Signature \_\_\_\_\_ Date \_\_\_\_\_



## Medical Information

Type of Illness	Yes	No	Type of Illness	Yes	No	Type of Illness	Yes	No
Heart disease	Yes	No	Fatigue	Yes	No	Lupus	Yes	No
High cholesterol	Yes	No	Keloid formation	Yes	No	Chrohn's disease	Yes	No
High blood pressure	Yes	No	Epistaxis (nosebleed)	Yes	No	Ulcerative colitis	Yes	No
Type II diabetes mellitus	Yes	No	Painful urination	Yes	No	Emphysema	Yes	No
Shortness of breath	Yes	No	Kidney disease	Yes	No	Heart palpitations	Yes	No
Peptic ulcer disease	Yes	No	Infertility	Yes	No	Myocardial infarction	Yes	No
Obesity hyperventilation syndrome	Yes	No	Recent wheezing	Yes	No	Daytime drowsiness	Yes	No
Coughing or choking at night	Yes	No	Skin cancer	Yes	No	Restless sleep	Yes	No
Belching acid or sour fluid in throat	Yes	No	Breast cancer	Yes	No	Loud snoring	Yes	No
Gallstones	Yes	No	Colon cancer	Yes	No	Awakening at night	Yes	No
Urinary incontinence	Yes	No	Hip pain	Yes	No	Swelling of legs	Yes	No
Thyroid disease	Yes	No	Knee pain	Yes	No	Clot in arms, legs, or lungs	Yes	No
Deep vein thrombosis	Yes	No	Ankle pain	Yes	No	Sleep apnea	Yes	No
Pulmonary embolism	Yes	No	Feet pain	Yes	No	Morning headaches	Yes	No
Hepatitis A/B/C	Yes	No	Other (List)	Yes	No	Other (List)	Yes	No

If you have sleep apnea, when were you diagnosed? Date: \_\_\_\_\_ Do you use a CPAP or BiPAP machine? Yes, No. Setting:

## Surgery History

Date of Surgery	Type of Surgery	Open / Lap

## Hospitalization History

Date Admitted	Date of Discharge	Reason

## Family Medical History

Do you have a family history for any of the following diseases?	Yes	No	If yes, what family member?
Congestive heart failure			
Chrohn's disease			
Ulcerative colitis			
Colon cancer			
Breast cancer			
Thyroid cancer			
Adrenal problems			
Obesity			

## Social Information

Do you take any herbal supplements? Yes, No. *If yes, please list.*

Do you use illegal substances? (Circle) Currently use, used in the past, sometimes, never.

Do you use tobacco? (Circle) Currently use, used in the past, sometimes, never.

Do you consume alcohol? (Circle) Currently use, used in the past, sometimes, never.

## Medical History for the Past Five Years

Primary Care Physician's Name	Practice Name	Phone	Fax
Address	City	State	Zip

Other Medical Professional

Primary Care Physician's Name	Practice Name	Phone	Fax
Address	City	State	Zip

Other Medical Professional

Primary Care Physician's Name	Practice Name	Phone	Fax
Address	City	State	Zip

Other Medical Professional

Primary Care Physician's Name	Practice Name	Phone	Fax
Address	City	State	Zip

## Dietary History

Diet Program	Yes	No	Doctor Supervised	Duration	Pounds Lost
Jenny Craig					
Nutrisystems					
Weight Watchers					
Opti/Medi Fast					
Phen/Fen					
Meridia					
Lindora					
TOPS					
O.A.					
Acupuncture					
Other (List)					
Other (List)					

**Patient Weight History**

Birth weight \_\_\_\_\_ • High school weight \_\_\_\_\_ • Marriage weight? \_\_\_\_\_

Is your body frame large, medium, or small? \_\_\_\_\_

What is your height? \_\_\_\_\_ • What was your highest weight in past five years? \_\_\_\_\_

What was your lowest weight in past five years? \_\_\_\_\_

**Exercise Routine**

What type of exercise do you do?	Duration/Frequency	Home/Gym/Outdoors/Other

**What are your weight loss goals for the next year?**

**Why do you want surgical weight loss surgery?**

**Is there anything you would like to tell WLIA about yourself that was not asked in this questionnaire?**