

Patient Registration
Jeffrey B. Monash, MD
General and Bariatric Surgery

Please bring this registration form to your first visit

Name (first) _____ (middle) _____ (last) _____

Age _____ Date of Birth _____ Social Security # _____

Address _____

(city) _____ (state) _____ (zip) _____

Telephone (h) _____ (c) _____ (w) _____

Occupation _____ Employer's Name _____

Marital Status Married Single Divorced Widowed Separated

Spouse/Partner's Name _____

Emergency Contact _____ (relation) _____ (telephone) _____

Advanced Directive	Do you have a living will?	Yes	No
	Healthcare Power of Attorney?	Yes	No

If Yes, Contact Person _____ (telephone) _____

Primary Pharmacy _____ (telephone) _____

Primary Care Physician _____ (telephone) _____

Referring Physician _____ (telephone) _____

Primary Insurance _____

(ID#) _____ (Group#) _____

Policy Holder's Name _____ (DOB) _____

Secondary Insurance _____

(ID#) _____ (Group#) _____

I hereby acknowledge receipt of Dr. Monash's HIPAA Notice of Privacy Practices,

Signature _____ Today's Date _____

Have you ever been diagnosed with, or suffered from, the following (*please circle*)?

Diabetes

Depression

High Blood Pressure

Leaking of Urine

High Cholesterol

Swollen Ankles

Sleep Apnea

Blood Clot

Reflux/Heartburn

Social Anxiety

Back Pain

Menstrual Irregularities

Joint Pain

Frequent Headaches

Please list any other past or present medical problems

Please list any previous surgeries or procedures (*include dates*)

Medications

Dosages

Medication Allergies and Reactions _____

Family History of Significant Medical Problems

Mother _____ Father _____

Siblings _____ Children _____

Do you smoke cigarettes? Yes No If yes, _____ packs per day for _____ yrs

Have you quit? If yes, _____ yrs smoked Quit Date _____

Do you drink alcohol? Yes No If yes, _____ drinks per week

Please check any of the following that you have, or have had in the recent past

Neurologic

- Dizziness
- Temporary vision loss
- Confusion
- Headache
- Paralysis
- Numbness in hands/feet
- Weakness
- Seizures

Hematologic/Immunologic

- Fever
- Chills
- Night sweats
- Easy bruising
- Fatigue
- Swollen lymph nodes
- Bleeding gums

Gastrointestinal

- Difficulty swallowing
- Constipation
- Diarrhea
- Indigestion
- Nausea
- Abdominal pain
- Vomiting
- Blood in stool

Endocrine

- Excessive thirst
- Menopausal
- Hair loss

Otolaryngologic

- Cataracts
- Nearsightedness
- Farsightedness
- Hard of Hearing

Obstetric

- Number of pregnancies
- Number of live births

Respiratory

- Choking at Night
- Shortness of breath
- Wheezing
- Productive cough
(mucous or blood)
- Chronic cough

Cardiovascular

- Chest pain
- Irregular heartbeat
- Leg cramps with exercise
- Blood clot
- Low blood pressure
- Swelling of feet or ankles

Genitourinary

- Frequent urination
- Painful urination
- Leaking of urine
- Blood in urine
- Difficulty emptying bladder

Psychiatric

- Anxiety
- Depression
- Unusual Stress
- Bulimia
- Anorexia
- Bipolar
- Schizophrenia

Skin

- Itching
- Sores or ulcerations
- Rashes or discoloration

Musculoskeletal

(Pain or Weakness)

- Shoulder Hip
- Back Knee
- Foot Ankle
- Hand Other

DIET	TIME LENGTH	YEAR	WEIGT LOST
Appetite Suppressant Diet			
Adkins Diet			
Beverly Hills Diet			
Bioslim			
Cabbage Soup Diet			
Caborad			
Carbohydrate Addicts Diet			
Dexatrim			
Diabetic Diet			
Diuretics			
Fit For Life			
Herbal Remedies			
Hospital Diet			
Jenny Craig			
Laxatives			
Low Carbohydrate Diet			
Low Fat Diet			
Medifast			
Meridia			
Metabolife			
Metabolite			
NutriSystem			
Optifast			
Overeater's Anonymous			
Perricone Promise			
Phen-Fen			
Phentermine			
Physician Supervised Diet			
Redux			
Richard Simmons Deal-A-Meal			
Slim Fast			
South Beach Diet			
Starvation Diet			
Sugar Busters			
The Diet Center			
The Grapefruit Diet			
The Pritkin Diet			
The Scarsdale Diet			
The Zone			
TOPS			
Trim Spa			
Weight Loss Camp			
Weight Watchers			
Xenical			