UCDMC Bariatric OPTIFAST® Program

Patient Application

(Please Fax completed application to 916-734-8487)

Name _____ Sex_____ Date_____

Address _____ City _____ State ___ Zip Code _____

Home Phone: _____ Work: _____ Cell: _____

Date of Birth _____/_____/_____ Height _____ Current Weight _____

Primary Care Physician _____ PCP Phone: _____

Insurance Carrier_____ Subscriber: _____

Subscriber ID _____ Group # _____ SSN: _____

WEIGHT HISTORY: To the best of your recollection, what was your weight:
One year ago _____ Five years ago _____

FAMILY HISTORY: Have your parents, brothers or sisters had:

	Yes	No		Yes	No
Diabetes	____	____	Coronary Heart Disease	____	____
High Blood Pressure	____	____	Obesity	____	____

MEDICAL HISTORY: Do you have any of the following conditions or symptoms:

	Yes	No		Yes	No
Diabetes	____	____	Shortness of breath	____	____
Kidney disease	____	____	Swelling of legs	____	____
High blood pressure	____	____	Back pain	____	____
Missing menstrual periods	____	____	Falling asleep at odd times	____	____

Are you now or have you ever been under psychiatric care? _____

What methods of weight control have you previously tried?

Diet alone _____ Medications _____ Surgery _____ Group programs _____ Other_____

List all medications that you are presently taking: _____
_____

Why do you want to enroll in this program? _____
_____

What concerns do you have about your ability to be successful in this program?_____
_____

Do you foresee any financial hardships by being in this program?_____
_____

Do you have any questions about the program? (please write on back of this form)