UCSF Medical Center

**Bariatric Surgery Center**

**UCSF Medical Center**

**400 Parnassus Avenue, Room A655**

# UCSF BARIATRIC SURGERY CENTER
# NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

Please complete this form to provide information regarding your medical condition. Feel free to ask your primary care physician for assistance. All information will be kept confidential. Please return the completed questionnaire with the following:

- ☐ Formal letter from your primary care physician, *including a 6 month summary of diet and weight history*, a list of co-morbid conditions you have in addition to obesity, and why you are being referred for bariatric surgery.
- ☐ Current insurance authorization for an initial surgical consultation.
- ☐ Photocopy of the front and back of your insurance card.

We strive to be detail-oriented and thorough. Your answers here will become part of the UCSF medical record and will be confidential.

Name: _____

Date of Birth: _____

Home phone: _____

Other phone: _____

Address: _____

_____

City / State / Zip: _____

Email address: _____

Primary language: _____

What is your current weight?_____

What is your current height?_____

Insurance: _____

Subscriber No: _____

Group _____

Insurance: _____

Subscriber No: _____

Group _____

Social Security No: _____

How did you find UCSF Bariatric Surgery?

[ ] referred by a friend / relative
[ ] referred by a physician or other provider
[ ] referred by my insurance
[ ] referred by a UCSF bariatric patient
[ ] website: _____
[ ] found you on TV, radio, or magazine

Names of the doctors who referred you, your primary care doctor and any other doctor from whom you are receiving care?

Doctor who referred you: _____ City: _____

Primary care doctor: _____ City: _____

Additional doctor: _____ City: _____