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GASTRIC BALLOON PATIENT APPLICATION

DATE: _____ ☐ **MALE** ☐ **FEMALE**

PATIENT NAME: _____ , _____ _____
Last Name First Name Middle Initial

DOB: _____

EMAIL ADDRESS: _____

HOME: _____ **CELL**: _____ **WORK**: _____

EMPLOYER NAME: _____

☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **WIDOWED** ☐ **SEPARTED**

EMERGENCY CONTACT: _____ **RELATIONSHIP**:_____**PHONE**: _____

PRIMARY CARE DOCTOR: _____ **PHONE #**: _____

QUESTIONS

CURRENT BMI: _____ **CURRENT WEIGHT**: _____ **GOAL WEIGHT**:_____

HOW DID YOU HEAR ABOUT ORBERA/RESHAPE GASTRIC BALLOON?

☐ **FAMILY/FRIEND** ☐ **INTERNET** ☐ **TV COMMERCIAL** ☐ **MAGAZINE**
☐ **PRIMARY CARE PHYSICIAN**

WHICH GASTRIC BALLOON ARE YOU INTERESTED IN? ORBERA OR RESHAPE (circle one)

WHY ARE YOU INTERESTED IN A GASTRIC BALLOON?

_____

_____

HAVE YOU TRIED OTHER METHODS OF WEIGHT LOSS? IF SO, WHAT DID YOU TRY AND WHAT WAS THE OUTCOME? (i.e. diet programs, exercise programs, etc.)

_____

_____

WHY DO YOU THINK YOU WILL BE SUCCESSFUL WITH A GASTRIC BALLOON VERSUS ANOTHER WEIGHT LOSS PROCEDURE (i.e. bariatric surgery)?

_____

_____

MEDICAL HISTORY: (check all that apply)

Structural abnormality of the GI tract or motility disorder (esophageal stricture, diverticulum, atresia, stenosis, mass)

Inflammatory disease of the GI tract (ulcers, Crohn's)

Pregnancy/breast feeding

Bleeding conditions

Alcoholism/substance abuse

Liver conditions (cirrhosis/hepatic insufficiency)

Take prescription aspirin, anti-inflammatory agents

Abdominal surgeries; please specify _____

_____ _____

Signature of Patient or Parent/Guardian if minor **Date**