Kent C. Sasse, M.D., MPH, FACS, FASCRS, FASMBS

DEMOGRAPHIC SHEET

Patient Legal Name: ____
Last First Middle

Preferred name (if different from first name): ____

Seminar Date: ______/______/______

How did you hear about us?

❑ Television	❑ Print	❑ Doctor
❑ Radio	❑ Friends and Family	❑ Other: ________

DOB: __________ Gender: Male___Female___ Social Security #: ___________________________

Mailing Address: ____
Address City State Zip Code

Physical Address (if different from above): ____

Daytime Phone Number: _________________________ Home Phone: _________________________

Cell Phone: ____________________________ Email: _______________________________________

May we email you correspondence at the email listed above: Yes___ No___

Can we leave detailed messages on your answering machine/voicemail? Yes___No___ N/A___

Preferred Form of Contact (please choose one): Phone___ Email___ Patient Portal____

Required Government Information:

Race (Check the ONE you most identify with):

❑ White	❑ Black/African American	❑ Other Race/Unknown
❑ American Indian/Alaskan Native	❑ Native Hawaiian/Pacific Islander	❑ Declined
❑ Asian		

Ethnicity:

❑ Hispanic or Latino	❑ Not Hispanic or Latino	❑ Declined

Religion:

❑ Buddhist	❑ Jewish	❑ Jehovah's Witness
❑ Catholic	❑ Protestant/Christian	○ Bloodless
❑ Hindu	❑ Unknown/NA	
❑ Islam	❑ Declined	

Marital Status:

❑ Single	❑ Widowed	❑ Other: ___________
❑ Married	❑ Divorced	

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Name: ____

Continuity of Care:

Preferred Pharmacy in Nevada: ________________Cross Streets or Phone#: __________________

Referring Physician: ______________________________________ Phone#: ____________________

Primary Care Physician: __________________________________ Phone#: ____________________

Employment Information:

Employment: Employed___ Unemployed___ Retired___ Student___

Status: Full Time___ Part Time___ Not applicable___

Employer/Institution: ____

Work Contact #: ____

Can we contact you at work? Yes___ No___ Not applicable___

Can we leave detailed messages on your voice mail? Yes___ No___ Not applicable___

Payment Information:

Is this a self-pay visit? Yes___ No___

Is this visit billed to insurance? Yes___ No___

Primary Insurance: _______________________________ ID #: ______________________________

Policy Holder: _______________________________ Relationship to Patient: ___________________

Policy Holder's DOB: _____________ Policy Holder's Social Security #: _______________________

Issuing Employer: ____________________________ Customer Service #: _____________________

Secondary Insurance: ____________________________ ID #: ______________________________

Policy Holder: ____________________________________ Relationship to Patient: ______________

Policy holder's DOB: _______________ Policy Holder's Social Security #: ______________________

Issuing Employer: ____________________________ Customer Service #: _____________________

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Name: ____

Bariatric Health History

Name: ____
First Middle Last

Date of Birth: ______________________Social Security #: ____________________________

Primary Care Physician: ______________________ Telephone: _______________________

Weight History: ________ Height: _________ Weight: ____________ BMI: ____________

How long have you been obese (Lifelong or from what age?): ____________________________

Medical Problems: Please mark Yes | No for the following medical problems that you are being treated for by your physician team.

Arthritis _____

Atrial Fibrillation _____

COPD _____

Diabetes _____

Heart Disease _____

Heart Arrhythmia _____

Hepatitis _____

High Blood Pressure _____

High Cholesterol _____

Sleep Apnea _____

-if yes do you use a c-pap ____ bi-pap___

Please mark Yes | No for any of the items you may suffer from.

Asthma _____

Deep Vein Thrombosis (DVT) _____

Depression _____

GERD _____

Hiatal Hernia _____

Infertility _____

Pancreas Disease _____

Peptic Ulcer _____

Pickwickian Syndrome _____

Polycystic Ovarian Syndrome _____

Snoring _____

Stroke _____

Thyroid Problems _____

Urinary Incontinence _____

Bowel/Fecal Incontinence _____

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Name: ____

GOVERNMENT REQUIRED INFORMATION

Occupation: ____________________

Marital Status:

- ❑ Single
- ❑ Married
- ❑ Widowed
- ❑ Divorced
- ❑ Partner
- ❑ Other: _________

Use of alcohol:

Never ____ Yes ____ if yes, amount drinks per day: _____________

Former ____ Dates ____/_____/____ to ___/____/____

Number of drinks per day: _____

Use of tobacco:

Never ____ Yes ____ if yes, amount per day: _____________

Former ____ Dates ____/_____/____ to ___/____/____

Amount per day: ______________

Use of Drugs:

Never ____ Yes ____ if yes, type and amount per day: _____________

Former ____ Dates ____/_____/____ to ___/____/____

Type and amount per day: ______________________

Have you had a Flu vaccine? Yes___ No___ If so, when ____/____/____

Have you had a Pneumonia vaccine? Yes___ No___ If so, when ____/____/____

Have you had any surgeries? Yes___ No___

Name of Surgery: ____________________________________ Year/Month: ____________________

Name of Surgery: ____________________________________ Year/Month: ____________________

Name of Surgery: ____________________________________ Year/Month: ____________________

Name of Surgery: ____________________________________ Year/Month: ____________________

Name of Surgery: ____________________________________ Year/Month: ____________________

Have you had a colonoscopy? Yes___ No___

If so, who was your GI doctor? ____

K Sasse Surgical Associates, PC | 75 Pringle Way, 8th Floor, Suite 804 | Reno, NV 89502 | 775.829.7999 (p) | 775.829.7970 (f) | www.sassesurgical.com
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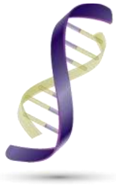

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Name: ____

Are you taking any medications? ***Yes________*** ***No________***

Name: ____________________Frequency: ______________________ Dose: _______ Reason: ____________

Name: ___________________ Frequency: ______________________ Dose: _______Reason: ___________

Name: ___________________ Frequency: ______________________ Dose: _______Reason: ___________

Name: ___________________ Frequency: ______________________ Dose: _______Reason: ___________

Name: ___________________ Frequency: ______________________ Dose: _______Reason: ___________

Name: ___________________ Frequency: ______________________ Dose: _______Reason: ___________

Name: ___________________ Frequency: ______________________ Dose: _______Reason: ___________

Do you take Aspirin or Coumadin? Yes___ No___

Do You Have any Allergies? ***Yes______*** ***No _______ (please fill out below)***

Allergic to: _______________________________ Reaction: ____________________________

Allergic to: _______________________________ Reaction: ____________________________

Allergic to: _______________________________ Reaction: ____________________________

Allergic to: _______________________________ Reaction: ____________________________

Allergic to: _______________________________ Reaction: ____________________________

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Name: ____

FAMILY HISTORY

Please check all that apply, list all relatives and label each with M or P:
(Maternal (M) =Mother's side or Paternal (P) =Father's side)

____ ***Bleeding Disorder***

Type: ______________________________Relatives Affected: _____________ (M | P) ____

Type: ______________________________Relatives Affected: ____________ (M | P) ____

____ ***Cancer***

Type: ______________________________Relatives Affected: _____________ (M | P) ____

Type: ______________________________Relatives Affected: _____________ (M | P) ____

____ ***Diabetes***

Type: ______________________________Relatives Affected: _____________ (M | P) ____

Type: ______________________________Relatives Affected: _____________ (M | P) ____

____ ***Heart Attack***

Relative Affected: ____ (M | P): ____

Relative Affected: ____ (M | P): ____

____ ***Heart Disease***

Relative Affected: ____ (M | P): ____

Relative Affected: ____ (M | P): ____

OTHER IMPORTANT MEDICAL INFORMATION

Yes___ No___ Do you have kidney problems or a single kidney?
Yes___ No___ Have you had cancer or multiple myeloma?
Yes___ No___ Do you have a pacemaker?
Yes___ No___ Have you had any organ transplants?

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Name: ____

GENERAL BARIATRIC DIET HISTORY

What alternative means of weight loss has been used? (Check all the apply)

- ❑ Atkins Diet
- ❑ Weight Watchers
- ❑ Low Calorie
- ❑ Low Fat
- ❑ Low Sugar
- ❑ Low Carb
- ❑ South Beach Diet
- ❑ Jenny Craig
- ❑ Nutrisystem
- ❑ Curves
- ❑ Gym Membership
- ❑ Fit for Life
- ❑ Overeaters Anonymous
- ❑ Prior Weight Loss Surgery
- ❑ Exercise Programs
- ❑ Personal trainer
- ❑ Richard Simmons
- ❑ Jazzercise
- ❑ iMetabolic
- ❑ Liquid Diet/Protein Shakes
- ❑ Sensa
- ❑ Physician Supervised Weight Loss Program
- ❑ Fen Phen
- ❑ Lipozene
- ❑ Meridia
- ❑ HCG
- ❑ Xenical
- ❑ Alli
- ❑ Qsymia
- ❑ Belviq
- ❑ Contrave
- ❑ Other___________

What are problems are you experiencing because of your weight? (Check all that apply)

- ❑ Embarrassment in social situations
- ❑ Problems at work
- ❑ Inability to care for children and family
- ❑ Difficulties with bathing and hygiene
- ❑ Inability to perform activities of daily living
- ❑ Pain in back
- ❑ Pain in feet and ankles
- ❑ Pain in hips and knees
- ❑ Swelling hands and feet
- ❑ Trouble sitting in booths
- ❑ Sitting in a regular size office chair
- ❑ Insomnia
- ❑ Headaches
- ❑ Lower Extremity Edema
- ❑ Malaise/Fatigue
- ❑ Varicose Veins
- ❑ Irregular Periods
- ❑ Dermatitis
- ❑ Not being able to reach a computer keyboard
- ❑ Not being able to fit into a public restroom
- ❑ Getting in and out of bathtub
- ❑ Playing with or caring for children
- ❑ Riding a bike with family
- ❑ Doing yard work
- ❑ Doing housework
- ❑ Taking walks
- ❑ Bending over to pick something up off the floor
- ❑ Having relations

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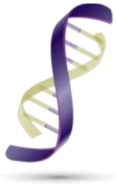

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DIET HISTORY

Please fill out the following lines to the best of your knowledge for diets that you have tried or failed within the last 3-5 years. Please provide documentation for any of the most recent diets attempted within the last 2 years.

Examples of Diets: Akins, Weight Watcher's, Jenny Craig, Physician Supervised, Low Calorie, Low Carbohydrates, Increase of physical exercise, Grapefruit diet, Juice Diet, Fast/Cleanse, pharmaceutical therapies.

Date: ___________ Diet: ________________________ Pounds lost: ________ Pounds gained: _________

Date: ___________ Diet: ________________________ Pounds lost: ________ Pounds gained: _________

Date: ___________ Diet: ________________________ Pounds lost: ________ Pounds gained: _________

Date: ___________ Diet: ________________________ Pounds lost: ________ Pounds gained: _________

Date: ___________ Diet: ________________________ Pounds lost: ________ Pounds gained: _________

Date: ___________ Diet: ________________________ Pounds lost: ________ Pounds gained: _________

Date: ___________ Diet: ________________________ Pounds lost: ________ Pounds gained: _________

Date: ___________ Diet: ________________________ Pounds lost: ________ Pounds gained: _________

Date: ___________ Diet: ________________________ Pounds lost: ________ Pounds gained: _________

Date: ___________ Diet: ________________________ Pounds lost: ________ Pounds gained: _________

Date: ___________ Diet: ________________________ Pounds lost: ________ Pounds gained: _________

Date: ___________ Diet: ________________________ Pounds lost: ________ Pounds gained: _________

Date: ___________ Diet: ________________________ Pounds lost: ________ Pounds gained: _________

Date: ___________ Diet: ________________________ Pounds lost: ________ Pounds gained: _________

Date: ___________ Diet: ________________________ Pounds lost: ________ Pounds gained: _________

Date: ___________ Diet: ________________________ Pounds lost: ________ Pounds gained: _________

Date: ___________ Diet: ________________________ Pounds lost: ________ Pounds gained: _________

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