Reshaping Lives California
Patient Application – Initial Screening

Name: ____________________________

Address: __________________________

Phone: ____________________________

E-mail: ____________________________

Surgical Procedure Needed: __________________________

Medical Insurance: __________________________

List any medications you are currently taking:

______________________________

______________________________

______________________________

Please circle all existing or past co-morbidities:

Heart Disease  Stroke  Hypertension  Lung Disease
Kidney Disease  Diabetes  Cancer  Family History of Cancer
Active Substance Abuse  History of Substance Abuse
Allergies:

________________________________________________________________________________________

Weight _______ Height _______

Emergency Contact:

Name: ___________________ Relationship to you: __________________________

Phone: ____________________________

Single / Married: __________________________

Rent/Mortgage: __________________________

Occupation (if applicable): __________________________

Monthly Salary: __________________________

Spouse Information (If applicable):

Occupation: __________________________

Monthly Salary: __________________________

Total of any other income:

Food Stamps: __________________________

Disability: __________________________

Social Security: __________________________

Unemployment: __________________________

General Assistance: __________________________

Child Support: __________________________

Other: __________________________