Morbid Obesity Questionnaire

General Information

Last Name: …….. First Name: ……..
Date of Birth: …….. Age: …….. Sex: ……
Height: ……. Cm Weight: …… Kg BMI:- Weight (kg): _____
- Height (m^2)

Name, address and telephone number of present attending Physician:
……
Frequency of visits to Physician: ☐ Occasionally ☐ Frequently
Date of last visit: ….. /….. /……
What is the severity of the Disease? ☐ Mild ☐ Moderate ☐ Severe

Do you smoke? ☐Yes ☐ No If Yes, how many cigarettes per day? _____
For how many years? _____
Did you ever smoke? ☐Yes ☐ No If Yes, when did you stop? _____

Condition Profile

Previous Diet under medical supervision weight after the diet and period of diet:
Date 1: …….. Weight 1: ……..
Date 2: …… Weight 2: ……

Please check the illnesses below that you have ever had:

☐ Diabetes	…… Year	☐ Hyper uricemia	…… Year
☐ HTA	…… Year	☐ Surgical History	…… Year
☐ Hyper Cholesterolemia	…… Year	☐ Ulcer Disease	…… Year
☐ Hyper Triglyceridemia	…… Year	☐ Others	…… Year
☐ Thyroid Diseases	…… Year		

Treatment:

- Medication (Name and dosage):

1. …… 5. ……
2. …… 6. ……
3. …… 7. ……
4. …… 8. ……

Surgery: Yes ☐ No ☐
If yes, describe the surgery: ☐ Gastric by pass
☐ Gastric banding
☐ Others

Have you ever been hospitalized or got to the emergency room for this condition? Yes ☐ No ☐
Has treatment changed during the last five years? Yes ☐ No ☐
If yes, describe the change:
……
Do other members of your family have obesity problem? Yes ☐ No ☐
(If a parent is deceased, please list the cause of death)
……

Attending Physician: …… Date: ……./……./…….

I hereby declare that the above mentioned information is complete, real and adequate, waiving, fully and irrevocably, the medical confidentiality on all the past and current medical files, documents and prescriptions related to any of us and those that will develop during the policy contract, in favor of the Medical committees and doctors, requesting from them, and other insurance companies or any other guarantor which we had contracted with for medical and/or life insurance, to provide the insurance company and/or GlobeMed Lebanon with all the information and documents available at their side on our medical condition and of copies thereto, permitting GlobeMed Lebanon, within its capabilities, to inform our treating physician with the information available at its side on our medical condition, in addition to the rejection or approval of coverage decisions at all healthcare providers, with all possible means, either through e-mail, or SMS or any other available mean.

Insured's Signature: …… Date: ……./……./…….