BARIATRIC DEPARTMENT PATIENT INTAKE FORM

Please answer all questions to the best of your ability.

Patient name:________________________________**Date:**______________

SS#:________________________________**Age:**______________

Address:________________________________**Date of Birth:**______________

City/State/Zip Code:________________________________**Sex: MALE**______**FEMALE**__________

Phone (home):______________**(work):**______________**(cell):**______________**Marital Status:**______________

e-mail address:______________________**How did you hear about us?**______________________

Primary Care Physician:______________________**Phone:**______________________

Address of Primary Care Physician:____

Other Physicians involved in your care:____

____

Employment status: Full-time______________ **Part-time**______________**Not Employed**______________

Employer:________________________________**Occupation:**______________

(If self-employed, please state the name of the Company)

Employer Address:____

Emergency Contact Name:______________________**Realationship:**______________________

Phone (home):______________**(work):**______________**(cell):**______________

Patient Insurance Information: Company____

Subscriber Name:________________________________**Subscriber Date of Birth:**______________

Employer:________________________________**Policy #:**______________________

Group #:________________________________**Phone #:**______________________

Secondary Insurance Information: Company:____

Subscriber Name:________________________________**Subscriber Date of Birth:**______________

Employer:________________________________**Policy #:**______________________

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Group#:____Phone#:____

By signing below, I authorize Methodist Physicians Clinic to share my medical information relating to my use or need for weight loss surgery with my health insurance plan. This information can include spoken or written facts about my medical condition including copies of my records from Methodist Physicians Clinic healthcare providers, Methodist Hospital, Methodist Jennie Edmundson Hospital or Methodist Women's Hospital. Methodist Physicians Clinic will use and she this information with my health insurance plan to see if I has coverage and/or benefits for weight loss surgery. This authorization will last for one year after the date I sign this form. If I change mind before that time, I can contact the Methodist Physicians Clinic Director of Health Information Management in writing and tell them that I do not want them to share any more information with my health insurance plan. I understand this will not change any action taken before I revoked this authorization. I know that I have a right to see or copy the information Methodist Physicians Clinic has given to my health insurance plan. I understand that I may refuse to sign this form. My decision to sign this form or not will not affect the way my healthcare providers treat me. If I refuse to sign this form I understand that this means I will no longer receive assistance from Methodist Physicians Clinic to determine my health insurance benefits for weight loss surgery. I understand that Methodist Physicians Clinic does not promise to find ways to pay for my weight loss surgery and I know that I may have to pay the costs of my care.

Patient Signature:____Date:________________________________

(If you have already signed an insurance verification form, you do not need to sign this again)

How long have you been overweight? (Please circle the most appropriate response)

All my life (childhood)   Adolescent (high school/teenager)   Adult   After Pregnancy

After a Specific Event or Injury   Other:____

Have you had prior weight loss surgery?   Yes   No

If yes, pleas indicate type of surgery:_____________________________________Date:________________________________

Where was surgery was performed:______________________________________By whom:____________________________

What is the most you have ever weighed?   Weight:____________________Date:_________________________________

What diets and medications have you tried in the past to lose weight? (Please include dates and amount of weight loss)

____

____

____

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Have you ever been treated for an eating disorder?

Anorexia **Yes** **No** **Bullemia** **Yes** **No**

Binge Eating **Yes** **No** **Other:**____

Do you have any food allergies or food intolerances? (Please list these foods)________________________________

____

Do you skip meals? Yes__________**No**____________**Which meals?**_____________________**How often?**___________________

Do you do your own grocery shopping? Yes_________**No**__________

Who does the cooking at your house?______________________________

Do you eat out? Yes__________**No**_________ **How often?**_________________**Where?**_________________________________

List any diet restrictions you have or any special diet guidelines you follow:____________________________________

Please list all of your past surgeries, include all out-patient surgeries.

Type of Surgical Procedure	Date	Place	Surgeon

Have you ever been hospitalized for any other medical illness?

Reason for Hospitalization	Date	Place	Physician

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Have you ever been admitted to a mental health/psychiatric hospital or received treatment for a psychological or psychiatric Condition:

Reason for Hospitalization/Treatment	Date	Place	Physician

Current Medications: Please include any herbal supplements as well.

Type of Medication	Dosage	Time of day taken	Prescribing Physician

Do you have any allergies to medications, food, latex or others? Yes No

Please list allergies below	Type of Reaction

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Do you have or have you ever been diagnosed with: **(please circle Yes or No and provide onset information)**

a. Hypertension	**Yes**	**No**	**Onset:**______
Congestive Heart Failure	**Yes**	**No**	**Onset:**______
Chest Pain	**Yes**	**No**	**Onset:**______
Other Heart Conditions:	**Yes**	**No**	**Onset:**______
b. Diabetes	**Yes**	**No**	**Onset:**______
Other Endocrine Disorders (Thyroid, Adrenal)	**Yes**	**No**	**Onset:**______
c. Sleep Apnea	**Yes**	**No**	**Onset:**______
Blood clots to your lungs (Pulmonary Emboli)	**Yes**	**No**	**Onset:**______
Shortness of Breath	**Yes**	**No**	**Onset:**______
Other Lung Conditions (Asthma, Bronchitis)	**Yes**	**No**	**Onset:**______
d. Arthritis/Orthopedic Conditions of Your:			
Neck:	**Yes**	**No**	**Onset:**______
Upper Spine/Back	**Yes**	**No**	**Onset:**______
Lower Spine/Back	**Yes**	**No**	**Onset:**______
Hips	**Yes**	**No**	**Onset:**______
Knees	**Yes**	**No**	**Onset:**______
Shoulders	**Yes**	**No**	**Onset:**______
Ankles/Feet	**Yes**	**No**	**Onset:**______
e. Fibromyalgia	**Yes**	**No**	**Onset:**______
f. Lower Extremity Problems:			
Varicose Veins	**Yes**	**No**	**Onset:**______
Lymphedema/Ankle Swelling	**Yes**	**No**	**Onset:**______
Venous Skin Ulcerations/Breakdown or			

	Discolorations to skin	**Yes**	**No**	**Onset:**________________________
	Other lower Extremity Conditions	**Yes**	**No**	**Onset:**________________________
g.	**Gastrointestinal Disease or Disorders:**			
	Heartburn/Reflux	**Yes**	**No**	**Onset:**________________________
	Difficulty Swallowing	**Yes**	**No**	**Onset:**________________________
	Diarrhea	**Yes**	**No**	**Onset:**________________________
	Constipation	**Yes**	**No**	**Onset:**________________________
	Ulcers	**Yes**	**No**	**Onset:**________________________
	Colitis	**Yes**	**No**	**Onset:**________________________
	Diverticulitis	**Yes**	**No**	**Onset:**________________________
	Irritable Bowel Syndrome or IBS	**Yes**	**No**	**Onset:**________________________
	Fecal Incontinence	**Yes**	**No**	**Onset:**________________________
	Other Gastrointestinal Conditions	**Yes**	**No**	**Onset:**________________________
h.	**Genitourinary Disease or Disorders:**			
	Urinary Incontinence	**Yes**	**No**	**Onset:**________________________
	Other Genitourinary Conditions	**Yes**	**No**	**Onset:**________________________
i.	**Gynecological Disease or Disorders:**			
	Amenorrhea (absence of periods)	**Yes**	**No**	**Onset:**________________________
	Dysmenorrhea (painful/heavy periods)	**Yes**	**No**	**Onset:**________________________
	Infertility	**Yes**	**No**	**Onset:**________________________
	Other Gynecological Conditions	**Yes**	**No**	**Onset:**________________________
j.	**Psychiatric/Psychological Disorders:**			
	Depression	**Yes**	**No**	**Onset:**________________________
	Bipolar Disorder	**Yes**	**No**	**Onset:**________________________

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Suicidal Thoughts **Yes** **No** **Onset:**____

Physical/Sexual Abuse **Yes** **No** **Onset:**____

Other Psychiatric/Psychological Conditions **Yes** **No** **Onset:**____

Family History: List all medical problems of family members, such as Heart Disease, Lung disease, Diabetes, Cancer or Obesity along with the relationship to the patient:

____

____

____

Do you use tobacco products? Yes______________If yes, how much_________/day and type___________ No________Quit__________

Do you drink alcohol? Yes______________If yes, how much____________/day or week No_____________ Quit____________

Have you ever had a substance abuse problem? Yes___________ If yes, specify_______________ No__________ Quit___________

COMPLICATIONS FROM ANESTHESIA: Have You or Anyone in Your Family had complications from anesthesia?

Yes____________ No___________ If yes, please describe:____

BLEEDING TENDENCIES: Have you ever experienced any prolonged bleeding from dental or surgical procedures?

Yes____________ No___________ If yes, please describe:____

Can you walk up a flight of stairs without stopping? **Yes** **No**

How far can you walk without stopping?____

Can you put on/tie you shoes and socks? **Yes** **No**

Can you perform adequate hygiene after a bowel movement? **Yes** **No**

Can you perform necessary household chores/activities? **Yes** **No**

Can you fit in a theater/airplane/amusement park seat? **Yes** **No**

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What can't you do because of your obesity?____

____

____

How do you think weight loss surgery will help you medically, psychologically or personally?

____

____

____

Record in the space provided what you might typically eat including type and amount of food.

Meal Times	Food Eaten and Amount
Breakfast Time _______	
Snack Time _______	
Lunch Time _______	
Snack Time _______	
Dinner Time _______	
Snack Time _______	