Med Center Health®

Medical Center
Surgical Weight Loss Program

Please return this completed packet in the self-addressed, postage paid envelope. You can email this packet to surgicalweightloss@mchealth.net or fax to 270-780-2793.

Make sure to include a copy of the front and back of your insurance card. When we receive this packet we will verify coverage of benefits and call to make your intake appointment. Please be honest and completely fill out all forms.

I know there are several forms but this will help cut down on forms on the day of your intake appointment.

If you have any questions, contact our office Monday through Friday 8am -4:30pm @ 270-796-6333.

We are here to help you!

Sincerely,

Surgical Weight Loss Team

Dr. Raphael Nwanguma	Janet "J.R." Robinson, Practice Coordinator
Yolanda Reid, APRN	Karen, Patient Service Coordinator
Oundrea, Clinic Support	LaTasha, Patient Registration

Med Center Health

Medical Center
Surgical Weight Loss Program

Patient Information Packet

Preferred Procedure:

❍ Laparoscopic Sleeve Gastrectomy

❍ Laparoscopic Roux-en-Y Gastric Bypass

❍ Lap Band Removal

Patient Information:

First Name:_____ Middle Name:_____ Last Name:_____

Social Security Number:_____ Date of Birth:_____ Age:_____ Gender: ❍ Female ❍ Male

Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Partnered ❍ Widow(er)

Ethnicity: ❍ African American ❍ Hispanic ❍ Native American or Alaska Native ❍ Choose not to specify

❍ Asian ❍ Caucasian ❍ Native Hawaiian / Other Pacific Islander ❍ Other:_____

What is your height?_____ft _____in How much do you weigh?_____lbs. BMI:_____

Address Information:

Street Address:_____

City:_____ State:_____ Zip Code:_____

E-mail:_____ Phone (home):_____

Phone (work):_____ Phone (cell):_____

OK to leave message at: ❍ Home ❍ Work ❍ Cell

Insurance Information: – <u>Please attach a copy of the front and back of all insurance cards</u>

Payment Type: ❍ Insurance ❍ Self Pay

Primary Insurance:

Insurance Company:_____

Policy Number:_____ Group #:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Customer Service Phone:_____ Provider Phone:_____

Emergency Contact:

First Name:_____ Last Name:_____

Relation to you:_____Phone:_____

Primary/Referring Physician:

First Name:_____ Last Name:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____ Phone:_____

Have you discussed Weight Loss Surgery with your physician? **❍ Yes ❍ No**

Is your physician supportive? **❍ Yes ❍ No**

Medical History:

❍ Hypertension	❍ Diabetes	❍ GERD/Heartburn/Reflux	❍ High cholesterol
❍ Sleep apnea	❍ Back/Joint pain	❍ Heart disease	❍ PCOS
❍ Osteoporosis	❍ Lower leg swelling	❍ Vascular disease	❍ Pulmonary hypertension

Allergies: (examples: medicines/food/latex/iodine/Shellfish) ☐ **NONE**

_____

_____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

List Prescribed Medications:	**Taken for what condition:**	**Dosage/How Often:**
☐ **NONE**		

List any Over-the-Counter medications, herbal supplements or vitamins that you take on a regular basis.

Product:	**Taken for what purpose:**	**Dosage/How Often:**

Surgical Procedure(s):	☐ **NONE**	**Year**		**Year**
Gallbladder	(Open)	_____	Tonsillectomy	_____
Gallbladder	(Laparoscopic)	_____	D & C	_____
Appendectomy	(Open)	_____	Ear Surgery:_____	_____
Appendectomy	(Laparoscopic)	_____	Back Surgery:_____	_____
Hysterectomy	(Vaginal)	_____	Heart Surgery: _____ CABG/Stents	_____
Hysterectomy	(Abdominal)	_____	Valve Replacement	_____
Ovary Surgery:	❍ Ovaries Removed	_____	Pacemaker	_____
Hernia: ❍ Hiatal	❍ Umbilical	_____	Wisdom teeth_____	
Tubal Ligation		_____	Knee: ❍ Right ❍ Left	_____
Cesarean Section		_____	Breast Biopsy: ❍ Right ❍ Left	_____
Colonoscopy		_____	Anti-reflux procedure / Nissen Fundoplication	_____
Colostomy		_____	Kidney Surgery	_____
Colon Resection		_____	Other Hernia or Abdominal Surgery_____	
Endoscopy		_____	Other:_____	

Anesthesia Problems: Please tell us about any problems that you have had with anesthesia: ❍ **NONE**

❍ Nausea ❍ Heart Stopped ❍ Woke up during procedure

❍ Vomiting ❍ Stopped Breathing ❍ Other:_____

❍ Difficulty Waking Up ❍ Difficulty Urinating

Weight Loss History:

Greatest weight within the past 12 months? _____

How long have you been overweight?_____Years How long have you been 35 pounds' overweight?_____ Years

How long have you been 100 pounds or more overweight?_____Years When did you start dieting?_____Age

What is the most weight you have ever lost on a single diet?_____lbs. How did you lose the weight?_____

How long did you sustain the weight loss?_____ ❍ No diet attempts of any kind

Have you ever had a "stomach stapling", Nissen or other gastric restriction or anti-reflux procedure?

❍ **Yes** ❍ **No**

(If yes, please provide this information when entering in your previous surgical history.)

Previous Weight Loss Surgery (WLS): _____

(We will need a copy of the Operation Report from your previous weight loss surgery.)

Date of Surgery:_____ Surgeon: _____

Surgeon Location: _____

List any complications of WLS: _____

Original Weight prior to Surgery: _____ ❍ Estimated ❍ Actual – Lowest Weight Achieved: _____ ❍ Estimated ❍ Actual

Check all that apply:

Unsupervised Diet Attempts: ❍ **NONE**

❍ Body for Life/Bill Phillips	❍ High Protein	❍ Low Fat	❍ Cabbage Soup
❍ Pritikin	❍ Stillman Diet	❍ Mayo Clinic	❍ Fasting
❍ Gloria Marshall	❍ Herbal Life	❍ Calorie Counting	❍ Scarsdale
❍ Richard Simmons	❍ Sugar Busters	❍ Atkin's Diet	❍ Slim Fast
❍ Health Spa	❍ Low Carbohydrate	❍ South Beach	❍ Other:_____

Supervised Diet Attempts: ❍ **NONE**

❍ Nutri-System	❍ Overeaters Anonymous	❍ Weight Watchers	❍ Jenny Craig
❍ TOPS	❍ Optifast	❍ HMR	❍ DASH
❍ LA Weight Loss	❍ Diet Center	❍ Other:_____	

Over-the-Counter or Prescribed Medications for Weight Loss: ❍ **NONE**

❍ Acutrim	❍ Dexatrim	❍ Ionamin/Adipex	❍ Phendiet	❍ Prozac
❍ Wellbutrin	❍ Amphetamines	❍ Didrex	❍ Tenuate	❍ Phentrol
❍ Redux	❍ Byetta	❍ Plegine	❍ Sanorex	❍ Meridia
❍ Xenical	❍ Diuretics	❍ Pondimin	❍ Phenteramine	
❍ Fen-Phen, # of months:_____		❍ Other:_____		

Behavioral Treatments for Weight Loss: ❍ **NONE**

❍ Hospitalization ❍ Hypnosis

❍ Physical Therapy ❍ Psychological Therapy

❍ Residential Programs ❍ Other:_____

Exercise: ❍ **NONE**

❍ Walking or Running ❍ Stationary cycle or treadmill

❍ Swimming ❍ Weight Training

❍ Team Sports ❍ Other:_____

Eating Habits, Do you:

Snack between meals? ❍ Yes ❍ No

Eat a lot of sweets? ❍ Yes ❍ No

Drink caffeine-containing drinks? ❍ Yes ❍ No

●If yes, how many cups per day?_____

Eat large meals? (gorge) ❍ Yes ❍ No

Drink carbonated beverages? ❍ Yes ❍ No

●If yes, how many cans/bottles per day?_____

Drink soda pop? ❍ Yes ❍ No ❍ Diet ❍ Regular

Have you used any of the following to control your weight? (Check all that apply)

❍ Binging and Purging ❍ Binging followed by food restriction ❍ Vomiting

❍ Excessive Exercise ❍ Excessive Calorie Restriction/Fasting

If so, when and how long was this period of behavior? _____

Do you currently force yourself to vomit after eating? ❍ Yes ❍ No ❍ Occasionally

Why do you feel you eat? ❍ Physical Hunger ❍ Loneliness ❍ Anxiousness

❍ Makes me happy ❍ Bored

What reasons do you feel contribute to your weight? ❍ Over Consumption ❍ Inactivity ❍ Emotional Wellbeing

What else contributes to your weight struggle, i.e. how do you account for why you have been unable to lose weight and/or maintain?

_____

_____

Please tell us how your weight is interfering with your health and life? _____

_____

Why are you seeking weight loss surgery? _____

_____

Please tell us why you feel you can be successful with weight loss surgery, despite the extreme lifestyle and dietary changes required?

_____

_____

If you use eating as an emotional outlet, what will you substitute when your eating is restricted?_____

_____

_____

What is your greatest fear regarding surgery?_____

_____

Thank you for taking the time to fill out our Patient Profile Packet.

Please check to make sure that you have completed all the following before sending in your packet:

- ☐ Filled out this form as completely as possible
- ☐ **Make a copy of the front and back of your insurance card**.
- ☐ Send a copy of your ID
- ☐ Obtain and include Operative reports from any previous weight loss surgeries

Date Completed: _____

Fax, Mail or Email completed packet and Insurance Card to:

Med Center Health Surgical Weight Loss Program
825 2nd Ave East Suite A4
Bowling Green, Kentucky 42101
Phone: 270-796-6333
Fax: 270-780-2793

surgicalweightloss@mchealth.net

Med Center Health

Medical Center
Surgical Weight Loss Program

PFSH Form

Name: _____ DOB: ___/____/___ Age: _____ Date: _____

Medical History: (Check all that apply)

General:	☐ **NONE**	
☐ Fevers	☐ Weight Gain	☐ Tired / No Energy
☐ Night Sweats	☐ Insomnia	☐ Hair Loss
☐ Appetite Change	☐ Other:_____	

Head and Neck:	☐ **NONE**	
☐ Wear contacts / glasses	☐ Vision Problems	☐ Hearing Problems
☐ Sinus Drainage	☐ Nose Bleeds	☐ Hoarseness
☐ Dentures, Partial / Full	☐ Allergies	☐ Glaucoma
☐ Regular Ear Infections	☐ Blurred / Double Vision	☐ Other:_____

Cardiovascular:	☐ **NONE**	
☐ Heart Attack	☐ Chest Pain w/ Activity	☐ Rhythm Changes
☐ Congestive Heart Failure	☐ High Blood Pressure	☐ Palpitations
☐ Varicose Veins	☐ Dyspnea on Exertion	☐ Ankle Swelling
☐ Ankle / Leg Ulcers	☐ Elevated Triglycerides	☐ Phlebitis / DVT
☐ Clogged Heart Arteries	☐ Rheumatic Fever / Valve Damage / MVP	☐ Rapid Heart Beat
☐ Irregular Heart Beat	☐ Cramping in legs when walking	☐ Heart Murmur
☐ Atrial Fibrillation	☐ Elevated Cholesterol	☐ Other:_____

Respiratory:	☐ **NONE**	
☐ Asthma	☐ Emphysema / COPD	☐ Bronchitis
☐ Pneumonia	☐ Chronic Cough	☐ Shortness of Breath at Rest
☐ Use of Cpap / Bipap	☐ Use of Oxygen	☐ Snoring
☐ Pulmonary Embolism	☐ Sleep Apnea	☐ Other:_____

Gastrointestinal:	☐ **NONE**	
☐ Heartburn	☐ Hiatal Hernia	☐ Ulcers
☐ Diarrhea	☐ Blood in Stool	☐ History of Liver Enzymes
☐ Constipation	☐ IBS	☐ Umbilical Hernia
☐ Difficulty Swallowing	☐ Hemorrhoids	☐ Fissure / Polyps
☐ Rectal Bleeding	☐ Black, Tarry Stool	☐ Ventral Hernia
☐ Abdominal Pain	☐ Enlarged Liver	☐ Cirrhosis / Hepatitis
☐ Gallbladder Problems	☐ Jaundice	☐ Pancreatic Disease
☐ Nausea / Vomiting	☐ GERD	☐ Incisional Hernia
☐ Barrett's Esophagus	☐ Crohn's Disease	☐ Other: _____

Bladder/Kidney: ☐ **NONE**

☐ Kidney Stones ☐ Blood in Urine ☐ Prostate Problems

☐ Kidney Failure / Renal Insufficiency ☐ Leaking urine w/ cough/laugh/sneezing ☐ Men: PSA test in last year?

☐ Trouble starting urine ☐ Burning / Pain on urination ☐ Urinary Urgency/Frequency

☐ Overall Loss of Bladder Control ☐ dialysis:_____

Gynecologic: (for women only) ☐ **NONE**

☐ Problems Conceiving / Infertility ☐ Currently Pregnant ☐ Uterine / Ovarian Cancer

☐ PCOS ☐ Menstrual Irregularity ☐ Menstrual Pain

☐ Excessively Heavy Periods ☐ Plan to have more children ☐ Post Menopausal

How many pregnancies have you had:_____ Date of Last Pap Smear?_____

How many miscarriages or abortions have you had:_____ Date of last menstrual period?_____

Breast: ☐ **NONE**

☐ Nipple Discharge ☐ Lumps / Fibrocystic Disease ☐ Other:_____

☐ Pain ☐ Cancer Date of last Mammogram:_____

Musculoskeletal: ☐ **NONE**

☐ Shoulder Pain ☐ Neck Pain ☐ Elbow Pain

☐ Hip Pain ☐ Wrist Pain ☐ Back Pain

☐ Foot Pain ☐ Knee Pain ☐ Ankle Pain

☐ Plantar Fasciitis ☐ Heel Pain ☐ Ball of Foot Pain

☐ Broken Bones ☐ Carpal Tunnel Syndrome ☐ Lupus

☐ Muscle Pain / Spasm ☐ Sciatica ☐ Rheumatoid Arthritis

☐ Fibromyalgia ☐ Other:_____

Neurologic: ☐ **NONE**

☐ Balance Disturbance ☐ Dizziness ☐ Restless Leg Syndrome

☐ Stroke ☐ Seizures or convulsions ☐ Weakness

☐ Knocked Unconscious ☐ Numbness / Tingling ☐ Multiple Sclerosis

☐ Pseudo tumor Cerebri (loss of vision from high pressure in brain) ☐ Other:_____

Psychiatric: ☐ **NONE** **Are you currently under the care of a mental health provider? ☐ Yes ☐ No**

☐ Depression ☐ Anxiety

☐ Bipolar Disorder ("manic-depression") ☐ Seen a Psychiatrist or Counselor

☐ Alcoholism / Substance Abuse ☐ Been hospitalized for psychiatric problems

☐ Been in a chemical dependency program ☐ Attempted suicide

☐ Currently taking medications for psychiatric problems or for depression ☐ Victim of Mental/Emotional/Sexual/Physical Abuse

☐ Attention Deficit Disorder ☐ Other:_____

Endocrine: ☐ **NONE**

☐ Parathyroid ☐ Hypothyroid ☐ Goiter

☐ Low Blood Sugar ☐ Excessive Thirst ☐ Endocrine Gland Tumor

☐ "Pre-Diabetes" ☐ Diabetes (Diet or Pills) ☐ Diabetes (Insulin Shots)

☐ Abnormal Facial Hair ☐ Excessive Urination ☐ Gout

☐ Other:_____

Blood/Lymphatic: ☐ **NONE**

☐ Low Platelets (thrombocytopenia) ☐ Anemia ☐ HIV / AIDS

☐ Bruise Easily ☐ Lymphoma ☐ Swollen Lymph Nodes

☐ Bleeding/Clotting Disorder ☐ Blood thinning medicine use ☐ History of DVT / PE

☐ Prior blood Transfusion ☐ Cancers_____

Other:_____

Skin: ☐ **NONE**

☐ Frequent Skin Infections ☐ Keloids (Excessively Raised Scars) ☐ Poor Wound Healing

☐ Psoriasis ☐ Rashes under Breasts / Skin Folds ☐ Rosacea

☐ Hair or Nail Changes ☐ Other:_____

_____

Social History:

Do you smoke now? ❍ Yes ❍ No If yes, how many packs per day?_____

Have you smoked in the past? ❍ Yes ❍ No If you have quit, how many years since?_____

For how many years did you use tobacco? _____Years

Do you use snuff or chew? ❍ Yes ❍ No If yes, how frequently do you use?_____

Do you consume alcohol now? ❍ Yes ❍ No

If yes, how many times per week? _____ If yes, how many drinks each time?_____

For how many years do/did you drink alcohol? _____Years

Is anyone concerned about the amount you drink? ❍ Yes ❍ No If you have quit, how many years since?_____

Do you use street drugs now? ❍ Yes ❍ No If yes, what drugs?_____

If yes, how frequently do you use these drugs? _____ If you have quit, how many years since?_____

How many hours a day do you watch TV? ❍ Never ❍ Rarely ❍ 3-5 hours ❍ 5+ hours

What hobbies do you have that are important to you? _____

Could someone help care for you if you were seriously ill? ❍ Yes ❍ No Who?_____

Are there people for whom you are the primary care giver? ❍ Yes ❍ No Who?_____

On a scale of 1 to 5 (1 = least satisfied, 5 = very satisfied), rate the following situations in your life.

Married Life? ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5

Present job/activities? ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5

Overall satisfaction with yourself? ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5

Family Medical History: (Check all that apply)

Disease	Mother	Father	Siblings (specify brother or sister)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Morbid Obesity							
Diabetes- Age Occurred							
High Blood Pressure							
Stroke- Age Occurred							
Heart Attack- Age Occurred							
Cardiovascular Disease							
Sleep Apnea							
Cancer: Type & Age Occurred							
Death- Age & Cause							
If Still Living, what age							

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Medical Center
Surgical Weight Loss Program

General Conditions of Admission, Consent, Assignment of Benefits & Financial Agreement

Name: _____ DOB: _____

Consent to Diagnostic Tests, Procedures and Medical Treatment:
I do voluntarily consent to care involving diagnostic tests, medical treatment and procedures by the physicians/practitioners of Commonwealth Health Cooperation, d/b/a The Medical Center Surgical Weight Loss Program, their assistants and designees, and other employees of The Medical Center Surgical Weight Loss Program as is necessary or advisable in their judgment . This consent includes testing for communicable diseases, including but not limited to Human Immunodeficiency Virus (HIV), hepatitis or any other blood-borne infectious disease if ordered for a diagnostic purpose or due to occupational exposure of a healthcare worker. I acknowledge no guarantee has been made to me as to the results of examination and treatment.

Independent Contractor Acknowledgement: I understand and acknowledge **other physicians and practitioners involved in my care, including but not limited to my attending physician, consulting physicians, physician assistants, nurse practitioners, radiologists, anesthesiologists, nurse anesthetists, emergency department physicians and pathologists are not agents or employees of The Medical Center Surgical Weight Loss Program.** I further understand I may be billed separately for services by these providers. These providers have independent relationships with insurance companies, and the hospital makes no guarantee as to any preferred provider relationships with these physicians/practitioners.

Assignment of Benefits and Financial Agreement: I certify all information given by me is correct and I accept responsibility for the charges for the care provided. I agree to the assignment of all third-party benefits to The Medical Center Surgical Weight Loss Program, and to any physician, practitioner, organization or independent contractor who provided products or services, and agree to pay all charges not covered by third-party payers. If I am covered by an ERISA plan, with this assignment I specifically authorize my providers to receive copies of all notifications and information that I am legally entitled to receive under the terms of my insurance/health plan and to act on my behalf to appeal benefit determinations. I acknowledge any claim for benefits from a third party payer may be filed by The Medical Center Surgical Weight Loss Program as a courtesy to me. However, I am primarily responsible for monitoring the filing process and making certain the claim is filed in compliance with the provisions specified by the applicable third party payer. The filing of the claim by The Medical Center Surgical Weight Loss Program in no way absolves me from liability for any portion of the bill not paid by a third party payer for any reason.

Unless other payment arrangements are approved by The Medical Center Surgical Weight Loss Program, the account balance is due upon demand. Failure to remit payment for the services may result in the placement of an account with a collection agency or attorney for collection. All amounts due, as reflected by the final statement and/or amended final statement, shall bear interest from the due date until paid at a per annum rate of eight percent (8%). In the event a claim is reduced to judgment, it shall accrue interest at the judgment rate of six percent (6%) until paid in full. Further, I agree to pay all costs of collection including court costs, interest, attorney fees and collection agency fees.

Clinical Decision Support Tools:
I understand that Clinical Decision Support (CDS) tools, aided by Artificial Intelligence (AI) technology, may assist my healthcare team by analyzing medical data (such as imaging, test results, or health records) to support diagnosis, treatment planning, and decision-making. I understand that these tools do not replace my healthcare provider, but support them by offering additional analysis and recommendations.

I understand that CDS tools and AI may be used to support my care and treatment. I further consent to the use of CDS tools aided by AI in my medical care as described above.

Contact Information: I agree, The Medical Center Surgical Weight Loss Program, Commonwealth Health Corporation and their agents, attorneys or collection agencies may contact me regarding medical information or information about my account or for the purposes of collection by telephone at any number provided by me including wireless telephone numbers, and via text messaging or e-mail to any e-mail address provided. Methods of contact may include the use of pre-recorded or artificial voice messages and/or automated dialing.

Release of Information: I authorize the release of all or part of my records, including information stored in The Medical Center Surgical Weight Loss Program corporate-wide database, to my physician(s), whose name I provided at the time of registration, and to any physician or practitioner who has or will provide services to me. I authorize the release of statistical information as required by any local, state or federal agency or managed care program. I authorize the release of my social security number to the manufacturer of any implantable medical device in accordance with the Medical Device Tracking Act of the FDA. I authorize the release of my HIV test results to healthcare personnel in the event of an occupational exposure.

I authorize The Medical Center Surgical Weight Loss Program and any other holder of medical or other information to release information about me (including medical information concerning psychological or psychiatric conditions, alcoholism and/or drug related conditions and HIV or other blood-borne infectious diseases) as required to complete any claim for benefits due to services rendered to me to any person or corporation which is or may be responsible for all or part of the total charge incurred. The persons or corporations to which this information may be released includes, but is not limited to insurance companies, the Social Security Administration, its intermediaries and carriers, state agencies and workers' compensation carriers, as well as the review organization employed by my employer or the employer of the insured member of my family and any corporation engaged by The Medical Center Surgical Weight Loss Program to make collection of any unpaid charges. I further authorize my employer to release to The Medical Center Surgical Weight Loss Program or any agency engaged for the purpose of collecting any unpaid charges, verification of my employment status, including the amount of salary or wages and the number of hours worked.

Information Received:

_____ *(initial)* I understand there are benefits and risks associated with taking controlled substances, including the risk of developing drug tolerance or dependence. I am aware of the risks, benefits and alternatives. I consent to treatment with a controlled substance if my doctor deems it appropriate. I understand a complete prescription history may be obtained from my pharmacy.

_____ *(initial)* I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES.

_____ *(initial)* This authorization is valid until revoked in writing.

_____ *(initial)* My medical/financial information may also be released to the following persons.

_____

_____ *Signature*

_____ *Date*

_____ *Time*

_____ *Relationship (if not patient)*

_____ *Witness*

Med Center Health

Medical Center
Surgical Weight Loss Program

Bariatric Nutrition Counseling Interview

NAME: _____DOB: _____ DATE: _____

Procedure (please circle): Banding Bypass Sleeve Plication Revision

Age: _____ Sex: Male Female Height: _____ Weight: _____

BMI: _____ Highest weight: _____ Goal weight: _____

HISTORY

Depression Hypertension Diabetes Migraines
GERD Thyroid High Cholesterol Joint Pain

Additional Health issues: _____

Family History (obesity, diabetes, etc.): _____

Weight history: _____

Previous weight loss efforts: Weight Watchers OptifastAdkins Diet
South Beach Diet Nutrisystem Calorie counting Jenny Craig
HMR phentermine Over the counter weight loss aids

Most successful weight loss effort: _____

Eating habits (eat too fast, large portions, boredom, etc…):

_____
_____
_____

Worst eating habit: _____

Do you eat 3 meals on most days? _____

How often do you eat fast food? _____

Occupation: _____

Personal goals after procedure:

_____
_____

NAME: _____ DOB: _____

Please write down everything you can remember you ate and drank in the last 24 hours. Write down when, what and how much you ate in the spaces below.

What time	What you ate/drank
Example: 9:45 a.m.	*1 piece of toast* *1 cup of coffee with 2 sugars*

Physical Activity

Are you currently involved in an activity/exercise program? _____
If yes, please describe what activity and how frequently you engage in it:

Activity	Frequency (daily, once a week, etc)

How many minutes do you spend on exercise each day? _____minutes

How would you rank exercise as an important healthy lifestyle practice? (circle one)

1 2 3 4 5 6 7 8 9 10

The Medical Center Surgical Weight Loss Program

NAME: _____ DOB: _____

Physical Therapy Screening

Can you walk more than 200 feet without increased pain?	YES	NO
Have you had any falls in the past year?	YES	NO
If yes, were there any injuries that have restricted your mobility? Please list.		
Were any of these falls related to loss of balance?	YES	NO
Do you have a bone or joint problem that is made worse by increased activity?	YES	NO
Do you have pain on a regular basis? Minimal Moderate Severe	YES	NO
Where is your pain?		
Do you have any numbness or tingling in your arms or legs?	YES	NO
Do you require assistance from another person to rise from lying down?	YES	NO
Are you able to rise from a seated position without excessive effort?	YES	NO

Name: _____

Primary Doctor: _____

Date: _____

Screening for Obstructive Sleep Apnea STOP BANG Questionnaire

Patient Name: _____ Date of Birth: _____

I have already been diagnosed with sleep apnea. YES ☐ NO ☐
(If yes, you do not need to complete the rest of this form.)

1. **S**noring: Do you snore loudly (loud enough to be heard through closed doors)? YES ☐ NO ☐
2. **T**ired: Do you often feel tired, fatigued, or sleepy during daytime? YES ☐ NO ☐
3. **O**bserved: Has anyone observed you stop breathing during your sleep? YES ☐ NO ☐
4. Blood **P**ressure: Do you have or are you being treated for high blood pressure? YES ☐ NO ☐
5. **B**MI: BMI more than 35 kg/m^2? YES ☐ NO ☐
6. **A**ge: Age over 50 yr old? YES ☐ NO ☐
7. **N**eck circumference: Neck circumference >40 cm? YES ☐ NO ☐
8. **G**ender: Male? YES ☐ NO ☐

High risk of Obstructive Sleep Apnea: Yes to 5-8 questions
Intermediate risk of Obstructive Sleep Apnea: Yes to 3-4 questions
Low risk of Obstructive Sleep Apnea: Yes to 0-2 questions

Chung F et al Brit J Anaesth 2012;108:768-75.

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Treatment with Controlled Substances

Patient Name:_____ DOB:_____

The physician/practitioner has discussed with me the option of treating my condition/pain with a controlled substance. By accepting the prescription for the controlled substance(s) that was prescribed to me, I acknowledge I understand there are inherent risks and benefits associated with treating my condition/pain with a controlled substance. These risks include developing drug tolerance and dependence.

It is my responsibility to take the medicine as prescribed and not more frequently than prescribed. I am not to share this medication with anyone else, including family members. The use of controlled substances can depress my senses and impact driving and work safety. It is discouraged during pregnancy, and may harm the unborn child. There is a potential for overdose, and if I suspect I have had an overdose I should call 911 or go to the emergency room as soon as possible.

The medication should be stored in a safe place, out of the reach of children, and should be properly disposed of after expiration. Any requests for refills must be made during weekday hours before the prescription has expired and may require an office visit.

I give permission for my entire prescription history to be obtained from my pharmacy.

_____ _____

Witness

Patient Signature or Person Authorized to Consent for Patient

_____ _____ _____

Date Time

Relationship to Patient