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            Melissa Pursley, Practice Manager
Yolanda Reid, APRN               Karen, Patient Service Coordinator
JR, Abby, Taylor– Clinic Support LaTasha, Patient Registration
Patient Information Packet

Preferred Procedure:
- Laparoscopic Sleeve Gastrectomy
- Lap Band Removal
- Laparoscopic Roux-en-Y Gastric Bypass

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: – Please attach a copy of the front and back of all insurance cards

Payment Type:  ☐ Insurance  ☐ Self Pay

Primary Insurance:

Insurance Company: _______________________________  Group #: _______________________________
Policy Number: _______________________________  Subscriber Date of Birth: _______________________________
Subscriber Name: _______________________________  Customer Service 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

_____________________________________________________________

_____________________________________________________________

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_____________________________________________________________

_____________________________________________________________

_____________________________________________________________

_____________________________________________________________

### Pharmacy Name:
_____________________________________________________________

### Pharmacy Address:
_____________________________________________________________

### Pharmacy Phone: _____________________________ Pharmacy Fax:

_____________________________________________________________

### List Prescribed Medications:

<table>
<thead>
<tr>
<th>Product</th>
<th>Taken for what condition</th>
<th>Dosage/How Often</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Product</th>
<th>Taken for what purpose</th>
<th>Dosage/How Often</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
### Surgical Procedure(s):

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Open/Laparoscopic</th>
<th>Year</th>
<th>Tonsillectomy</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gallbladder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appendectomy</td>
<td></td>
<td></td>
<td>Ear Surgery:</td>
<td></td>
</tr>
<tr>
<td>Hysterectomy</td>
<td></td>
<td></td>
<td>Back Surgery:</td>
<td></td>
</tr>
<tr>
<td>Ovary Surgery:</td>
<td>Ovaries Removed</td>
<td></td>
<td>Pacemaker</td>
<td></td>
</tr>
<tr>
<td>Hernia:</td>
<td>Hiatal</td>
<td></td>
<td>Wisdom teeth</td>
<td></td>
</tr>
<tr>
<td>Tubal Ligation</td>
<td></td>
<td></td>
<td>Knee:</td>
<td></td>
</tr>
<tr>
<td>Cesarean Section</td>
<td></td>
<td></td>
<td>Breast Biopsy:</td>
<td></td>
</tr>
<tr>
<td>Colonoscopy</td>
<td></td>
<td></td>
<td>Anti-reflux procedure / Nissen Fundoplication</td>
<td></td>
</tr>
<tr>
<td>Colostomy</td>
<td></td>
<td></td>
<td>Kidney Surgery</td>
<td></td>
</tr>
<tr>
<td>Colon Resection</td>
<td></td>
<td></td>
<td>Other Hernia or Abdominal Surgery</td>
<td></td>
</tr>
<tr>
<td>Endoscopy</td>
<td></td>
<td></td>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

### 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  ☐ Dextram  ☐ Ionamin/Adipex  ☐ Phendiet  ☐ Prozac
☐ Wellbutrin  ☐ Amphetamines  ☐ Didrex  ☐ Tenuate  ☐ Phentrol
☐ Redux  ☐ Byetta  ☐ Plegine  ☐ Sanorex  ☐ Meridia
☐ Xenical  ☐ Diuretics  ☐ Pondimin  ☐ Phentermine
☐ 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

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

Date Completed: ______________________
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.

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:
I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES.
This authorization is valid until revoked in writing.

Signature _______________________________________________________ Date ______________________

Witness ____________________________________________________________ Time ______________________

Relationship (if not patient) ______________________________________________

Original - Chart Copy - Patient

Surgical Weight Loss Program
GENERAL CONDITIONS OF ADMISSION
03-456001 (2441) 11/19
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  Optifast/Adkins 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:

_________________________________________________________________________
_________________________________________________________________________
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.

<table>
<thead>
<tr>
<th>What time</th>
<th>What you ate/drank</th>
</tr>
</thead>
</table>
| 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:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Frequency (daily, once a week, etc)</th>
</tr>
</thead>
</table>

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

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

Name: _____________________________________________________

Primary Doctor: __________________________________________________

Date: ________________________________________________________
Name: ____________________________ DOB: ___/___/___ Age: _____ Date: _______________________

**Medical History:** (Check all that apply)

<table>
<thead>
<tr>
<th>Category</th>
<th>Checkmark</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General:</strong></td>
<td>□ NONE</td>
<td>□ Weight Gain □ Tired / No Energy</td>
</tr>
<tr>
<td>□ Fevers</td>
<td></td>
<td>□ Night Sweats □ Appetite Change</td>
</tr>
<tr>
<td>□ Night Sweats</td>
<td></td>
<td>□ Insomnia □ Hair Loss</td>
</tr>
<tr>
<td>□ Appetite Change</td>
<td></td>
<td>□ Other: ________________________</td>
</tr>
<tr>
<td><strong>Head and Neck:</strong></td>
<td>□ NONE</td>
<td>□ Vision Problems □ Hearing Problems</td>
</tr>
<tr>
<td>□ Wear contacts / glasses</td>
<td></td>
<td>□ Sinus Drainage □ Nose Bleeds</td>
</tr>
<tr>
<td>□ Sinus Drainage</td>
<td></td>
<td>□ Dentures, Partial / Full □ Other:</td>
</tr>
<tr>
<td>□ Dentures, Partial / Full</td>
<td></td>
<td>□ Allergies □ Glaucoma</td>
</tr>
<tr>
<td>□ Regular Ear Infections</td>
<td></td>
<td>□ Blurred / Double Vision □ Other:</td>
</tr>
<tr>
<td><strong>Cardiovascular:</strong></td>
<td>□ NONE</td>
<td>□ Heart Attack □ Congestive Heart Failure</td>
</tr>
<tr>
<td>□ Heart Attack</td>
<td></td>
<td>□ Varicose Veins □ Ankle / Leg Ulcers</td>
</tr>
<tr>
<td>□ Congestive Heart Failure</td>
<td></td>
<td>□ Ankle / Leg Ulcers □ Elevated Triglycerides</td>
</tr>
<tr>
<td>□ Varicose Veins</td>
<td></td>
<td>□ Clogged Heart Arteries □ Rapid Heart Beat</td>
</tr>
<tr>
<td>□ Ankle / Leg Ulcers</td>
<td></td>
<td>□ Irregular Heart Beat □ Heart Murmur</td>
</tr>
<tr>
<td>□ Clogged Heart Arteries</td>
<td></td>
<td>□ Atrial Fibrillation □ Other:</td>
</tr>
<tr>
<td>□ Irregular Heart Beat</td>
<td></td>
<td>□ Elevated Triglycerides □ Phlebitis / DVT</td>
</tr>
<tr>
<td>□ Atrial Fibrillation</td>
<td></td>
<td>□ Elevated Cholesterol □ Other:</td>
</tr>
<tr>
<td><strong>Respiratory:</strong></td>
<td>□ NONE</td>
<td>□ Asthma □ Emphysema / COPD □ Bronchitis</td>
</tr>
<tr>
<td>□ Asthma</td>
<td></td>
<td>□ Pneumonia □ Chronic Cough □ Shortness of Breath at Rest</td>
</tr>
<tr>
<td>□ Pneumonia</td>
<td></td>
<td>□ Use of Cpap / Bipap □ Snoring</td>
</tr>
<tr>
<td>□ Use of Cpap / Bipap</td>
<td></td>
<td>□ Pulmonary Embolism □ Other:</td>
</tr>
<tr>
<td>□ Pulmonary Embolism</td>
<td></td>
<td>□ Sleep Apnea □ Other:</td>
</tr>
<tr>
<td><strong>Gastrointestinal:</strong></td>
<td>□ NONE</td>
<td>□ Heartburn □ Diarrhea □ Ulcers</td>
</tr>
<tr>
<td>□ Heartburn</td>
<td></td>
<td>□ Constipation □ Constipation</td>
</tr>
<tr>
<td>□ Diarrhea</td>
<td></td>
<td>□ Difficulty Swallowing □ Umbilical Hernia</td>
</tr>
<tr>
<td>□ Constipation</td>
<td></td>
<td>□ Rectal Bleeding □ Fissure / Polyps</td>
</tr>
<tr>
<td>□ Difficulty Swallowing</td>
<td></td>
<td>□ Abdominal Pain □ Ventral Hernia</td>
</tr>
<tr>
<td>□ Rectal Bleeding</td>
<td></td>
<td>□ Gallbladder Problems □ Cirrhosis / Hepatitis</td>
</tr>
<tr>
<td>□ Abdominal Pain</td>
<td></td>
<td>□ Nausea / Vomiting □ Pancreatic Disease</td>
</tr>
<tr>
<td>□ Gallbladder Problems</td>
<td></td>
<td>□ Barrett’s Esophagus □ Incisional Hernia</td>
</tr>
<tr>
<td>□ Nausea / Vomiting</td>
<td></td>
<td>□ Other: ________________________</td>
</tr>
<tr>
<td>□ Barrett’s Esophagus</td>
<td></td>
<td>□ Other: ________________________</td>
</tr>
<tr>
<td><strong>Bladder/Kidney:</strong></td>
<td>** NONE**</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
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<td></td>
</tr>
<tr>
<td>Kidney Stones</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Kidney Failure / Renal Insufficiency</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Trouble starting urine</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Overall Loss of Bladder Control</td>
<td>□</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Gynecologic: (for women only)</strong></th>
<th>** NONE**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems Conceiving / Infertility</td>
<td>□</td>
</tr>
<tr>
<td>PCOS</td>
<td>□</td>
</tr>
<tr>
<td>Excessively Heavy Periods</td>
<td>□</td>
</tr>
</tbody>
</table>

How many pregnancies have you had: ___________________________

How many miscarriages or abortions have you had: ___________________________

<table>
<thead>
<tr>
<th><strong>Breast:</strong></th>
<th>** NONE**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nipple Discharge</td>
<td>□</td>
</tr>
<tr>
<td>Pain</td>
<td>□ Cancer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Musculoskeletal:</strong></th>
<th>** NONE**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shoulder Pain</td>
<td>□</td>
</tr>
<tr>
<td>Hip Pain</td>
<td>□</td>
</tr>
<tr>
<td>Foot Pain</td>
<td>□</td>
</tr>
<tr>
<td>Plantar Fasciitis</td>
<td>□</td>
</tr>
<tr>
<td>Broken Bones</td>
<td>□</td>
</tr>
<tr>
<td>Muscle Pain / Spasm</td>
<td>□</td>
</tr>
<tr>
<td>Fibromyalgia</td>
<td>□</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Neurologic:</strong></th>
<th>** NONE**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance Disturbance</td>
<td>□</td>
</tr>
<tr>
<td>Stroke</td>
<td>□</td>
</tr>
<tr>
<td>Knocked Unconscious</td>
<td>□</td>
</tr>
<tr>
<td>Pseudo tumor Cerebri (loss of vision from high pressure in brain)</td>
<td>□</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Psychiatric:</strong></th>
<th>** NONE**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>□</td>
</tr>
<tr>
<td>Bipolar Disorder (“manic-depression”)</td>
<td>□</td>
</tr>
<tr>
<td>Alcoholism / Substance Abuse</td>
<td>□</td>
</tr>
<tr>
<td>Been in a chemical dependency program</td>
<td>□</td>
</tr>
<tr>
<td>Currently taking medications for psychiatric problems or for depression</td>
<td>□</td>
</tr>
<tr>
<td>Attention Deficit Disorder</td>
<td>□</td>
</tr>
</tbody>
</table>

Are you currently under the care of a mental health provider? □ Yes □ No

<table>
<thead>
<tr>
<th><strong>Endocrine:</strong></th>
<th>** NONE**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parathyroid</td>
<td>□</td>
</tr>
<tr>
<td>Low Blood Sugar</td>
<td>□</td>
</tr>
<tr>
<td>“Pre-Diabetes”</td>
<td>□</td>
</tr>
<tr>
<td>Abnormal Facial Hair</td>
<td>□</td>
</tr>
<tr>
<td>Other:</td>
<td>□</td>
</tr>
</tbody>
</table>

Date of Last Pap Smear: _______________

Date of last menstrual period?: _______________

Date of last Mammogram: _______________

Date of last Pap Smear: _______________

Date of last Mammogram: _______________

Date of last Pap Smear: _______________

Date of last Mammogram: _______________
### Blood/Lymphatic:

- **Low Platelets (thrombocytopenia)**
- **Bruise Easily**
- **Bleeding/Clotting Disorder**
- **Prior blood Transfusion**

**None**

- **Anemia**
- **Lymphoma**
- **Blood thinning medicine use**
- **Cancers**

**HIV / AIDS**

**Swollen Lymph Nodes**

**History of DVT / PE**

**Other:**

### Skin:

- **Frequent Skin Infections**
- **Psoriasis**
- **Hair or Nail Changes**

**None**

- **Keloids (Excessively Raised Scars)**
- **Rashes under Breasts / Skin Folds**
- **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
<table>
<thead>
<tr>
<th>Disease</th>
<th>Mother</th>
<th>Father</th>
<th>Siblings (specify brother or sister)</th>
<th>Maternal Grandmother</th>
<th>Maternal Grandfather</th>
<th>Paternal Grandmother</th>
<th>Paternal Grandfather</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morbid Obesity</td>
<td></td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>High Blood Pressure</td>
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<tr>
<td>Stroke</td>
<td></td>
<td></td>
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<tr>
<td>Heart Attack</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
<td></td>
<td></td>
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<tr>
<td>Sleep Apnea</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Cancer: Type &amp; Age Occurred</td>
<td></td>
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<tr>
<td>Death: Age &amp; Cause</td>
<td></td>
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<tr>
<td>If Still Living, what age</td>
<td></td>
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</tbody>
</table>
Screening for Obstructive Sleep Apnea

STOP BANG Questionnaire

Patient Name: ___________________________ Date of Birth: ___________________________

I have already been diagnosed with sleep apnea.
(If yes, you do not need to complete the rest of this form.)

YES ☐ NO ☐

1. Snoring: Do you snore loudly (loud enough to be heard through closed doors)?

YES ☐ NO ☐

2. Tired: Do you often feel tired, fatigued, or sleepy during daytime?

YES ☐ NO ☐

3. Observed: Has anyone observed you stop breathing during your sleep?

YES ☐ NO ☐

4. Blood Pressure: Do you have or are you being treated for high blood pressure?

YES ☐ NO ☐

5. BMI: BMI more than 35 kg/m²?

YES ☐ NO ☐

6. Age: Age over 50 yr old?

YES ☐ NO ☐

7. Neck circumference: Neck circumference >40 cm?

YES ☐ NO ☐

8. Gender: 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

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

TREATMENT WITH CONTROLLED SUBSTANCES CONSENT
03-456008 Rev. 11/19