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BARIATRIC SURGERY NEW PATIENT FORM

PROVIDER OF CHOICE:

☐ Jeffrey Baker, MD ☐ Edmund Chute, MD

PROCEDURE OF CHOICE:

☐ Adjustable Gastric Band ☐ Sleeve Gastrectomy

☐ Roux-en-Y Gastric Bypass ☐ Unsure

HAVE YOU HAD A PREVIOUS BARIATRIC SURGERY?

☐ Yes ☐ No

PATIENT NAME:

First name

Last name

DATE OF BIRTH:

MM/DD/YYYY

PATIENT ADDRESS:

Line 1

Line 2

City

State

Zip

PHONE NUMBER:

EMAIL ADDRESS:

PRIMARY INSURANCE INFORMATION:

Primary insurance company name

Office phone number

Subscriber's name

Insurance ID number

Insurance group number

SECONDARY INSURANCE INFORMATION:

Secondary insurance company name

Office phone number

Subscriber's name

Insurance ID number

Insurance group number

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PRIMARY DOCTOR:

Provider first name

Provider last name

Clinic phone number

Organization/Clinic

Clinic fax number

How long have you been a patient here?

Clinic address

Line 2

City

State

Zip

DOCTOR/SPECIALIST:

Specialist's first name

Specialist's last name

Specialty clinic phone number

Specialist's clinic name

Specialty clinic fax number

How long have you been a patient here?

Clinic address

Line 2

City

State

Zip

PSYCHOLOGIST/PSYCHIATRIST:

Psychologist/psychiatrist first name

Psychologist/psychiatrist last name

Psychologist/psychiatrist phone number

Psychologist/psychiatrist organization/clinic

Psychologist/psychiatrist fax number

How long have you been a patient here?

Clinic address

Line 2

City

State

Zip

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PERSONAL WEIGHT HISTORY:

Height in feet and inches

Present weight

Age you first became overweight

Age you became 100 pounds overweight

Weight at age 18

Highest weight in five years

Lowest weight in five years

PREVIOUS DIETARY WEIGHT LOSS EFFORTS:

1. Name of program or doctor, start date (M/Y), end date (M/Y), starting weight, ending weight

2. Name of program or doctor, start date (M/Y), end date (M/Y), starting weight, ending weight

3. Name of program or doctor, start date (M/Y), end date (M/Y), starting weight, ending weight

HEALTH INFORMATION:

How is your health in general?

☐ Good ☐ Fair ☐ Poor

CENTRAL NERVOUS SYSTEM/PSYCHOLOGICAL:

Have you been depressed? ☐ Yes ☐ No

Have you been suicidal? ☐ Yes ☐ No

Hospitalized for depression? ☐ Yes ☐ No

Do you have or have you had any other mental health problems? ☐ Yes ☐ No

Are you taking medications for depression? ☐ Yes ☐ No

Do you have a history of substance or alcohol abuse? ☐ Yes ☐ No

Please describe your mental health problems:

Do you have pseudo tumor cerebri? ☐ Yes ☐ No

Where were you diagnosed with pseudo tumor cerebri?

CARDIOVASCULAR HEALTH:

Do you have hypertension (high blood pressure)? ☐ Yes ☐ No

If yes, for how many years?

Do you have heart disease? ☐ Yes ☐ No

Please describe your heart disease:

Have you taken phen-fen? ☐ Yes ☐ No

State when you took phen-fen, for how long and the number of pounds you lost while on it.

Do you have elevated cholesterol or triglycerides? ☐ Yes ☐ No

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PULMONARY HEALTH:

Do you have lung problems?
☐ Yes ☐ No Describe your lung problems:

Do you smoke, vape or use nicotine products? How long have you used nicotine products?
☐ Yes ☐ No

Do you have asthma? Do you have sleep apnea? Do you use CPAP (Continuous Positive Airway Pressure)?
☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

Does your family say you have loud and irregular snoring?
☐ Yes ☐ No

WHAT IS THE CHANCE THAT YOU WOULD DOZE OFF WHEN YOU ARE:

Sitting and reading?
☐ Never ☐ Slight ☐ Moderate ☐ High

Watching television?
☐ Never ☐ Slight ☐ Moderate ☐ High

Sitting inactive in a public place, like a theater or meeting?
☐ Never ☐ Slight ☐ Moderate ☐ High

A passenger in a car?
☐ Never ☐ Slight ☐ Moderate ☐ High

Lying down to rest in the afternoon?
☐ Never ☐ Slight ☐ Moderate ☐ High

Sitting quietly after lunch (when you have not had alcohol)?
☐ Never ☐ Slight ☐ Moderate ☐ High

Sitting and talking to someone?
☐ Never ☐ Slight ☐ Moderate ☐ High

In a car, stopped in traffic?
☐ Never ☐ Slight ☐ Moderate ☐ High

GASTROINTESTINAL HEALTH:

Do you have frequent heartburn?
☐ Yes ☐ No

Do you have gastroesophageal reflux disease (GERD)?
☐ Yes ☐ No

Are you taking medication for GERD?
☐ Yes ☐ No

How many years have you taken medication for GERD?

Do you have a history of jaundice or hepatitis?
☐ Yes ☐ No

Have you had a stomach ulcer?
☐ Yes ☐ No

Have you had an upper endoscopy (gastroscopy)?
☐ Yes ☐ No

When did you have this procedure?

Where was it done?

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GENITOURINARY HEALTH:

Do you have kidney problems?

☐ Yes ☐ No

Have you ever been diagnosed with urinary stress incontinence?

☐ Yes ☐ No

MUSCULOSKELETAL HEALTH:

Do you have bone pain?

☐ Yes ☐ No

Do you have muscle problems?

☐ Yes ☐ No

Do you have joint pain?

☐ Yes ☐ No

Which joints? (Please check all that apply.)

☐ Spine ☐ Knees ☐ Other

☐ Hips ☐ Ankle

Do you have fibromyalgia?

☐ Yes ☐ No

Have you ever been diagnosed with degenerative disc disease?

☐ Yes ☐ No

Have you ever been diagnosed with degenerative joint disease?

☐ Yes ☐ No

HEMATOLOGY/ONCOLOGY HEALTH:

Do you have a history of abnormal bleeding?

☐ Yes ☐ No

Do you or have you had anemia (low hemoglobin)?

☐ Yes ☐ No

Do you have a history of clotting?

☐ Yes ☐ No

Do you currently have open sores on your legs or feet, or a history of these?

☐ Yes ☐ No

Are you HIV positive?

☐ Yes ☐ No

Have you ever been MRSA+?

☐ Yes ☐ No

Have you ever been VRE+?

☐ Yes ☐ No

Have you had cancer?

☐ Yes ☐ No

When did you have cancer? (MM/DD/YYYY)

Where was the cancer?

ENDOCRINE HEALTH:

Do you have diabetes mellitus ("sugar diabetes")?

☐ Yes ☐ No

Do you take pills for this?

☐ Yes ☐ No

Do you take insulin for this?

☐ Yes ☐ No

When were you diagnosed with diabetes? (MM/DD/YYYY)

Have you ever been diagnosed with PCOS?

☐ Yes ☐ No

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FAMILY HEALTH HISTORY:

Have any of your family members had any of these illnesses (even if deceased)? Please check all that apply:

Father health history

- ☐ Weight
- ☐ Heart problems or attack
- ☐ Sleep apnea
- ☐ Joint problems
- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke or blood clots

Mother health history

- ☐ Weight
- ☐ Heart problems or attack
- ☐ Sleep apnea
- ☐ Joint problems
- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke or blood clots

Brother(s) health history

- ☐ Weight
- ☐ Heart problems or attack
- ☐ Sleep apnea
- ☐ Joint problems
- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke or blood clots

Sister(s) health history

- ☐ Weight
- ☐ Heart problems or attack
- ☐ Sleep apnea
- ☐ Joint problems
- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke or blood clots

MEDICATIONS:

Please list all medications, including non-prescription medications and supplements with the following information:
(Name of medication/supplement, dose, how often taken, purpose of medication)

ALLERGIES:

Please list any allergies to foods or medications and the reactions that you have to them:
(Food/medication, nature of reaction, when reaction occurred)

SURGICAL PROCEDURES:

Please list any previous surgeries that you have had and the date:

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REVIEW OF UNRELATED MEDICAL SYSTEMS:

Please mark all that you have now or that you have had in the past:

- ☐ Excessive fatigue
- ☐ Urgency to urinate
- ☐ Leg/foot swelling
- ☐ Fluttering in chest
- ☐ Ear drainage
- ☐ Muscle weakness
- ☐ Growths in mouth
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Lump in neck
- ☐ Diarrhea
- ☐ Interolerant of heat
- ☐ Crohn's disease
- ☐ Ringing in ears
- ☐ Phlegm production
- ☐ Frequent nausea
- ☐ Lump in armpit
- ☐ Shortness of breath
- ☐ Double vision
- ☐ Hearing loss
- ☐ Muscle problems
- ☐ Abnormal heart valve
- ☐ Numbness
- ☐ Sinus infections
- ☐ Spinal cord/brain injury
- ☐ Frequent infections
- ☐ Trouble speaking
- ☐ Intolerant of cold
- ☐ Gallstones
- ☐ Blurry vision
- ☐ Leg cramping
- ☐ Seizures
- ☐ Stiff neck
- ☐ Lump in groin
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Heart attack
- ☐ Frequent ear infections
- ☐ Frequent cough
- ☐ Lumps in nose
- ☐ Excessive urination
- ☐ Blood clot in lungs
- ☐ Blood clot in leg
- ☐ Vomitting
- ☐ Lump in breast
- ☐ Chest pain
- ☐ Can't sleep lying down
- ☐ Frequent runny nose
- ☐ Sores in mouth
- ☐ Blood in stool
- ☐ Wake at night unable to breath
- ☐ Change in vision
- ☐ Prostate problems
- ☐ Nose bleeds
- ☐ Stroke
- ☐ Pins and needles feeling
- ☐ Pneumonia
- ☐ Abnormal bleeding
- ☐ Trouble swallowing
- ☐ Constipation
- ☐ Pancreas problem
- ☐ Thyroid problem
- ☐ Kidney stones
- ☐ Muscular dystrophy
- ☐ Easy bruising
- ☐ Abnormal immune system

Is there anything else that you would like us to know to provide you the best possible care?

ALL PATIENTS AND PROSPECTIVE PATIENTS MUST READ AND SIGN BELOW:

Although I understand that Ridgeview's Insurance Specialists will call my insurance company on my behalf to verify coverage for bariatric surgery, I understand that it is ultimately my responsibility to know whether or not bariatric surgery and the pre- and post-op required appointments are a covered benefit.

I will not hold Ridgeview, its staff or supporting staff responsible for insurance misinformation, insurance changes, coverage changes or plan changes. It is my responsibility to inform Ridgeview in writing (mail or email) of any changes to insurance plans or coverage.

Signature:

Date: