The Nebraska Medical Center
Department of Bariatric Surgery
Patient Personal Information Form

Name: _____ **DOB:** _____ **Age:** _____
(Last) (First) (Middle Initial)

Address: _____

Phone (home/cell): _____

Social Security # _____ **Sex:** _____ **Marital Status:** _____

Employer: _____ Phone: _____

Address: _____

Work Phone: _____ **E-mail Address:** _____

Preferred method of contact: _____

Emergency Contact (Name and Phone #): _____

Address (if different from above): _____

Please fill out the following information and answer all questions to the best of your ability. We understand that some of this may be difficult, but a complete history is very important for your evaluation. We have repeatedly been told by patients that the dietary history is the hardest part to fill out because it brings up all of the problems and issues they've had with their weight over the years. Our intent in asking these questions is not to make patients feel bad; we ask them because it's necessary to understand what has been tried in the past, as many insurance companies require this information. Filling this form out completely is vital and will allow us to submit the most accurate and up-to-date information to your insurance carrier in an effort to obtain authorization/approval for your bariatric surgery.

Thank you,

Dr. Corrigan McBride
Dr. Matthew Goede
Dr. Vishal Kothari
Dr. Dmitry Oleynikov

Please list all of the physicians you are currently seeing:

Physician's Name	Physician's Specialty	Address, City, State & Zip	Phone number and Fax number for Doctor

Please provide your Health Insurance information:

Insurance Carrier	Address, City, State & Zip	*Phone Number* and *FAX Number* for Insurance Customer Service
PRIMARY		
SECONDARY		

Current Weight: _____ pounds **Height:** _____

(If you do not know your height and weight, please see your primary doctor to have this checked)

What is your goal weight? _____ pounds

What was your weight at age 18? _____ pounds

If applicable, how much did you weigh when you became pregnant for the first time?
_____ pounds

Race: _____

Please list three health-related reasons why you want surgery:

1. _____

2. _____

3. _____

Please list three other reasons why you want surgery:

1. _____

2. _____

3. _____

Please list all of the **diets** you have tried in the past 5 years, including the name of the physician who supervised your weight loss, if applicable:

Date	Diet Type	Weight Lost (lb.)	Regained? (lb.)

Supervising Physician's Name: _____

Have you ever taken Phen-Fen? ___Yes ___No If yes, please list both beginning and end dates: _____

Have you had a follow-up Echocardiogram since stopping Phen-Fen? _____

Do you exercise regularly? ___ Yes ___ No If yes, what type of exercise and how often? _____

_____

If you do not exercise, what prevents you from exercising now? _____

_____

Do you have any of the following (check Yes or No): **If Yes, for how long?**

	YES	NO	
Arthritis/Degenerative Joint Disease	☐	☐	_____
Diabetes	☐	☐	_____
Wheezing or shortness of breath with exertion?	☐	☐	_____

When walking up the stairs, how many steps/flights can you climb before noticing shortness of breath?

_____ Steps / Flights (enter number in blank and circle either steps or flights)

After how many steps/flights do you have to stop and rest?

_____ Steps / Flights (enter number and circle steps or flights)

How long do you have to rest before you can talk? _____ min.
Before you can walk? _____ min.

Do you have any of the following (check Yes or No): **If Yes, for how long?**

	YES	NO	
High Cholesterol or Lipids	☐	☐	_____
Reflux	☐	☐	_____
Migraine Headaches	☐	☐	_____
High Blood Pressure	☐	☐	_____
Irregular menstrual cycle (women)	☐	☐	_____
Joint pain	☐	☐	_____
Pseudotumor cerebri	☐	☐	_____
Sleep Apnea	☐	☐	_____
Urinary incontinence	☐	☐	_____
Venous stasis disease	☐	☐	_____

Have you ever had or do you currently have any of the following (check Yes or No); if yes, how long have you had it or how long ago did you have it?

	YES	NO	
Heart Attack	☐	☐	_____
Stroke	☐	☐	_____
Emphysema	☐	☐	_____
Asthma	☐	☐	_____
Cancer	☐	☐	_____
Ulcers	☐	☐	_____
Kidney Stones	☐	☐	_____

	YES	NO	
Depression	☐	☐	_____
Bipolar Disease	☐	☐	_____
Fibromyalgia	☐	☐	_____

Please list any other condition(s) for which you see a physician: _____
_____
_____

Please list all **surgeries** you have had (you may attach a separate sheet if needed):

Surgery Year

1. _____

2. _____

3. _____

4. _____

Please list all **medications** you are currently taking, including all over-the-counter medications (you may attach a separate sheet if needed):

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

Are there any medications you are "supposed" to be taking but are not? ___Yes ___No
If yes, please list: _____

Are you taking any over-the-counter medication to help you lose weight? ___Yes ___No
If yes, please list above.

List any medications you have had an **allergic reaction** to, include the type of reaction (i.e. rash, itching, difficulty breathing, etc.):

1. _____

2. _____

3. _____

Family history- please provide the following information regarding the health of your relatives:

Relative	Current age (or age at time of death)	Health Problems (attach separate sheet if needed)	Overweight? Yes or No
Mother			
Father			
Brother(s)			
Sisters(s)			
Children			

Marital status: Are you currently married? **___Yes ___No** If yes, how long? _____

Is this your first marriage? **___Yes ___No** If no, how many previous marriages have you had? _____

On a scale of 1 to 5 (1 = unhappy, 5 = very happy), how happy are you in your present marriage? _____

Employment status: Are you currently employed? ___Yes ___No

If yes, how long have you been employed? _____ Years _____ Months

On a scale of 1 to 5 (1 = unhappy, 5 = very happy), how happy are you in your present job? _____

Are you disabled? ___Yes ___No If yes, reason for disability: _____
_____

Date of onset of disability: _____Occupation prior to disability: _____
_____

On a scale of 1 to 5 (1 = unhappy, 5 = very happy), how would you rate your **overall** satisfaction with yourself? _____

Please answer the following questions:	**YES**	**NO**
Do you smoke cigarettes, cigars, and/or a pipe or chew tobacco? Amount/packs per day: _____ If you were a smoker and quit, when did you quit? _____	☐	☐
Do you drink alcohol? If yes, amount per week: _____	☐	☐
Have you ever had a drinking problem or been told to cut down?	☐	☐
Have you ever or do you currently use drugs?	☐	☐

	YES	**NO**
Have you had a fever in the past two weeks?	☐	☐
Have you had a runny nose, sore throat or cough in the past two weeks?	☐	☐
Do you often experience ringing in your ears?	☐	☐
Do you ever have double vision?	☐	☐
Have you ever had chest pain?	☐	☐
Have you ever felt your heart beating in your chest?	☐	☐
Have you ever seen a cardiologist (heart specialist), had any heart tests, experienced a heart attack or any other heart-related problems?	☐	☐

	YES	NO
Do you ever experience heartburn?	☐	☐
How often?		
_____ Less than once per week		
_____ 1-2 times per week		
_____ 3-4 times per week		
_____ 5 times per week or more		
Do you take medications for heartburn?	☐	☐
If yes, please list on page 5.		
Do you have pain with swallowing?	☐	☐
Do you ever leak urine when you cough, sneeze or laugh?	☐	☐
If yes, do you wear a pad for protection?	☐	☐
Have you ever had blood in you urine?	☐	☐
☐		
Do you have chronic and/or severe headaches?	☐	☐
Do you have pain in your back?	☐	☐
Do you have pain in your hips?	☐	☐
Do you have pain in your knees?	☐	☐
Do you have pain in your ankles?	☐	☐
Do you have pain in your feet?	☐	☐
Do you have swelling in your legs?	☐	☐
Have you ever had an ulcer or non-healing sores on your legs?	☐	☐
Do you have any seasonal or pet allergies?	☐	☐
Do you have any rashes?	☐	☐
Do you get yeast infections or other infections of your skin?	☐	☐
If you take medication, please list on page 5.		

	YES	NO
Have you ever taken steroids for any reason?	☐	☐
When was the last time you took steroids and why? _____ _____		
Have you ever had a seizure?	☐	☐
Have you ever noticed a breast mass or been diagnosed with breast cancer?	☐	☐
Have you ever been told you had a thyroid or "glandular" problem?	☐	☐
Have you ever had anemia or "low iron" or "low blood counts?"	☐	☐
Have you ever had a bleeding problem?	☐	☐
Do you have any religious or other objections to blood transfusion?	☐	☐

	YES	NO
Do you snore?	☐	☐
Do you often wake up with a headache?	☐	☐
Have you ever fallen asleep at the wheel?	☐	☐
Do you take a nap every day?	☐	☐
Do you feel rested when you wake up in the morning?	☐	☐
Do you ever wake up from a deep sleep choking?	☐	☐
Has anyone ever told you that you stop breathing while you are sleeping?	☐	☐

In what position do you sleep? ___ sitting up ___ flat on back ___ on side ___ on stomach

How many pillows do you use under your head? _____

How often do you awaken from sleep to catch your breath? _____

Have you ever had a sleep study?	☐	☐

	YES	NO
If you have sleep apnea, do you use a C-pap or Bi-pap?	☐	☐
What are the settings? _____		

	YES	NO
Have you ever had a serious problem with depression or anxiety?	☐	☐
If yes, have you ever been hospitalized for it?	☐	☐
If you take medication, please list on page 5.		
Are you currently seeing a mental health counselor, psychologist or psychiatrist?	☐	☐
If yes, please list on page 2.		
Have you ever taken medication for your nerves?	☐	☐
Are you taking anything now?	☐	☐
If yes, please list on page 5.		
Have you ever attempted suicide?	☐	☐
If so, please list date(s): _____ _____		
Do you eat a large quantity of foods in a short period of time?	☐	☐
Do you ever feel "out of control" when you eat?	☐	☐

Reproductive System (females only):

At what age did you start your period? _____

Have you gone through menopause? ___ Yes ___ No
If yes, at what age? _____

Are/Were your periods: ___ Regular ___ Irregular

What was the date of your last menstrual period? _____
Do you experience cramping? ___ Yes ___ No

Have you ever been pregnant? ___ Yes ___ No
If yes, how many children have you had? _____
Have you had any miscarriages? ___ Yes ___ No

PERSON TO NOTIFY IMMEDIATELY FOLLOWING SURGERY:

Name: _____

Relationship: _____

Phone (please list order of preference):

___ _____ (home)

___ _____ (work)

___ _____ (cell)

Will he/she be waiting at the hospital during your surgery? ___ Yes ___ No

***How did you hear about us?** _____

_____ _____

Patient Signature Date

EPWORTH SLEEPINESS SCALE

NAME:_____

DATE: _____

For the situations below, please rate your sleepiness according to the following scale:

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

*Example: If you are sitting and reading and feel that you have a high chance of dozing off, then put a #3 in the blank to the right.

SITUATION	CHANCE OF DOZING
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (such as in a theater or a meeting)	_____
As a passenger in a car for an hour without break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL (add the above numbers)	_____

University of Nebraska Medical Center Bariatric Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I, _____, understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures.

I understand that I have the right to review the notice prior to signing this consent.

I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address I've provided.

I understand that I have the right to object to the use of my health information for directory purposes.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to the restriction requested.

I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I wish to have the following restrictions to the use of disclosure of my health information:

_____

_____

_____

I fully understand and accept/decline the terms of this consent.

_____

Signature Date

University of Nebraska Medical Center

Bariatric Surgery Program

I certify that I attended the Nebraska Medical Center Bariatric Surgery Information Session on

_____/_____/20____.

*After considering the risks and benefits of the procedure, I want the following operation:

_____ Laparoscopic Adjustable gastric band
_____ Realize Band
_____ Lap Band
_____ Unsure

_____ Gastric Bypass – my surgeon will decide about laparoscopic vs. open

_____ Sleeve

_____ Undecided

I understand that the Nebraska Medical Center Bariatric Surgery program will submit a request using the information I have provided and that I am responsible for the accuracy and truthfulness of the information in this packet.

_____ _____
Patient Signature Date

You may hold onto this form until after the Information Session if you are unsure of which operation to choose

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