Ascension Saint Agnes Bariatric Surgery Program
700 Geipe Road Suite 274
Catonsville, Maryland
Phone: 667-234-8725
Fax: 410-368-8726

I, _____, hereby authorize Ascension Saint Agnes Bariatric Program to apply for benefits for covered services rendered by Ascension Saint Agnes Bariatric Program, and request that the payments from:

_____
(Patient's Insurance Carrier)

Be made directly to Ascension Saint Agnes Bariatric Program. I certify that the information I have reported with regard to my insurance coverage is correct and I further authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent (or, in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration). I permit a copy of this authorization to be used in place of the original. Either my insurance company or I may revoke this authorization at any time, by written request.

_____ _____
Signature of Subscriber or Beneficiary Date

Patient Registration- Please Print Clearly
Patient's Name

First_____ Middle_____ Last_____

Date of Birth:_____ SS#_____ M_____ F_____

Address:_____ City:_____

State:_____ Zip:_____ Home Phone:_____

Cell Phone:_____ Work Phone:_____

Email Address:_____

Race:

- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Black/African American
- ☐ White
- ☐ Hispanic
- ☐ Other
- ☐ Unreported/Decline to Report

Primary Language Spoken:

- ☐ English
- ☐ Spanish
- ☐ Russian
- ☐ Indian

Patient Name: _____

☐ Sign Language

☐ Other _____

Emergency Contact:_____Relationship:_____

Emergency contact's Primary #: _____

Emergency Contact's address: _____

Primary Care Physician: _____

Address: _____

Phone: _____ Fax: _____

Referring Physician: _____

Primary Lab Company Used:

☐ Labcorp

☐ Quest

☐ St. Agnes Lab

Primary Pharmacy Used:_____

Address: _____

Phone #: _____ Fax #: _____

Insurance Information: Please have cards available at appointment for scanning

Insurance Company: _____

Address: _____

Policy ID# _____ Group # _____

Policy Holder Name: _____DOB_____

Secondary Insurance Company (if applicable) _____

Address: _____

Policy ID# _____ Group # _____

Policy Holder Name: _____DOB_____

St. Agnes Bariatric Surgery Program
New Patient Intake Form

Today's Date: _____ Height: _____

Name: _____ Birth date: _____

Employment status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired

I am interested in *Please circle one*: ☐ Gastric Bypass ☐ Sleeve ☐ Unsure

Have you ever been to see us before for a consultation? ☐ Yes ☐ No

What is your Email address? Please print _____

OK to contact you by email? ☐ Yes ☐ No

Previous Bariatric Surgery? ☐ Yes ☐ No Type: _____

Top weight: Lowest weight:

Bariatric Surgeon: When performed:
(We would like to have a copy of the operative report at your consultation)

Has your Psychological evaluation been done? Yes No Date Scheduled: _____

Have you seen the Nutritionist yet? Yes No Date Scheduled: _____

How did you hear about us? _____

Did you attend an informational session? ☐ Yes ☐ No When? _____

Do you have 6 months of diet history with you today? ☐ Yes ☐ No

Surgeons Initials_____

Ascension Saint Agnes Bariatric Surgery Program
700 Geipe Rd Suite 203
Catonsville MD 21228
667-234-2573
www.MDBariatrics.com

PATIENT HISTORY FORM:

Knowing your detailed medical history information is very important for our assessment of your health. Obesity and its associated diseases and risk factors increase mortality and surgical complications. **We rely on the information you provide, therefore it is imperative for safety and insurance purposes that a detailed medical history be performed.**

I am also aware of the following:

- NO tobacco products are permitted for 8 weeks before surgery- this gives your lungs a chance to better provide oxygen to your blood, which can help decrease the risk of infection, pneumonia, and especially improve wound healing.
- Second hand smoke is also irritating to the lungs.
- We will not operate on any patient that is an active smoker and may require you to take a laboratory test that confirms you are smoke free.

PATIENT STATEMENT

I am aware that Bariatric surgery is not a "quick fix" but rather a tool for controlling weight, combined with exercise and proper nutrition. I am aware that I will be expected to follow up post op on a regular basis, and be required to take vitamins, and supplements for the rest of my life. I am also aware that reversal of this surgery is not recommended. The information on my medical history form is true and correct to the best of my belief.

_____

Patient's signature

_____

Date

Surgeons Initials_____

YOUR NAME _____ YOUR EMAIL ADDRESS_____

PRIMARY CARE PHYSICIAN

FULL NAME _____

ADDRESS _____

_____

PHONE # _____ FAX #_____

SPECIALIST PHYSICIAN (pulmonologist, gastroenterologist, endocrinologist)

FULL NAME _____

ADDRESS _____

_____

PHONE # _____ FAX #_____

FULL NAME _____

ADDRESS _____

_____

PHONE # _____ FAX #_____

FULL NAME _____

ADDRESS _____

_____

PHONE # _____ FAX #_____

FULL NAME _____

ADDRESS _____

_____

PHONE # _____ FAX #_____

Surgeons Initials_____

WEIGHT LOSS HISTORY

YOUR NAME _____

Most insurance companies require documented evidence of previous weight loss attempts so it is critical that you fill this out in detail. Please include dates as well as length of time of each diet, to the best of your knowledge.

How tall are you? _____

Have you completed a recent diet for this visit?_____

What was your best weight loss with dieting? _____

NON-SUPERVISED ATTEMPTS

- ☐ Body for Life/Bill Phillips
- ☐ Gloria Marshall
- ☐ Health Spa
- ☐ High Protein
- ☐ Hypnosis
- ☐ Low Carbohydrate
- ☐ Low Fat
- ☐ Calorie counting on my own
- ☐ Other_____
- ☐ Pritikin
- ☐ Richard Simmons
- ☐ Scarsdale
- ☐ Stillman Diet
- ☐ Sugar Busters
- ☐ Slim Fast
- ☐ Mayo Clinic
- ☐ Other _____
- ☐ Other _____

SUPERVISED ATTEMPTS

- ☐ Diet Pills from MD Type_____
- ☐ Diet Center Date: _____
- ☐ Optifast Date: _____
- ☐ HMR – Health Management Resources
- ☐ T.O.P.S. Date: _____
- ☐ New Directions
- ☐ Supervised calories counting diet by health professionals
- ☐ Other_____
- ☐ Diet Shots from MD Date: _____
- ☐ Overeaters Anonymous Date: _____
- ☐ Weight Watchers Date: _____
- ☐ Nutri-Systems Date: _____
- ☐ Jenny Craig Date: _____
- ☐ National Weight Loss Date: _____

MEDICATION PRESCRIBED FOR WEIGHT LOSS

Medications may be listed as both as generic and name brand. Check the one prescribed to you and the length of time you were on these medications.

- ☐ Acutrim
- ☐ Adipex-P
- ☐ Amphetamines
- ☐ Anorex
- ☐ Benzphetamine
- ☐ Dexatrim
- ☐ Dexfenfluramine
- ☐ Didrex
- ☐ Fastin
- ☐ Fenfluramine
- ☐ Ionamin
- ☐ Mazanor
- ☐ Meridia
- ☐ Obalan
- ☐ Orlistat
- ☐ Phendiet
- ☐ Phentermine
- ☐ Phentrol
- ☐ Piegine
- ☐ Pondimin
- ☐ Redux
- ☐ Sanorex
- ☐ Tepanol
- ☐ Tenuate
- ☐ Wehless
- ☐ Xenical

Surgeons Initials_____

REVIEW OF MEDICAL PROBLEMS (Please check and/or explain any of the items listed)

CARDIOVASCULAR

- ___ Heart problems _____
- ___ Chest pains _____
- ___ Previous Heart Attack _____
- ___ High blood pressure _____
- ___ Previous blood clots/PE _____
- ___ Shortness of Breath _____
- ___ SOB while exercising _____
- ___ High cholesterol _____
- ___ High triglycerides _____
- ___ Feel tired all the time _____

DIABETES AND ENDOCRINE SYSTEM

Diabetes Mellitus (Type 1 or 2)

When was your diabetes first diagnosed? _____

How long have you been taking oral agents? _____

How long have you been taking insulin? _____

Does your diabetes resolve with weight loss? _____

Pre-diabetic

(Abnormal glucose tolerance test)

Gestational _____

Age of diagnosis _____

Hypoglycemia or low blood glucose _____

Thyroid problems (requiring medication) _____

GASTROINTESTINAL

Gallbladder Problems

Do you have gallstones diagnosed by ultrasound? _____

Have you had your gallbladder removed open or laparoscopically? _____

Stomach Ulcers

Have you taken medicine for ulcers? _____

Were you ever diagnosed with stomach bacteria H.Pylori _____

Was H.pylori treated with antibiotics and when? _____

Surgeons Initials_____

Heartburn/GERD

Please answer the questions based on the Scale: 0 – No symptoms
1 – Symptoms not bothersome
2 – Symptoms noticeable and bothersome, but not daily
3 – Daily bothersome symptoms
4 – Symptoms affect daily activities
5 – Symptoms are incapacitating for daily activities

Questions (Circle one number to best describe intensity of the symptom)

How bad is your heartburn	0	1	2	3	4	5
Heartburn when lying down	0	1	2	3	4	5
Heartburn when standing up	0	1	2	3	4	5
Heartburn after meals	0	1	2	3	4	5
Does heartburn change your diet	0	1	2	3	4	5
Does heartburn wake you up from sleep	0	1	2	3	4	5
Do you have difficulty swallowing	0	1	2	3	4	5
Do you have pain with swallowing	0	1	2	3	4	5
Do you have bloating or gassy feelings	0	1	2	3	4	5
If you take medications for heartburn, does it affect your daily living	0	1	2	3	4	5
Total Score (0 to 50)						

How satisfied you are with your present reflux related condition? ☐ Satisfied ☐ Neutral ☐ Dissatisfied

Are you currently taking any medication for heartburn? ☐ Yes ☐ Occasionally ☐ No

Do you have a history of Gastroparesis? ☐ Yes ☐ No

Please check any of the medications you have taken in the past or are taking currently:

☐ Nexium ☐ Prilosec ☐ Prevacid ☐ Aciohex ☐ Protonix ☐ Zegerid ☐ Kapidex ☐ Dexilant
☐ Zantac ☐ Pepcid ☐ Tums ☐ Rolaids

Constipation/Irritable Bowel Syndrome/Colitis/Diverticulitis

Do you suffer from constipation? _____ Do you use laxatives frequently? _____

Do you have frequent diarrhea? _____ Do you have IBS? _____

Do you have Crohn's disease? _____ Do you have ulcerative colitis? _____

Do/did you have diverticulitis ? _____ Did you have colon surgery? _____

Surgeons Initials_____

RESPIRATORY

Asthma

Last attack? Are you using inhalers daily? _____

COPD ☐ Yes ☐ No _____

Bronchitis _____

# of times in past 2 years _____

Is it recurring? _____

Pneumonia? _____

Blood clots in lungs? _____

Blood clots in legs? _____

Smoking History

Starting age? _____

When did you stop? _____

How many packs per day? _____

Please answer the following questions:

Please answer the following questions with a YES or NO response.

1. Do you **SNORE LOUDLY**? (Loud enough to be heard through a closed door or your bed partner elbows= you at night)? ☐ **YES** ☐ **NO**
2. Do you often feel **Tired, Fatigued, or Sleepy** during the daytime (such as falling asleep while driving or= talking to someone)? ☐ **YES** ☐ **NO**
3. Has anyone **Observed** you **Stop Breathing** or **Choking/Gasping** during your sleep? ☐ **YES** ☐ **NO**
4. Do you have or are being treated for **High Blood Pressure**? ☐ **YES** ☐ **NO**
5. **Body Mass Index more than 35?** ☐ **YES** ☐ **NO**
6. **Age** older than **50 year old?** ☐ **YES** ☐ **NO**
7. **Neck Size**-For men- is your shirt collar 17 inches/43cm or larger? For women, is your shirt collar 16= inches/41cm or larger? ☐ **YES** ☐ **NO**
8. **Gender**= Male? ☐ **YES** ☐ **NO**

Previous Sleep Study or do you have one scheduled? ☐ **YES** ☐ **NO**

Do you currently use or have you previously been prescribed a CPAP or BiPAP machine? ☐ **YES** ☐ **NO**

MUSCULOSKELETAL

	MILD	**MODERATE**	**SEVERE**
Hip pain			
Knee pain			
Ankle pain			
Feet pain			
Back pain			
Neck pain			
Arthritis			

Surgeons Initials_____

Musculoskeletal continued

Are you using anti-inflammatory or pain medicine? _____

Do you have swelling of your legs? _____

Do you have swelling of your feet? _____

Do you have varicose veins? _____

Have you had ulcers of the leg? _____

Do you have a history of fibromyalgia _____

KIDNEY & BLADDER

Do you have renal insufficiency or kidney failure? _____

Have you had bladder or kidney infections? _____

Have you had kidney stones? _____

BLOOD

Have you ever had a bleeding problem? _____

Have you ever had low platelets? _____

Have you ever had a blood transfusion? _____

NEURO-PSYCHIATRIC

Depression/Anxiety _____

Because of obesity? _____

Requiring medication? _____

Seizures _____

Requiring Medication? _____

Severe headaches? _____

Requiring Medication? _____

Visual problems? _____

Been in counseling? _____

History of alcohol abuse? _____

How long have you been sober? _____

History of drug abuse? _____

How long have you been clean? _____

Eating disorder? _____

Bulimia? _____

Anorexia Nervosa? _____

ALLERGIES

Do you have any allergies to medicine or food? _____ _____

If so, what was the reaction? _____

Have you ever had reaction to anesthesia or has a family member had a reaction? ☐ Yes ☐ No

Are you allergic to Latex products? ☐ Yes ☐ No

Surgeons Initials_____

PAST SURGICAL HISTORY

We need a compete list of all your previous surgeries. Please list the type of surgery below:

Tonsillectomy _____

Cholecystectomy (gallbladder removal) _____

Appendectomy _____

Hysterectomy (removal of uterus) _____

Cesarean Section (C-section) _____

Oophorectomy (removal of ovary) _____

Previous Bariatric Surgery Yes No Type: _____

Hiatal Hernia surgery (for reflux) _____

Cardiac Surgery Yes No _____

Others:_____

HABITS

Do you consume alcohol and if so how much? _____

Any other habits that you have? _____

FOR WOMEN

Have you ever been diagnosed with polycystic ovarian syndrome? ☐ Yes ☐ No

Have you had problems conceiving? _____

How many pregnancies have you had? _____

How many children do you have/ _____

Any pain with periods? _____

SOCIAL

Are you employed? ☐ Full Time ☐ Part Time ☐ Retired ☐ Homemaker ☐ Unemployed

Employer _____

Describe your work and home life (family members, etc)

_____

_____

MEDICATIONS (Report **name, dose, and frequency** and what you are taking it for)

MEDICATION	DOSAGE	FREQUENCY	CONDITION

Surgeons Initials_____

Medication	**Dosage**	**Frequency**	**Condition**

Name and contact information of a close, supportive friend or family member who I can talk to if necessary:

_____

FAMILY HISTORY (Parents, Grandparents, Brothers, Sisters)

	Mother	**Father**	**Sibling**	**Aunt/Uncle**	**Grandparent**
Obesity					
Diabetes					
Heart disease					
High blood pressure					
Cancer					
Arthritis					
Early death					
Cause					

Has any member of your family suffered from Blood Clots or Pulmonary Embolism? ☐ Yes ☐ No

If yes, please describe:

_____=

_____

How did you hear about us?

_____=

_____

Surgeons Initials_____

NEURO-PSYCH SCREENING

Below is a list of problems and complaints that people sometimes experience. Please read each one carefully. After you have done so, use the scale below to describe HOW MUCH that each problem has BOTHERED or DISTRESSED you during the past week, including today.

NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
0	1	2	3	4

_____ 1. Nervousness or shakiness inside.
_____ 2. Unwanted thoughts, words, or ideas that won't leave your mind.
_____ 3. The idea that someone else can control your thoughts.
_____ 4. Feeling others are to blame for most of your troubles.
_____ 5. Trouble remembering things.
_____ 6. Feeling easily annoyed or irritated.
_____ 7. Feeling afraid in open spaces or on the street.
_____ 8. Thought of ending your life.
_____ 9. Hearing voices that other people do not hear.
_____ 10. Feeling that most people cannot be trusted.
_____ 11. Crying easily.
_____ 12. Feeling or being trapped or caught.
_____ 13. Suddenly scared for no reason.
_____ 14. Temper outbursts that you could not control.
_____ 15. Feeling afraid to go out of your house alone.
_____ 16. Feeling blue.
_____ 17. Worrying too much about things.
_____ 18. Feeling fearful.
_____ 19. Other people being aware of your private thoughts.
_____ 20. Feeling afraid to travel on buses, subways, or trains.
_____ 21. Having to avoid certain things, places, or activities because they frighten you.
_____ 22. Your mind going blank.
_____ 23. Feeling hopeless about the future.
_____ 24. Trouble concentrating.
_____ 25. Having thoughts that are not your own.
_____ 26. Having urges to beat, injure, or harm someone.
_____ 27. Having urges to break or smash things.
_____ 28. Having ideas or beliefs that others do not share.
_____ 29. Spells of terror or panic.
_____ 30. Getting into frequent arguments.
_____ 31. Feeling nervous when you are left alone.
_____ 32. Feeling so restless you couldn't sit still.
_____ 33. Feeling of worthlessness.
_____ 34. Feeling that familiar things are strange or unreal.
_____ 35. Shouting or throwing things.

Surgeons Initials_____

Surgeons Initials_____