MUSC Health

ASCREENCRIT

Bariatric Surgery Program
Initial Patient Application

Form Origination Date: 5/2016
Version: 1 Version Date: (5/2016)

Patient Name _____
MRN _____
PATIENT IDENTIFICATION LABEL

MUSC Bariatric Surgery Program Patient Information Form (Complete & Return)

Name _____Birth date ___/____/____Sex____ Marital Status_____
SS#_____ Address_____
City _____County _____ State _____Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Ethnicity_____ Email address_____

Occupation _____
Employer's Name & Address _____

Primary Care Provider (PCP) _____
Address of PCP _____ PCP phone _____
Referring Physician _____
Address of Referring _____ Referring phone _____

Emergency Contact Name _____ Relationship _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____

Insurance Information: (*Give as much information from your card, and enclose a copy if possible)*

Name of Primary Insurance _____	Name of Secondary Insurance _____
Address _____	Address _____
Customer Service Phone # _____	Customer Service Phone # _____
Prior Authorization Phone # _____	Prior Authorization Phone # _____
Policy or ID # _____	Policy or ID # _____
Group or Plan#_____	Group or Plan#_____
Subscribers Name on Card _____	Subscribers Name on Card _____
Relationship to Patient _____	Relationship to Patient _____
Subscribers Employer _____	Subscribers Employer _____

How did you hear about us?
☐ MUSCHealth Website ☐ Internet – other ☐ Facebookk ☐ Newspaper ☐ Magazine
☐ Television ☐ Physician: Name: _____ ☐ Friend: Name: _____

Indicate the Procedure you are interested in:
☐ Gastric Bypass ☐ Sleeve Gastrectomy ☐ **Other:** _____

Date you viewed online information video
Can the patient read or write? ☐ Yes ☐ No Form completed by: ☐ Patient ☐

MUSC Health
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MUSC Bariatric Surgery Program Nutrition Questionnaire
(Please Complete & Return)

Personal Information:

Name: _____

Date of Birth: _____ Email: _____

Height (inches): _____ Weight (pounds): _____

Previous Attempts at Weight Loss Efforts (Past 5 Years only):

List Programs (like Weight Watchers, Metabolic Medical Center), Diets (like Atkins, South Beach), Medications (like Phentermines, Belviq), Over the Counter products (like Alli, Metabolife), physician or dietitian supervised weight loss attempts, or weight loss surgery.

Name of weight loss program, diet, medication, past history of bariatric surgery	**Date/year you started**	**How long on it (days, weeks, months, or years)**	**How many pounds did you lose**

Daily Routine:

What do you do for work? _____ What are your typical work hours? _____

Who else lives in the home with you? _____

Who does the food shopping and preparation? _____

Do you plan meals in advance? _____ Do you shop from a list? _____

Where do you typically eat your meals (table, couch, bed, kitchen)? _____

Do you have any food allergies or intolerances? _____

Are you taking vitamin and mineral supplements? (please list) _____

Weight Loss Surgery Expectations:

Which type of weight loss surgery are you interested in? _____

How much weight do you hope to lose with surgery? _____

In what time frame do you expect to lose this weight? _____

Do you have any non-scale goals or things you are looking forward to with weight loss? _____

What do you feel is your biggest challenge when it comes to changing your eating habits? _____

_____

Note: Plan to attend a **MANDATORY** pre-surgery education class which is held in the Ashley River Tower Auditorium on the **1st and 3rd Tuesday of EVERY month from 12:30-3pm** (you don't need to register, just show up).

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Metabolic & Bariatric Surgery Program
New Patient Medical Questionnaire

PLEASE COMPLETE ENTIRE FORM

PATIENT NAME: _____

Person completing form: ☐ PATIENT ☐ OTHER (Name/Relation): _____

PRIMARY CARE PROVIDER:

Name	Address	Phone

CURRENT HEIGHT (inches): _____ **WEIGHT (pounds):** _____

PAST MEDICAL HISTORY	Additional Questions	YES	NO or NA
Diabetes	☐Type 1 ☐Type 2 ☐taking insulin	☐	☐
Thyroid Problems		☐	☐
High Blood Pressure		☐	☐
High Cholesterol (or lipids)		☐	☐
Congestive Heart Failure (CHF)		☐	☐
Heart Attack or Cardiac Stent		☐	☐
Sleep Apnea (OSA)	☐CPAP ☐BiPAP	☐	☐
Oxygen Dependent		☐	☐
Asthma		☐	☐
Emphysema (or COPD)		☐	☐
Pulmonary Embolus (PE) or Deep Vein Thrombosis (DVT)		☐	☐
IVC Filter for blood clot (Therapeutic Anticoagulation)		☐	☐
Arthritis	☐ Osteo ☐ Rheumatoid	☐	☐
Gout		☐	☐
Pain in joints, back, hip, or knees	☐ Joint ☐ Back ☐Hip ☐ Knee	☐	☐
Scleroderma		☐	☐
Connective Tissue Disease		☐	☐
Irritable bowel syndrome (IBS)		☐	☐
Diverticulosis/diverticulitis		☐	☐
Crohns' Disease or Ulcerative Colitis		☐	☐
GERD (Reflux or heartburn)		☐	☐
Constipation (Chronic)		☐	☐
Chronic Steroid/Immunosuppressant use		☐	☐
Polycystic Ovarian Syndrome (PCOS)		☐	☐
Kidney disease	☐ on Dialysis	☐	☐
Urinary Stress Incontinence		☐	☐
Cancer	☐ Chemotherapy ☐ Radiation	☐	☐
Other:		☐	☐

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Metabolic & Bariatric Surgery Program
New Patient Medical Questionnaire

PLEASE COMPLETE ENTIRE FORM

PAST SURGICAL HISTORY

PROCEDURE/OPERATION (Laparoscopic or Open)	DATE	SURGEON	HOSPITAL

Have you ever had bariatric or weight loss surgery? List type, date, surgeon, hospital:

_____

FAMILY HISTORY

RELATIONSHIP	STATUS	MEDICAL PROBLEM
Mother	☐ Alive ☐ Deceased	
Father	☐ Alive ☐ Deceased	
Sister	☐ Alive ☐ Deceased	
Brother	☐ Alive ☐ Deceased	
Maternal Grandmother	☐ Alive ☐ Deceased	
Maternal Grandfather	☐ Alive ☐ Deceased	
Paternal Grandmother	☐ Alive ☐ Deceased	
Paternal Grandfather	☐ Alive ☐ Deceased	

MEDICATIONS:

MEDICATION NAME	DOSE (mg, mcg, etc)	HOW OFTEN?	REASON FOR MED
1.			
2.			
3.			
4.			
5.			
6.			

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PLEASE COMPLETE ENTIRE FORM

MEDICATIONS (continued)

MEDICATION NAME	DOSE (mg, mcg, etc)	HOW OFTEN?	REASON FOR MED
7.			
8.			
9.			
10.			
11.			
12.			

Do you have any allergies? What is your reaction? _____

ADDITIONAL QUESTIONS

Do you smoke cigarettes, cigars, or use any nicotine products?	☐ Never	☐ Yes, current	☐ Former	Year Started: _____	Year Quit: _____
Do you use smokeless tobacco, such as E-cig/vaping, dip, or chewing tobacco?	☐ Never	☐ Yes, current	☐ Former	Year Started: _____	Year Quit: _____
Do you drink alcohol?	☐ Never	☐ Yes, current	☐ Former	Year Started: _____	Year Quit: _____
Do you use recreational drugs?	☐ Never	☐ Yes, current	☐ Former	Year Started: _____	Year Quit: _____
List type of recreational drugs used:					
Do you use birth control?	☐ Not applicable	☐ No	☐ Yes	Type:	
Do you use assistive devices for walking?	☐ No	☐ Yes	Type:		
Do you rely on others for transportation?	☐ No	☐ Yes	Who:		
Do you have additional support from at least 2 adults after you have weight loss surgery?	☐ No	☐ Yes	Who:		
Do you have financial concerns?	☐ No	☐ Yes	*You will be required to take vitamins/supplements for life after weight loss surgery. These could cost you approximately $20-35/month*		

If you have any questions while filling out this form, please contact us at 843-792-3046