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 ☐ Facebook ☐ 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
Medical University of South Carolina

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).

MUSC Health

ASCREENCRIT

New Patient Questionnaire

To be Completed by Patient

Form Origination Date: 7/07
Version: 2 Version Date: 6/10

Patient Name _____
MRN _____
PATIENT IDENTIFICATION LABEL

Form completed by ☐ Patient ☐ _____

PRIMARY CARE and REFERRING PHYSICIAN(S)

Physician Name Address Phone

_____

_____

_____

CURRENT MEDICAL PROBLEM

What problem brought you here? _____

What symptoms are you having? _____

When did your symptoms start? _____

Has your appetite changed in the last six months? ☐ Decreased ☐ Increased ☐ Stayed the same

Current Height _____ Weight _____ lbs

Has your weight changed in the last six months? ☐ No ☐ Yes If yes, gained _____ lbs lost _____ lbs

Has your overall energy / pep level changed? ☐ Decreased ☐ Increased ☐ Stayed the same

PAST MEDICAL / SURGICAL HISTORY

Have you had any difficulty with anesthesia in the past? ☐ No ☐ Yes, explain: _____

Have you had any problems with bleeding during or after surgery in the past? ☐ No ☐ Yes, explain: _____

_____

Please list any medical problems (e.g., diabetes, high blood pressure, cancer)

Problem	Problem
1.	5.
2.	6.
3.	7.
4.	8.

Females: Number of times you have been pregnant: _____ Number of live births: _____
Number of miscarriages: _____ Number of abortions: _____
Age when you started your period: _____ Age at menopause: _____
Hormone replacement: ☐ No ☐ Yes, number of years: _____

Please list any previous operations or procedures

Procedure or Operation	Date	Surgeon(s)	Hospital

Reviewing RN Signature _____ Date/Time _____

Patient Name _____
MRN _____
PATIENT IDENTIFICATION LABEL

FAMILY HISTORY

Are there any diseases that run in your family?

Disease	Family member affected

MEDICATIONS

In the boxes below, please list all medications or pills that you take, whether or not prescribed by a physician. Record them just as they are on the drug bottle / box. Please include all vitamins, herbal supplements, and/or over-the-counter medications.

Medicine or pill name	Dose (e.g., 50 mg)	How many times per day?	Why do you take this?

Please list any allergies.

Name	What happens if taken or eaten?	Name	What happens if taken or eaten?
1.		3.	
2.		4.	

Are you allergic to shellfish? ☐ No ☐ Don't Know ☐ Yes

Have you had an allergic reaction to contrast or dye injected in a medical test? ☐ No ☐ Don't Know
☐ Yes, what happened? ☐ Rash ☐ Short of breath ☐ Other _____

VACCINATIONS

Have you received a pneumonia vaccine within the past 5 years? ☐ No ☐ Don't Know ☐ Yes, date: _____

Have you received a flu vaccine this flu season? ☐ No ☐ Don't Know ☐ Yes, date: _____

Reviewing RN Signature _____ Date/Time _____

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SOCIAL HISTORY

☐ Single ☐ Married ☐ Separated / Divorced ☐ Widowed

What is your current or former occupation? _____

Do you currently or have you ever used tobacco? ☐ Never ☐ No / Quit ☐ Yes ☐ I would like to quit.

If yes or quit, how much per day? _____ Age you started: ____ Age you quit: _____

Type: ☐ Pipe ☐ Cigars ☐ Smokeless Tobacco

☐ Cigarettes, have you smoked this past year? ☐ No ☐ Yes

Do you or have you used alcohol? ☐ Never ☐ No / Quit ☐ Yes

If yes or quit, how much per day? _____

Type: ☐ Beer ☐ Wine ☐ Hard Liquor ☐ Moonshine

Do you or have you used recreational drugs? ☐ Never ☐ No / Quit ☐ Yes, type: _____

Prior to this illness, did you have any problems taking care of your daily activities of living (e.g., bathing, walking)?

☐ No (Independent) ☐ Need some help / assistance ☐ Need constant help (Dependent)

Do you currently have any problems taking care of your daily activities of living (e.g., bathing, walking)?

☐ No (Independent) ☐ Need some help / assistance ☐ Need constant help (Dependent)

Do you have difficulty falling asleep or staying asleep at night? ☐ No ☐ Falling asleep ☐ Staying asleep

Are you bothered by unpleasant sensations in your legs in the evening or in bed (such as tingling, "creepy crawly" feelings) that get better when you move your legs or get up and walk? ☐ No ☐ Yes

If you have a bed partner, does he / she report that you kick or move your legs excessively during your sleep?

☐ No ☐ Yes ☐ I sleep alone

Do you have an advance directive (living will, durable power of attorney)? ☐ No ☐ Yes, please provide copy.

Do you have any religious or cultural beliefs that you would like your doctor to know about? ☐ No ☐ Yes

If yes, explain: _____

_____

How do you learn best? ☐ Pictures ☐ Books / pamphlets ☐ Video ☐ Talking to others ☐ Computer

Do you have problems with transportation? ☐ No ☐ Yes

Do you have financial concerns? ☐ No ☐ Yes

EMERGENCY CONTACT INFORMATION

Name _____ Phone _____

Name _____ Phone _____

Reviewing RN Signature _____ Date/Time _____

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Do you currently have or have you had any of the following?

CONSTITUTIONAL

Fever ☐ No ☐ Yes
Chills ☐ No ☐ Yes
Loss of appetite ☐ No ☐ Yes
Pain ☐ No ☐ Yes, location:____
How bad is your pain? (circle one)
0 1 2 3 4 5 6 7 8 9 10
(no pain.....worst pain ever)
Type of pain (check all that apply): ☐ Burning ☐ Stabbing ☐ Tingling ☐ Dull ☐ Throbbing ☐ Constant ☐ Radiating ☐ Cramping ☐ Intermittent

EYES / EARS / NOSE / THROAT

Blurred or double vision ☐ No ☐ Yes
Hard of hearing ☐ No ☐ Yes
Nose bleeds ☐ No ☐ Yes

CARDIOVASCULAR

Shortness of breath ☐ No ☐ With activity ☐ At rest
High blood pressure ☐ No ☐ Yes
Chest pain / angina ☐ No ☐ Yes
Have you been treated for this in the past 30 days? ☐ No ☐ Yes
Heart murmur ☐ No ☐ Yes
Irregular heart beat ☐ No ☐ Yes
Ankles / feet swelling ☐ No ☐ Yes
High cholesterol ☐ No ☐ Yes
Congestive heart failure ☐ No ☐ Yes
Have you been treated for this in the past 30 days? ☐ No ☐ Yes
Heart attack or myocardial infarct (MI) ☐ No ☐ Yes
Have you been treated for this in the past 6 months? ☐ No ☐ Yes

PULMONARY

Sleep Apnea ☐ No ☐ Yes
Asthma ☐ No ☐ Yes
Wheezing / trouble breathing ☐ No ☐ Yes
Emphysema / COPD ☐ No ☐ Yes
Have you ever been treated for this? ☐ No ☐ Yes
Cough ☐ No ☐ Yes, wet / dry?____
Coughing blood ☐ No ☐ Yes
Tuberculosis (TB) ☐ No ☐ Yes

HEMATOLOIC

Anemia ☐ No ☐ Yes
Bleeding disease ☐ No ☐ Yes
Clotting disease ☐ No ☐ Yes
HIV positive ☐ No ☐ Yes
Do you bruise easily? ☐ No ☐ Yes
Swollen glands / lumps ☐ No ☐ Yes

ENDOCRINE

Diabetes ☐ No ☐ Yes
Thyroid problems ☐ No ☐ Yes

MUSCULOSKELETAL

Joint pain ☐ No ☐ Yes
Back pain ☐ No ☐ Yes
Arm numbness / weakness ☐ No ☐ Yes
Leg numbness / weakness ☐ No ☐ Yes

NEUROLOGY

Stroke ☐ No ☐ Yes, date:_____
If yes, did you have any problems afterwards? ☐ No ☐ Yes
Explain:_____
"Mini stroke" or TIA ☐ No ☐ Yes, date:_____
Seizure ☐ No ☐ Yes, date:_____

GASTROINTESTINAL

Stomach pain ☐ No ☐ Yes
Nausea / vomiting ☐ No ☐ Yes
Vomiting blood ☐ No ☐ Yes
Difficulty swallowing ☐ No ☐ Yes
Heartburn ☐ No ☐ Yes
Diarrhea ☐ No ☐ Yes
Bloody stool or black stool ☐ No ☐ Yes
Constipation ☐ No ☐ Yes
Change in bowel habits ☐ No ☐ Yes
Gallbladder disease ☐ No ☐ Yes
Hernia ☐ No ☐ Yes, type:_____

GENITOURINARY

Painful urination ☐ No ☐ Yes
Frequent urination ☐ No ☐ Yes
Incontinence ☐ No ☐ Yes
Blood in urine ☐ No ☐ Yes
Sexually transmitted disease ☐ No ☐ Yes

PSYCHOLOGICAL

Depression ☐ No ☐ Yes
Anxiety ☐ No ☐ Yes
Mania ☐ No ☐ Yes
Schizophrenia ☐ No ☐ Yes

IMMUNE SYSTEM / NUTRITIONAL / MISC

Cancer ☐ No ☐ Yes, date:_____
Type(s):_____
Has it spread to other locations? ☐ No ☐ Yes
If yes, where: _____
Chemotherapy ☐ No ☐ Yes
Have you had any in the past 30 days? ☐ No ☐ Yes
Radiation ☐ No ☐ Yes
Have you had any in the past 90 days? ☐ No ☐ Yes
Open wounds ☐ No ☐ Yes, where: _____

OTHER

_____
_____
_____
_____

Reviewing Physician Signature and Pager ID _____ Date/Time _____