Bariatric Surgery Intake Forms

Dear Prospective Client,

Thank you for your interest in the Bariatric Program at UNC Healthcare. We are happy that you have made the first step at improving your health and look forward to working with you.

Please call your insurance company to find out if weight loss surgery is a ***covered benefit***. If you need assistance we are happy to help. If you are considering paying out of pocket for the surgery, please call us so we can discuss options with you.

Complete the required paperwork attached, along with the medical release form, and mail it back to us at: *Division of Gastrointestinal Surgery, ATTN: Bariatric Coordinator, UNC Department of Surgery, CB# 7081, Chapel Hill, NC 27599-7081*.

Once we receive your application, we will set up an initial appointment for you at Meadowmont or Hillsborough.

On your initial appointment you will meet with a Nurse Practitioner and a Registered Dietitian.

This intake visit does not guarantee surgery.

Once you meet all of the requirements, we will set up an appointment for you to meet with one of the surgeons.

We look forward to meeting you,

Dr. Timothy Farrell
Dr. D. Wayne Overby
Dr. Meredith Duke
Tara Zychowicz, Nurse Practitioner
Lisa Prestia RN, Bariatric Coordinator
University of North Carolina Chapel Hill
The Division of GI Surgery/Bariatrics
Dept. of Surgery
4035 Burnett Womack CB 7081
Chapel Hill, NC 27599-7081
919-966-8436 office
919-966-8440 fax
www.uncweightlosssurgery.com

Bariatric Surgery Intake Forms

I am interested in: Gastric Bypass Gastric Band Revision/removal or Sleeve Gastrectomy

How did you hear about our program? _____

Contact Information

Patient: _____
Patient Address: _____
_____
_____
Patient Telephone: (_____) _____
Patient Email: _____
Date of Birth: _____

Referring MD: _____
MD Address: _____
_____
MD Telephone: (_____) _____
MD Email: _____

Primary MD: _____
MD Address: _____
_____
MD Telephone: (_____) _____
MD Email: _____

Psychologist: _____
Address: _____
_____
Telephone: (_____) _____

Insurance Carrier: _____**State:**_____
Have you called to verify that Bariatric Surgery is a covered benefit? _____
Does your insurance require a supervised diet? *(be sure to ask)* _____

Your Current Height: _____
Your Current Weight: _____

BMI: _____

Please note: we do not accept Charity Care

Bariatric Surgery Intake Forms

Bariatric History:

How long have you been looking into having weight loss surgery? _____
Have you ever been evaluated for weight loss surgery before? Yes / No _____
Have you ever had weight loss surgery, and are interested in a revision? _____
When did weight become a problem for you? Child Teen Adult With pregnancy
At what age did you first begin dieting: _____ years old
Are your family members heavy? Yes / No which ones? _____
What do you feel has caused you to be heavy? Major Illness Major Stressor
Medication Marriage Travel Trauma Divorce
Food choices Inactivity Genetics Other _____
What was your highest adult weight? _____ Lbs. When? _____
What was your lowest adult weight? _____ Lbs. When? _____

Eating patterns:

Describe your eating habits:_____
Do you skip meals? Yes / No If so, which? _____
What do you drink? _____
How often do you drink sugar sweetened beverages? _____
Do you have any difficulty swallowing? _____ _____
Are you allergic or intolerant to any foods? Yes / No If so, which? _____
Do you eat big meals, or having difficulty feeling full? Yes / No If so, which? _____
How often do you eat outside of the home/ include fast food? _____x's a week

Exercise or Activity:

Describe your exercise habits: _____
How often do you exercise? I don't Daily 2x/week 3x/week 4x/week
What are your barriers to exercise? _____
Can you walk up a flight of stairs without stopping? Yes/ No
Do you get chest pain or shortness of breath on exertion? _____
How far can you walk without stopping? <10 mins 15 mins 30 mins >30 mins

Psychological Eating/ Problems:

Do you have any mental health concerns? _____
Have you ever been hospitalized for mental health illness? _____
Are you experiencing any major life stressors currently? _____
Do you ever have binges (eating a large amount of food in a short period of time)? _____
Are you under the care of a psychologist/ psychiatrist/ counsellor? _____
Do you take any medications for mental health reasons? _____
If yes, who prescribes them for you? _____

Sleep

Describe your sleep habits: _____
Do you have any difficulty sleeping? _____
Have you ever been tested for sleep apnea? _____ Do you wear a CPAP?
Do you take sleep aides? _____

Weight Loss Attempts:

Program	Describe/ Year	Months on Program	Pounds Lost	Comments	Cost ($)
Diet pills (any)					
Weight Watchers					
Liquid Diets (Optifast or Slim Fast, etc.)					
Low calorie diets					
Low carb diets or Atkins					
Jenny Craig or Nutri-system					
Fad diets					
Physician Monitored Diet "Diet Clinics"					
Hypnosis/ counseling					
Surgery					
Dietitian counseling					
OA					
Gym Memberships Exercise plans					

What diet/ weight loss plan has worked the best?

What do you feel has been your biggest barrier to losing weight?

Why do you want to have weight loss surgery now?

What surgery are you most interested in having, and why?

Bariatric Surgery Intake Forms

Personal Health History:

Medical Problems (Circle all that apply)

Diabetes	High Blood Pressure	Sleep apnea	Cancer
Heart Disease	Reflux/Heartburn	High Cholesterol	Stroke
Stress Incontinence	Gallstones	Arthritis	COPD
Chronic Pain	Low back pain	Changes in Period/ PCOS	
Glaucoma	Blood Clots	Kidney or Liver Disease	
Venous Stasis	Heart Attack	CHF	
Asthma	Depression	Bipolar Disorder	

Any other Medical History/Hospitalizations:

_____
_____
_____
_____

Surgical History (YEAR):

Tonsillectomy _____ Gallbladder removal _____ Appendectomy _____
C-sections _____ Hernia Repair: _____

Any other operations:

_____
_____

Allergies: _____
_____

Current Medications:

Medication	Amount (mg)	Frequency	Since (year)

Social History:

Where are you from? _____
Where do you live now? _____
Education: _____
Describe your living arrangements? _____
Marital status:
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other
Children: _____
Any desire for children in future? Yes/ No
Current Occupation: _____ Employer: _____
Years at this position: _____ Can you take time off to recover? _____
Are you on disability? _____ If so, since when and for what reason?

_____

Who will help take care of you, if needed, after surgery? _____

Habits:

Do you take any vitamins, herbs, supplements: _____

_____

Do you (or did you) smoke? ☐Yes ☐ No ☐ Quit _____ years ago
You must be nicotine free x 3 months before surgery
Average daily tobacco habit: _____ packs/day for _____ years
Do you drink alcoholic beverages? ☐Yes ☐ No ☐ Quit _____ years ago
How much? _____
Do you use recreational drugs? ☐Yes ☐ No ☐ Quit _____ years ago
You must be drug and alcohol free x 6 weeks before surgery
Do you have, or have you had, a problem with drugs or alcohol? ☐ Yes ☐ No
Explain: _____

Family History:

Biological Father (alive or deceased) Age: ____ Medical Hx: _____

Biological Mother (alive or deceased) Age: ___ Medical Hx: _____

Extended Family (Siblings, Grandparents, your children): (list anything of importance)

_____

_____

_____

_____

Are you experiencing (currently):

Recent unexplained weight loss or weight gain		Fevers/Chills	Night Sweats
Dizziness	Headaches	Weakness	Fatigue
Coughing	Wheezing	Shortness of Breath	Chest Pain
Pressure in chest	Palpitations	Heartburn	Snoring (apnea)
Daytime Drowsiness	Insomnia	Trouble swallowing	Constipation
Change in Bowels/Bloody Stools		Abdominal Pain	Hernias
Pain or difficulty Urinating		Libido changes	Skin changes

Health Maintenance:

Do you see a healthcare provider regularly?

Do you see a dentist regularly?

When was your last:

Mammogram _____ Pap smear _____ Colonoscopy _____
Prostate Exam _____ Eye Exam _____ Birth Control? _____

Have you had any Routine Diagnostic Studies (please attach reports)
Lab work _____ Chest X-ray _____
EKG _____ Endoscopy: _____
Cardiology Tests _____ Other: _____

Have you attended an information seminar by one of our doctors?

Will you, the patient, commit to careful follow-up with us for up to 5 years?

☐ Yes ☐ No

_____

Signature of Patient ***Date***