



## Bariatric Surgery Intake Forms

Dear Prospective Patient,

Thank you for your interest in the Bariatric Program at UNC Healthcare. We are happy that you have made the first step in 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 following paperwork, 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.

We help you schedule a mental health evaluation with our program psychologists, as well as any additional preoperative screenings or requirements.

A Nutrition Class is required.

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. Marco Patti

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.uncweightlossurgery.com](http://www.uncweightlossurgery.com)  
[Facebook: UNC WLS Support Group](#)



# 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, or denied, 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? \_\_\_\_\_



## Bariatric Surgery Intake Forms

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

## 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 substance free x 12 months before surgery*

## 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)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# Bariatric Surgery Intake Forms

## **Are you experiencing (currently):**

Recent unexplained weight loss or weight gain	Fevers/Chills	Night Sweats
Dizziness	Headaches	Fatigue
Coughing	Wheezing	Chest Pain
Pressure in chest	Palpitations	Snoring (apnea)
Daytime Drowsiness	Insomnia	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*