North Carolina Surgery

PATIENT IDENTIFICATION

Patient's Legal Name ____
(LAST) (FIRST) (MIDDLE)

Rex Healthcare will compare your Legal Name to your name as it appears on your insurance card.

Gender ____ Last 4 numbers Social Security# (some insurances require full SS) ________________

Birth Date ____________________

PATIENT INFORMATION: Race__________Hispanic_____Non-Hispanic________Language______________

Mailing Address ____

Physical Address (if different from mailing address) ______________________________

City ______________________ State ________________ Zip Code ____________

Home Phone # ________________Mobile Phone #__________________Email Address____________

Referring Physician ____

Primary Care Physician____

Other Physicians to Whom You Want Communication Sent ________ ______________________

PATIENT EMPLOYMENT INFORMATION

Status: Full-time ____ Part-time ____ Retired ____ Retirement Date ________ Full Time Student? Y/N Other_______

Employer's Name ______________________________ Phone # ______________________

GUARANTOR INFORMATION (Person Financially Responsible if different than patient)

Name of Guarantor ______________________________ Relationship to Patient ______________

Last 4 Digits of Social Security # ____________ Gender ________ Birth Date ________________

Mailing Address ____

Physical Address (if different from mailing address) ______________________________

City ______________________ State ________________ Zip Code ____________

Home Phone # ______________________ Employer's Name ______________________

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact ______________________________ Relation to Patient ____________

Mailing Address ____

Physical Address (if different from mailing address) ______________________________

City ______________________ State ________________ Zip Code ____________

Home Phone # ________________Work Phone # __________________Cell Phone # ____________

PRIMARY INSURANCE

Name of Insurance Company ____

Policyholder's Name **(if other than patient)**______________________________ Relationship__________

Birth Date ______________ Gender ________

SECONDARY INSURANCE

Name of Insurance Company ____

Policyholder's Name **(if other than patient)**______________________________ Relationship__________

Birth Date ______________ Gender ________

ACCIDENT INFORMATION (Complete this section ONLY if your condition is accident related)

Type of Accident (Auto, Work, Other) ____________________ Description______________________

Accident Date and Time ____________________Place of Accident (City,County,State)________________

Patient/Authorized Representative Signature ______________________________Date____________

UNC HEALTH CARE

Patient Name____________________
Date of Birth____________________

Limited Release of Information to Family/Friends for Physician Clinics
HIM# 1315s

I give my permission to my physician practice that is part of the UNC Health Care System to share certain personal health information about me with the individuals listed below. These individuals will only be given information about me that is related to their involvement in my care or payment for my care.[1] I understand that I am not required to complete this form in order to obtain health care.

Name: ____________________ Phone Number: ____________________
Relationship: ____________________ Talk to this person about (*check each box that applies*):

☐ Any non-sensitive[2] information regarding my health care or payment for my health care.

OR

☐ Only these things:

	My appointments – scheduling & reminders		My test results
	My after visit summary (AVS)		My bills
	Other:		

Name: ____________________ Phone Number: ____________________
Relationship: ____________________ Talk to this person about (*check each box that applies*):

☐ Any non-sensitive[2] information regarding my health care or payment for my health care.

OR

☐ Only these things:

	My appointments – scheduling & reminders		My test results
	My after visit summary (AVS)		My bills
	Other:		

If I change my mind about the people or the contact information I have listed in this form, I will complete a new form with such changes.

____ DATE: ______________ TIME:__________
PATIENT SIGNATURE (or Authorized Representative)

PRINTED NAME & RELATIONSHIP (if not patient): ________________________________

[1] This form is not a substitute for a health care power of attorney or other formal designation of an individual authorized to make health care decisions for you if you are not able. If an individual listed above is your guardian or agent (under a power of attorney), or is otherwise authorized by law to act on your behalf, your health care provider may share as much of your personal health information with that person as the law permits.

This form is not a substitute for a valid HIPAA compliant written authorization when it is required to release copies of medical and billing records or information.

[2] Non-sensitive information excludes mental health, alcohol and substance abuse, HIV and other communicable diseases, and genetic testing. **This form is not considered sufficient authorization to release sensitive information.**

HDF5338 06/09/17

Chart Location: Consents

Rex Bariatric Specialists

Appointment Date:	
Name:	DOB:
Referring Physician:	Office Phone Number:
Primary Care Physician:	Office Phone Number:
Decision Maker in the Event of an Emergency:	
Decision Maker's Phone Number:	

Allergy: Please list all allergies and reactions	Reaction

Pharmacy Name	Pharmacy Address

Current Medications:

Medication name	Dosage	Amount You Take Daily
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		

Medical History: Please mark all that apply.

Acid Reflux/Heart Burn		Arthritis	
Anemia		Asthma	
Anxiety		Bipolar Disorder	
Blood Clots		Heart Arrhythmias (Atrial fibrillation)	
Cancer		Heart Disease (Heart attack)	
Congestive heart failure		Hepatitis (Liver infection)	
Chronic Constipation		High Cholesterol	
Chronic Diarrhea		HIV/AIDS	
Cirrhosis/Liver disease		Hypertension	
COPD/Lung fibrosis		Hypothyroidism or Hyperthyroid	
Depression		Kidney Disease	
Diabetes Mellitus Type 1 or 2		Lung Disease	
Diverticulitis		Pancreatitis	
Epilepsy		Pseudotumor Cerebri	
Fibromyalgia		Sleep Apnea	
Gallbladder disease		Stroke	
Gastric Ulcers		Other:	
Gout		Other:	

Surgical History: Please mark all that apply.

Appendectomy		Hysterectomy	
Back/Spine Surgery		Joint Replacement	
Brain Surgery		Open Heart Surgery	
Breast Surgery		Pacemaker	
Colon or Rectal Surgery		Plastics Surgery	
C-section		Prostate surgery	
Cosmetic Surgery		Small Intestine Surgery	
Defibrillator		Stent Placement	
Eye Surgery		Valve Replacement	
Fracture Repair		Vasectomy	
Gallbladder Surgery		Other:	
Hernia Surgery		Other:	

Prior Bariatric Surgery	Type:	
Results	Pre-op weight	Maximum weight loss
When/Where/Surgeon Name?		

Family History:

Relationship	Living/Deceased	Heart Disease	Cancer	Clotting Disorder	Diabetes	Hypertension	Kidney Disease	Lung Disease
Mother								
Father								
Sister								
Brother								
Daughter								
Son								

Social History: Please mark all that apply.

Current tobacco/nicotine use (also Vaping/Dipping)		Type?	How much per day?
Prior tobacco history		Type?	Quit Date?
Current alcohol use		How Often?	How Much?
Current drug use (also CBD/ marijuana)		Type of Drug?	How Often?

Domestic Abuse History:

Is abuse, violence, or sexual assault a problem for you in any way? ☐ Yes ☐ No

Does your partner/caregiver threaten you in any way? ☐ Yes ☐ No

System Review: Please list any active problems?

Constitutional		Visual disturbance		**Gastrointestinal**		**Blood**	
Appetite change		Hearing loss		Abdominal distention		Easy bleeding/bruising	
Chills		Tinnitus (ringing)		Abdominal pain		Blood clots	
Sweating		Hoarseness		Rectal bleeding		**Skin**	
Fatigue		Nose bleeds		Blood in stool		Pallor	
Fever		Voice change		Constipation		Rash	
Weight change		Dental problems		Diarrhea		Swelling	
Nervous System		**Heart and Lungs**		Nausea		**Psychiatric**	
Headaches		Chest pain		Vomiting		Nervous/anxious	
Dizziness		Leg swelling		**Muscle/Joints/Bones**		Self-injury	
Fainting		Palpitations		Arthralgia (joint pain)		**Other**	
Memory loss		Apnea		Back pain		**Urinary System**	
Eyes/Ears/Throat		Chest tightness		Gait problem		Frequent urination	
Redness		Wheezing/Stridor		Myalgia (muscle pain)		Blood in urine	

Obstructive Sleep Apnea Evaluation

Epworth Sleepiness Scale:

How likely are you to doze off or fall asleep in the following situations? Use the following scale to choose the most appropriate number for each situation.

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	
1. Sitting and Reading	
2. Watching TV	
3. Sitting inactive in a public place (e.g. a theater or a meeting)	
4. As a passenger in a car for an hour without a break	
5. Lying down to rest in the afternoon when circumstances permit	
6. Sitting and talking to someone	
7. Sitting quietly after lunch with alcohol	
8. In a car, while stopped for a few minutes in traffic	
Total Score:	

Sleep Apnea Treatment:

Question	
1. Are you currently using a dental device for snoring or sleep apnea?	Type of device
2. Have you ever worn a dental device or snoring or sleep apnea?	Type of device
3. Are you currently using CPAP/bi-level therapy? ☐ Yes ☐ No	
4. Have you ever been placed on CPAP/Bi-level therapy? ☐ Yes ☐ No	When did you start therapy?
5. Have you ever had surgery for snorting or sleep apnea? ☐ Yes ☐ No	

Sleep Behaviors: Please mark all that apply.

Behavior	
I have sometimes fallen asleep at inappropriate times such as driving, eating, or during a conversation.	
I have been told that I snore loudly.	
I sometimes wake up with a headache.	
I have been told that I stop breathing when I sleep.	

Mental Health History: Please mark all that apply.

Have you ever been diagnosed with any of the following:

Alcoholism	
Anxiety	
Bipolar Disorder	
Depression	
Obsessive Compulsive Disorder	
PTSD	
Schizophrenia	
Other:	

1. Have you ever been hospitalized for a psychiatric condition?
   a. If so when? ______________________
   b. Reason? ______________________
   c. Where? ______________________
2. Are you currently receiving treatment by a psychiatrist for medication management?
   a. Name of Psychiatrist ______________________
3. Are you currently receiving counseling from a psychologist?
   a. Name of Psychologist? ______________________
4. Over the last 2 weeks, how often have you been bothered by the following problems (score in the box below)?

0 = not at all
1= Several days
2= More than half the days
3= Nearly every day

a) Little interest of pleasure in doing things	
b) Feeling down, depressed, or hopeless	
c) Trouble falling or staying asleep or sleeping too much	
d) Feeling tired or having little energy	
e) Poor appetite or overeating	
f) Feeling bad about yourself, or that you are a failure, or have let yourself or family down	
g) Moving or speaking slowly where other people have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual	
Total Score:	

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

Rex Bariatrics

Name: ____________________________

DOB: __________________

NUTRITIONAL AND DIET QUESTIONNAIRE

A. Weight/Dieting History:

1. When did you begin to struggle with weight gain?
   a. Life-long struggle since childhood
   b. At age ________

2. Please list your heaviest adult weight (exclude pregnancies): __________ lbs __________ age.

3. Please list your lowest adult weight: __________ lbs __________ age.

4. Have you tried weight loss through structured dieting or other treatment? ☐ Yes ☐ No

5. If yes, list all food/ liquid diets or treatments attempted. Many insurance carriers require this information; therefore, please provide an accurate and complete listing.

Common Diets/Programs:
21 Day Diet
Atkins/Low Carb
Grapefruit
Jenny Craig
Liquid Protein
Metabolife
Nutri-System
Optifast/Medifast
Paleo
Physicians Weight Loss Center
Slim Fast
South Beach Diet
TOPS
Weight Watchers
Volumetrics
Zone Diet

Behavioral Treatments:
Diet Counseling/Worked with Dietitian
Exercise Trainer
Hypnosis
Personal Physician
Residential Diet Center

Name of Diet/Treatment	Lbs. Lost	Physician directed?

6. List all medications used by you for weight loss. Listed below are the most common medications. Please provide an accurate and complete list of any medications used in the past: Acutrim, Alli, Bontril, Didrex, Phentermine, Xenical, Dexatrim, Fen/Phen, Meridia, Redux.

7.

Medication & Dose	Start year	Length (Mos.)	Lbs. Lost	Physician directed

NUTRITIONAL PRE-SCREENING ASSESSMENT

8. What is motivating you to have weight loss surgery? Please list 3 reasons that will help motivate you to meet your goals.
    a.____
    b.____
    c.____

9. Have you had weight loss surgery in the past?
    a. Physician:______________________
    b. Date:______________________
    c. Type of Surgery: ______________________
    d. Weight When You Began Program:______________
    e. Total Pounds Lost:______________________

10. Have you ever been diagnosed and/ or have been treated for an eating disorder in the past?
    *a. Explain*______________________

11. Do you have diabetes?
    a. No
    b. Yes
        i. Type 1 Diabetes
        ii. Type 2 Diabetes (known as adult onset)

    Are you testing daily blood sugars daily? __________
    If yes, what is your recent blood sugar range? ____________
    Do you use insulin? _________
        Type________ Units________
        Type________ Units________

12. Are you on dialysis? ______________________
    *Renal dietitian contact info:*______________________

13. Current use of nicotine?
    (ie. Cigarettes/e-cigarettes/cigars/pipes/chewing tobacco/nicotine gums or patches)
    a. Type? ______________________
    b. Frequency/Amount ______________________

14. If you are a female of childbearing years,
    a. Have you had a baby in the last year? ______________________
    b. Are you currently breastfeeding? ______________________

NUTRITIONAL PRE-SCREENING ASSESSMENT

Diet Behaviors (circle all that apply)

1. Current challenges to improving my health include:
   a. Lack of time
   b. Lack of motivation
   c. Work Schedule
   d. Too expensive
   e. Social Calendar
   f. Family responsibility
   g. Illness or physical limitation
   h. Traveling for work, etc
   i. Other________________

2. My hidden sources of extra calories most likely come from:
   a. Large portions
   b. Soda/other beverages
   c. Sweets
   d. Chips
   e. Fried foods
   f. Eating while cooking
   g. Going out to eat
   h. Eating with distractions (TV/driving/etc)
   i. Eating when upset/stressed
   j. Eating when bored
   k. Other:________________

3. How do you feel about making behavioral changes?
   a. Ready to start making changes now
   b. Ready to think about making changes
   c. Not ready to make any changes to my current lifestyle

4. How many meals do you eat out per week?

a. Breakfast: ______	Fast food	Café	Cafeteria	Restaurant
b. Lunch: ________	Fast food	Café	Cafeteria	Restaurant
c. Dinner: ________	Fast food	Café	Cafeteria	Restaurant

5. Do you skip any meals?
   a. Breakfast — How many days per week?______
   b. Lunch — How many days per week?______
   c. Dinner — How many days per week?______

6. How often do you eat between meals?
   a. Seldom
   b. 1 time per day
   c. 2 time per day
   d. Graze throughout the day

7. What best describes your evening meal?
   a. Seldom eat dinner
   b. Lightest meal of the day
   c. Moderate size meal
   d. Largest meal of the day

8. Which sources of protein do you eat most often?
   a. Red meat (beef and pork)
   b. Fish and Chicken
   c. Eggs and Dairy
   d. Tofu, beans, and lentils

9. How your proteins are normally prepared? (choose all that apply)
   a. Grilled
   b. Sautéed with butter/ oils
   c. Baked/ Roasted
   d. Fried

NUTRITIONAL PRE-SCREENING ASSESSMENT

10. How many servings of fruit do you consume each day: ____________________

11. How many servings of vegetables do you consume each day: ______________
    a. Prepared with cheese, butter, or dressing
    b. Canned
    c. Fresh
    d. Frozen

12. Which types of carbohydrates do you choose most often:
    a. I avoid carbs
    b. Whole grains (brown rice/bulgar/barley/quinoa/ whole grain breads)
    c. Starchy vegetables (potatoes/peas/corn/beans)
    d. White/refined carbs (white rice/white pasta/white bread)
    e. Sweets (candies/cakes/muffins/etc)

13. How often do you eat low-fat dairy products?
    a. Seldom
    b. 1-2 times per week
    c. 1 time per day
    d. 2 times per day

14. Which types of drinks do you choose most often?
    a. Water
    b. Flavored water
    c. Fruit juice
    d. Coffee
    e. Sweet Tea
    f. Unsweet Tea
    g. Regular Soda
    h. Diet Soda/ seltzer waters

15. How many ounces of water do you drink on average each day? _________ ounces

16. How much alcohol do you consume?
    a. Less than 1 beverage per month
    b. 2-4 beverages per month
    c. 1-2 beverages per week
    d. 1-2 beverage per day
    e. 2-3 beverages per day
    f. Specify other: ______________________

17. How often do you exercise for 20 minutes or more each week?
    a. Seldom
    b. 1-2 times per week
    c. >3 times per week

    Please specify current exercise type/ duration___________________________
    Do you have any limitations/current barriers to increasing exercise?___________________
    What exercise has your physician asked you to do? _______________________________

18. How many hours of sleep do you typically get a night?
    a. 1-2 hours
    b. 3-4 hours
    c. 5-6 hours
    d. 7 or more hours.

19. What changes have you made since starting the bariatric program?
    a. Reduced refined carbohydrates ("white foods")
    b. Increased physical activity
    c. Increased water consumption
    d. _________________________