RMAP Patient Information Form **(Please Fill Out Completely)**

Surgeon Selected : ☐ Steven C. Simper MD, FACS ☐ Rodrick D. McKinlay MD, FACS ☐ Nicholas J. Paulk, MD

Please check one: ☐ Self Pay ☐ Insurance Pay **Procedure:** ☐ Gastric Bypass ☐ Gastric Banding ☐ Duodenal Switch ☐ Gastric Sleeve ☐ Revision ☐ Other _____

Name (First) (Middle) (Last)			*Date of Birth*	*Sex*	*Marital Status*
Address			*Phone (include area code)* ( )		*Cell Phone (include area code)* ( )
City	*State*	*Zip*	*Patient Email*		*Social Security #*
Occupation	*Employer*				*Your Ethnicity*
Employment Address			*Work Phone (include area code)* ( )		

Spouse / Guardian Information

Name (First) (Middle) (Last)			*Date of Birth*	*Relationship to Patient*	
Address	*City*	*State*		*Zip Code*	*Phone (include area code)* ( )
Employer	*Employment Address*				*Phone(include area code)* ( )

Emergency Contact (First) (Last)	*Relationship*	*Phone (include area code)* ( )	
Address	*City*	*State*	*Zip*

Primary Care Physician	*Address*	*Phone (including area code)* ( )	***Fax (include area code)*** ( )
Referring Physician	*Address*	*Phone (including area code)* ( )	***Fax (include area code)*** ( )

How did you hear about our clinic?

☐ *Physician*	☐ *Internet*	☐ *Radio*	☐ *TV*	☐ *Facebook*	☐ *Pinterest*	
☐ *Hospital*	☐ *Patient/Friend*	☐ *Billboard*	☐ *Work*	☐ *Insurance Company*	☐ *Yellow Pages*	☐ *Other* _____

PRIMARY HEALTH INSURANCE COMPANY (fill in completely)

Name of Insured (employee) _____

Name of Insurance Company _____

Address of Insurance Company _____

_____

Phone Number of Insurance Company ( ) _____

Employer's Name _____

Policy or ID Number of Employee _____

Group Number _____

Effective date of Coverage _____ /Copay_____

SECONDARY HEALTH INSURANCE COMPANY (fill in completely)

Name of Insured (employee) _____

Name of Insurance Company _____

Address of Insurance Company _____

_____

Phone Number of Insurance Company ( ) _____

Employer's Name _____

Policy or ID Number of Employee _____

Group Number _____

Effective date of Coverage _____ /Copay_____

It is my responsibility to pay any deductible amount, co-insurance or any other balance not paid by my insurance. Finance charges (at an annual rate not to exceed 18%) may be added when my account becomes 90 days past due. If it becomes necessary for my account to be turned over to a collection agency, I understand that an additional collection fee of up to 40% may be added to my balance. I understand I will be responsible to pay all collection fees, attorney fees and court costs. Confidential Record: Information contained here will not be released except when you have authorized us to do so. Note: This form will be submitted to your insurance company with the letter of medical necessity and your medical records.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to: **Steven C. Simper M.D., Rodrick D. McKinlay M.D., or Nicholas J. Paulk M.D.** This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information, including medical history and medical records, to my insurance company and immediate family.

Signed _____ Date:_____ Date Revised or Updated: _____

Patient/ Responsible Party

Rocky Mountain Associated Physicians Inc.

Medical History

Surgeon You Have Selected: ___**Dr. Simper** ___**Dr. McKinlay** ___**Dr. Paulk**

Date: _____ Date Revised or Updated: _____

Name: _____ Date of Birth:_____

Height_____ Weight _____

Describe your present symptoms briefly:

_____

_____

Chief Complaint: _____

Past Medical History

Previous Weight Loss Surgeries

Procedure	Hospital	Year	Procedure	Hospital	Year
1.			2.		

Previous Other Surgeries

Procedure	Year	Procedure	Year
1.		4.	
2.		5.	
3		6.	

Hospitalizations: List any diseases you have had that required hospitalization (approximate year)

_____ _____

_____ _____

Allergies: Drugs Other

_____ _____

_____ _____

Current Medication:

_____ Dose _____ Frequency_____ Condition_____

_____ Dose _____ Frequency_____ Condition_____

_____ Dose _____ Frequency_____ Condition_____

_____ Dose _____ Frequency_____ Condition_____

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_____ Dose _____ Frequency_____ Condition_____

_____ Dose _____ Frequency_____ Condition_____

_____ Dose _____ Frequency_____ Condition_____

Family History:

	Age	Health (good, fair, poor)	If deceased Cause	Age
Father				
Mother				
Brothers				
Sisters				
Husband/ Wife				
Sons				
Daughters				

Do you know of any blood relative who has or had: (Circle and give relationship)

Stroke	Cancer
High blood pressure	Tuberculosis
Diabetes	Bleeding tendency
Heart attack	Overweight (20-99 lbs)
Morbid obesity: (100 lbs over ideal weight)	

REVIEW OF SYSTEMS

Musculoskeletal

Do you have problems with your back?... Yes No
- Under physician care?..... Yes No
- Hip pain?..... Yes No
- Arthritic?..... Yes No
- Under physician care?..... Yes No

Swelling in the ankles?..... Yes No
Knee pain?..... Yes No
- Arthritic?..... Yes No
- Under physician care?..... Yes No

Have you ever had a problem with bleeding from a minor cut or tooth extractions?..... Yes No

Cardiovascular

Have you ever had chest pain or tightness....
- When exerting yourself?..... Yes No
- When excited or upset?..... Yes No
- After heavy meals?..... Yes No
- Do you have palpitations?..... Yes No
- Do you have heart problems?..... Yes No
- Under a physician's care?..... Yes No
- For how many years?..... _____

Does the chest pain.....
- Radiate down the arm?..... Yes No
- Occur only at rest?..... Yes No
- Disappear if you rest?..... Yes No
- Describe the chest pain _____
- Do you have high blood pressure?.. Yes No
- For how many years? ..... _____
- Under a physicians care? ..... Yes No

Pulmonary

Have you had shortness of breath:
- Doing normal work?..... Yes No
- Climbing a flight of stairs?..... Yes No
- Under a physician's care? ..... Yes No

Do you have a chronic cough?..... Yes No

Experience Asthma? ..... Yes No
- For how many years? ..... _____
- Under a physician's care? ..... Yes No
- Experience Obstructive Sleep Apnea?.. Yes No
- For how many years? ..... _____

Do you need more than one pillow to sleep?. Yes No

- Under a physician's care? ……. Yes No

Gastrointestinal

Have you ever had pain in the stomach which..

- Occurs one or two hours after a meal?.. Yes No
- Is brought on by eating fried, greasy foods?. Yes No
- Awakens you at night?…… Yes No
- Is relieved by eating?…… Yes No
- Is relieved by antacid medications?…… Yes No
- Occurs while eating or immediately after? Yes No
- Is relieved by a bowel movement?…. . Yes No

Do you have …

- Abdominal Cramps…… Yes No
- Alternating diarrhea and constipation… Yes No
- Pain during or after bowel movement… Yes No
- Blood in the stool?…… Yes No
- Black stools?…… Yes No
- Need for laxative or enemas? …… Yes No
  How often?_____
- Do you have Acid reflux? …… Yes No
- For how many years? …… _____
- Under a physician's care? …… Yes No

Genitourinary

Have you ever had..

Burning when urinating?…… Yes No
Loss of control of bladder?…… Yes No
Blood in the urine?…… Yes No
Trouble starting to urinate?…… Yes No
Trouble holding the urine?…… Yes No
Frequency/awakening at night?…… Yes No
Passed a kidney stone?…… Yes No

Reproductive

Men: Have you ever had…..

Prostate problems?…… Yes No
Prostate cancer?…… Yes No
Loss of sexual function?…… Yes No

Women:

Are you still having monthly menstrual periods? Yes No
Are your periods: Irregular__ Heavy__ Painful__
Have you ever had bleeding between periods? Yes No
Date of last period_____
Have you ever taken birth control pills? Yes No
Number of pregnancies __ Live births __Miscarriages ___
C- sections ___ Stillbirths ____ Premature births___
Complications?_____

Neurological

Have you ever fainted? …… Yes No
Have you ever had a convulsion?…… Yes No
Double vision?…… Yes No
Do you have severe headaches?…… Yes No

- Do they occur on one side of the head? Yes No

Weakness in arms or legs? …… Yes No

General

Do you have diabetes? …… Yes No

- For how many years? ……_____
- Under physicians care?…… Yes No
- Is it controlled with medication?…… Yes No

Do you experience extreme weakness or fatigue?. Yes No

- For how many years? ……_____
- Under a physician's care? …… Yes No

Hernia:

- Hiatal…… Yes No
- Umbilical…… Yes No
- Inguinal…… Yes No
- Untreated…… Yes No

Psychosocial

Do you experience any of the following conditions?

Bipolar disorder …… Yes No
Anxiety/panic disorder …… Yes No
Personality disorder …… Yes No
Psychosis …… Yes No
Depression …… Yes No

- Under a physicians care? …… Yes No
- Controlled with medication? …… Yes No

Personal Habits: (Check)

Tobacco Use

__None __Rare __Occasional __Frequent
How many years did/have you smoked? _____
If so when did you quit?_____

Alcohol Use

__None __Rare __Occasional __Frequent

Substance Abuse (Prescription/Illegal)

__None __Rare __Occasional __Frequent

WEIGHT MANAGEMENT HISTORY: This form is submitted to your insurance company with your letter of medical necessity. Approval or denial of your request for surgery depends on meeting the criteria put forth by your insurance company. Failure of multiple attempted dietary programs is a standard requirement. **Please fill out in detail.**

Please Indicate Approximate Weights – How many years have you been morbidly obese?_____

	Normal	Obese	Morbidly obese (100 pounds over ideal weight)
Childhood 1-10 years			
Adolescence 11-18 years			
Young Adult 18-30 years			
Adult 30-60 years			

Number of visits yearly to your physician for medical problems (asthma, hypertension, heart problems, joints, arthritis, respiratory, circulation, etc.) related to obesity. _____

Doctors who are following, or have followed, your weight problems: *NAME*	*Diet programs your doctor has you trying, or has had you try:*	**WT LOST**	**WT REGAINED**	**LENGTH OF PROGRAM**	**Est. Cost**

Please provide to the best of your knowledge any Weight Loss Program you have tried over the years. This information is key to surgery authorization. Do your best to provide as much info as possible.

PROGRAM	YEAR	WT. LOSS	WT. REGAINED	LENGTH OF PROGRAM	EXPENSE
WEIGHT WATCHERS					
TOPS					
OVEREATERS ANONYMOUS					
DIET CENTERS					
Jenny Craig Nutri System					
Quick Weight Loss Center					
LA Weight Loss					
BEHAVIOR MODIFICATION					
JAWS WIRED					
APPETITE SUPPRESSANT PILLS _____					
SHOTS					
HYPNOSIS					
HOODIA					
SET FOR LIFE					
200 PLUS – DANA THORNOCK					
HOW TO LOWER YOUR FAT THERMOSTAT					
HERBAL LIFE					
SLIM FAST					
AMERICAN HEART ASSOCIATION DIET					
SLIM FOR LIFE					
RICHARD SIMMONS					
ACUPUNCTURE					
FAD DIETS					
SELF IMPOSED DIET ATTEMPTS					
OTHER					

Physical Exercise - Last 5 years (what was your normal routine?)

PROGRAM	TIME SPENT per Week	WT. LOSS	WT. REGAINED	LENGTH OF PROGRAM	EXPENSE
Bicycling					
Jogging / Walking					
Swimming					
Spa / Gym					
Aerobic/Video tapes					
Health Rider					
Home gym equip.					
Curves					
Other					

Describe the limitations (physical, emotional, employment) morbid obesity imposes on you in your daily activity: