

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?

<input type="checkbox"/> Physician	<input type="checkbox"/> Internet	<input type="checkbox"/> Radio	<input type="checkbox"/> TV	<input type="checkbox"/> Facebook	<input type="checkbox"/> Pinterest	
<input type="checkbox"/> Hospital	<input type="checkbox"/> Patient/Friend	<input type="checkbox"/> Billboard	<input type="checkbox"/> Work	<input type="checkbox"/> Insurance Company	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> 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

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..

Do you have ...

- 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

- 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: <i>NAME</i>	<i>Diet programs your doctor has you trying, or has had you try:</i>	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: