UNC
DEPARTMENT OF SURGERY

Bariatric Surgery Intake Form

Dear Prospective Client,

Thank you for your interest in the Bariatric Program at UNC Chapel Hill. 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 attacheŘ◊ {l·ØŜ l·ă l· t5C anŘ ŜYl·ƛt l·ă l·y˝l·ŭűl·ŎKYˆŜyű ű2 YˆŜfŀăăl·ψŘl·Øŀă ƔˆYˆŜŘ◊dzyŎ◊ŜŘdz {dzō2ŜŎű [ƛyŜY . l·ℕƛl·úℕƛŎ {dzℕƎŜℕѐ Lyűl·ʔŜ C2ℕYˆ óăŜŎdzℕŜú hw LJℕƛyű l·yŘ 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, it will be reviewed and someone from our office will contact you to set up an initial appointment for you.

On your initial appointment, you will meet with the Nurse Practitioner, Registered Dietitian, and Clinical Psychologist. This detailed visit will combine an informational video, followed by an individualized psychological screening, a nutrition evaluation, and a physical examination. Blood work may be ordered.

After this appointment all your paperwork will be submitted to your insurance company for approval; this may take up to 6 weeks. Some insurance companies require supervised diet and exercise attempts for up to six months prior to covering your surgery.

Once approved, we will set up an appointment with one of our surgeons for your pre-surgical evaluation and if appropriate, a surgery date will then be set.

We look forward to meeting you,

Dr. Timothy Farrell
Dr. Meredith Duke
Dr. Wayne Overby
Tara Zychowicz, Nurse Practitioner
Lisa Prestia RN, Bariatric Coordinator

University of North Carolina Chapel Hill
The Division of GI Surgery/Bariatrics
Dept. of Surgery
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Chapel Hill, NC 27599-7081
919-966-8436 office
919-966-8440 fax
www.uncweightlosssurgery.com

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I am interested in: ☐ Gastric Bypass ☐ Gastric Band Revision ☐ Sleeve Gastrectomy

How did you hear about our program?

Patient Information

Name: Date of Birth:

Address:

Telephone: Home/Cell Work

Email Address:

Your current Height: **Your current Weight:**

BMI: **To Calculate Your BMI Click Here**

Referring MD:

Name:
Address:

Telephone: Email Address:

Primary MD:

Name:
Address:

Telephone: Email Address:

Psychologist:

Name:
Address:

Telephone: Email Address:

Insurance Information

Please list your insurance company name, ID/plan number and group number on this page.

Subscriber Name & Birthdate (if different from patient):

*(**BCBS or Wellpath plans with Duke, please check here:** ☐)*

Plan name:

1. Call your insurance company.

   Phone Number:

2. Give your insurance ID/plan and group number.

   Plan Number:

   Group Number:

3. Get the name of the person with whom you spoke to at the insurance office.

   Name:

4. Confirm that WEIGHT LOSS SURGERY is a **covered benefit**.

   →Ask, "Is weight loss surgery a covered benefit?" ☐ ¸9{ ☐ **bh**

5. Ask if there is a prerequisite to have a supervised diet before surgery.

   →*Ask, "Do I need a special diet or exercise plan completed before surgery?"

   ☐ ¸9{ ☐ **bh**

   (Most companies require 6-12 months diet/exercise before surgery.)

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Bariatric History:

How long have you been looking into having weight loss assistance? Years

Have you ever been evaluated for weight loss surgery before? ☐ YES ☐ NO

When did weight become a problem for you? ☐ Child ☐ Teen ☐ Adult ☐ w/pregnancy

At what age did you first begin dieting: Years Old

Are your family members heavy? ☐ YES ☐ NO

List relation to family members (sibling, mother, father, etc.):

What do you feel has caused you to be heavy?

☐ Major Illness ☐ Major Stressor ☐ Medication ☐ Marriage

☐ Trauma ☐ Travel ☐ Divorce

☐ Food choices ☐ Inactivity ☐ Genetics

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 meals:

Do you drink sugar-sweetened beverages? ☐ YES ☐ NO

Who does the grocery shopping/ meal preparation?

Are you allergic/ intolerant to any foods? ☐ YES ☐ NO

If so, which foods:

Do you eat big meals? ☐ YES ☐ NO

If so, which meals:

Do you find it difficult to feel full, or satisfied? ☐ YES ☐ NO

What are your favorite foods, or those you eat most often?

Do you consider yourself a slow eater or fast eater? ☐ SLOW ☐ FAST

How often do you eat outside of the home/ include fast food? /times per week

Exercise or Activity:

Describe your exercise habits:

How often do you exercise? ☐ None ☐ 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

How far can you walk without stopping? ☐ <10mins ☐ 15mins ☐ 30mins ☐ >30mins

Can you put on/tie you shoes and socks? ☐ YES ☐ NO

Can you perform adequate hygiene after going to the bathroom? ☐ YES ☐ NO

Can you perform necessary household chores/activities? ☐ YES ☐ NO

Can you fit in a theater/airplane/amusement park seat? ☐ YES ☐ NO

Psychological Eating/ Problems:

Do you have any mental health concerns? ☐ YES ☐ NO

If yes, what:

Do you ever have binges (eating a large amount of food in a short period of time)? ☐ YES ☐ NO

Have you ever been a victim of Physical, Sexual, or Emotional abuse? ☐ YES ☐ NO

Are you experiencing any major life stressors currently? ☐ YES ☐ NO

Are you under the care of a psychologist/ psychiatrist/ counsellor? ☐ YES ☐ NO
(If so, we need a letter of support)

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?

Please keep a food journal for a few days before your upcoming appointment and bring it with you.

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Personal Health History:

Medical Problems (Circle all that apply)

☐ Diabetes	☐ High Blood Pressure	☐ Sleep apnea	☐ COPD
☐ Heart Disease	☐ Reflux/Heartburn	☐ High Cholesterol	
☐ Stress Incontinence	☐ Gallstones	☐ Arthritis	
☐ Chronic Pain	☐ Low back pain	☐ Menstrual changes / 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	Hernia Repair
C-sections	Appendectomy	

List any other opertations and year:

Allergies:

Current Medications (Include Vitamins, Herbs, and Supplements):			
Medication	**Amount (mg)**	**Frequency**	**Since (year)**

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Social History:

Where are you from?

Where do you live now?

Education:

Describe your living arrangements:

Marital status: Children: ☐ YES ☐ NO

Any desire for children in future? ☐ YES ☐ NO

Current Occupation: Employer:

Years at this position: Can you take time off to recover? ☐ YES ☐ NO

Previous occupation (if disabled or unemployed)

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

Habits:

Do you (or did you) smoke? ☐ YES ☐ NO ☐ Quit /years ago

Average daily tobacco habit: packs/day for years

Do you drink alcoholic beverages? ☐ YES ☐ NO ☐ Quit /years ago

How many a day? Week? Month?

Do you use recreational drugs? ☐ YES ☐ NO ☐ Quit /years ago

Do you have, or have you had a problem with drugs or alcohol? ☐ YES ☐ NO

Explain:

Family History:

☐ **Cancer** ☐ **Heart attack** ☐ **Stroke** ☐ **Diabetes** ☐ **High B/P**

Biological Father (ALIVE) Age: Medical Hx:

Biological Mother (ALIVE) Age: Medical Hx:

Extended Family (Siblings, Grandparents, children): *(List anything of importance)*

Are you experiencing (currently):

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

Health Maintenance:

Do you see a healthcare provider regularly? ☐ YES ☐ NO

Do you see a dentist regularly? ☐ YES ☐ NO

When was your last (if applicable):

Mammogram Pap smear Colonoscopy

Prostate Exam Eye Exam

Have you had any Routine Diagnostic Studies: (please attach reports)

- ☐ Lab work
- ☐ Chest X-ray
- ☐ EKG
- ☐ Cardiology Tests
- ☐ Other:

Concerns, Questions, Comments?

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

_____

Signature of Patient ***Date***

SAVE & PRINT

You may also 'save' and send as an attachment via email to melissa_davis@med.unc.edu

Subject Line: Bariatric Intake Form (Secure)