



Insurance: _____

MRN: _____

Seminar: _____

Appt: ____/____/____ @ _____

For office use only. Please do not write in this space.

UCLA BARIATRIC SURGERY NEW PATIENT APPLICATION

Your appointment will be delayed if this form is incomplete

PLEASE PRINT LEGIBLY

PERSONAL INFORMATION:

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: Male Female

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Cell phone: (____) _____ - _____ Primary Language Spoken _____

E-Mail Address: _____

Current Occupation: _____

Marital Status: Single Married Divorced Widowed

Number of Children _____ Ages of Children _____

With whom do you reside?

Myself Spouse/Partner Children Roommate Others _____

Highest level of education:

- Middle School Graduate School
- High school diploma or equivalent None of the above
- Technical/vocational school Prefer not to answer
- College (2 or 4 year)

Have you ever been seen at a UCLA hospital or clinic for any reason? YES NO

What is your UCLA patient ID number?

PRIMARY CARE PHYSICIAN INFORMATION:

Provide the correct and COMPLETE contact information for your Primary Care Physician (PCP). It is important that we are able to easily and reliably communicate with your Doctor in order to give you the best care. Please fill out each requested item below. Email is optional.

Name: _____
Company: _____
Address: _____
City/Town: _____
State: _____ Zip/Postal Code: _____
Phone Number: (____) _____ - _____ Ext: _____
Fax Number: (____) _____ - _____
Email Address: _____

Please include other MD names that you would like us to notify about your consultation.

Name: _____
Company: _____
Address: _____
City/Town: _____
State: _____ Zip/Postal Code: _____
Phone Number: (____) _____ - _____ Ext: _____
Fax Number: (____) _____ - _____
Email Address: _____

INSURANCE INFORMATION:

Name as appears on card: _____ Type: HMO PPO Medi-cal Medicare
Insurance Company: _____ Medical Group: _____
Group #: _____ Member ID #: _____
Phone Number on back of card for Providers: (____) _____ - _____

BARIATRIC BACKGROUND INFORMATION:

How long have you been contemplating bariatric surgery? _____
Have you done any research regarding bariatric surgery? YES NO
If YES, what type _____
How did you hear about this program?
 Doctor: _____ Friend Internet Other: _____

DIETING HISTORY:

Age you first started dieting: _____ Approx. weight at age 18 _____

Mark all the diets you have been on in the past:

- Jenny Craig
- Atkins or Zone
- South Beach Diet
- Trim Spa
- Weight Watchers
- Lindora
- Phen Fen or its later derivatives
- Dr. Phil/ Dr. Ornish or similar programs
- Weight loss boot camps or 'farms'
- Personal trainer supervised weight loss program
- Optifast
- Nutrisystems
- Slimfast
- Optifast
- Thyroid Medications
- 'Speed' or similar drugs
- Xenical
- Meridia
- Alli
- Overeaters Anonymous/ similar group therapies
- Hypnosis
- Jaw Wiring
- Diet pills or shots (over the counter/ TV promotions/diet clinics)
- Dietitian supervised weight loss program
- None of the above
- Other: _____

In the past TWO years, which one of the following MD or nutritionist-supervised programs have you been on, for how long and how much weight did you lose?

Program	< 3 months	4-6 months	6 months+	I lost less than 10 lbs	I lost 10-20 lbs	I lost 20lbs+
Jenny Craig	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nutri-systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight watchers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opti-fast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lindora	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fen/Phen Redux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meridia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Xenical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Over the counter diet aids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atkins Diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What was the most successful weight loss you achieved and how much weight did you lose? What was your age?

What behaviors did you learn from dieting that you still use today?

FOOD PREFERENCE:

Are you a sweet eater? Yes No If so, what? _____

Frequency on a weekly basis? _____

Are you a pasta/bread/carbohydrates eater? Yes No If so, what? _____

Frequency on a weekly basis? _____

Are you a fast food eater? Yes No If so, what? _____

Frequency on a weekly basis? _____

Do you snack between meals? Yes No If so, what do you snack on? _____

Frequency on a weekly basis? _____

Is snacking from habit? Yes No Boredom? Yes No Do you binge eat? Yes No

How often? _____

On a typical day, how much soda or other non-alcoholic beverages do you consume daily?

Beverage	None	8oz or less (1 can)	16-24oz (2-3 cans)	36-64oz	More than 64oz
Soda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diet Soda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Juice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crystal Lite or similar artificially sweetened drink	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports drink (i.e. Gatorade)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Energy Drinks (i.e. Red bull)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decaffeinated coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee drink (i.e. latte, cappuccino)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PERSONAL MEDICAL HISTORY:

PLEASE MARK ALL THAT APPLY

Cardiac History:

- | | | |
|--|--|---|
| <input type="checkbox"/> High blood pressure
(including medication
controlled) | <input type="checkbox"/> Abnormal heart rhythms | <input type="checkbox"/> Known abnormal EKGs |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> I have or have had a
pacemaker | <input type="checkbox"/> Swelling of the legs
during the day |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Murmurs | <input type="checkbox"/> None of these |
| | <input type="checkbox"/> Pulmonary hypertension | <input type="checkbox"/> Other: _____ |

PERSONAL MEDICAL HISTORY (cont.):

Endocrine history:

- Insulin treated diabetes
- Oral medication treated diabetes
- Hyperlipidemia (cholesterol/other lipids)
- Hyperthyroidism**
- Hypothyroidism**
- Endocrine cancers (thyroid, adrenal, pituitary, etc)
- Hypoparathyroidism**
- None of these
- Other: _____

Pulmonary History:

- Known obstructive sleep apnea on CPAP or BiPap
- Obstructive sleep apnea NOT on CPAP or BiPap
- Never been tested for obstructive sleep apnea
- History of pneumonia
- Emphysema
- Asthma
- Shortness of breath on exertion (i.e. going up stairs)
- Lung or other airway cancer
- None of these
- Other: _____

Urinary History:

- Stress urinary incontinence
- "Suspension surgery" for stress incontinence
- Benign prostatic hypertrophy
- Any prostate cancer
- Frequent urinary tract infections
- Kidney failure history
- Dialysis dependent
- Urological cancers
- None of these
- Other: _____

Psychological history:

- Depression
- Anxiety
- Panic attacks
- Chronic fatigue
- Anorexia/bulimia
- History of suicide
- Obsessive compulsive disease
- Bipolar disorder
- Multiple personality disorder
- Schizophrenia or similar diagnosis
- None of these
- Other: _____

GYN History (women only):

- Menopause
- Irregular periods/vaginal bleeding not related to menopause
- Endometriosis
- Polycystic ovarian disease
- Infertility
- Tubal ligation
- Hysterectomy
- GYN hormones (i.e. birth control, depo shots)
- Any GYN cancer
- None of these
- Other: _____

PERSONAL MEDICAL HISTORY (cont.):

Gastrointestinal History:

- Heartburn (gastric reflux disease)
- Gastric emptying problems (i.e. frequent non-intentional vomiting)
- Barretts esophagitis
- Pernicious anemia
- Gastric polyps
- Biliary colic (gallbladder pains)
- Diarrhea
- Constipation
- Diagnosed irritable bowel syndrome
- Celiac sprue
- Lactose intolerance
- Inflammatory bowel disease (i.e. uncreative colitis, Crones disease)
- Rectal bleeding
- Colon or small intestine polyps
- Fatty liver
- Liver cirrhosis
- Any gastrointestinal cancer
- None of these
- Other: _____

Hematological History:

- Abnormal bleeding (do not clot easily)
- Hemophilia
- Known clotting disorder (i.e. hypercoagulable disease)
- History of pulmonary embolus
- IVC filter
- History of blood transfusion
- Any for m of immunodeficiency (i.e. HIV)
- Hepatitis A exposure
- Hepatitis B exposure but blood tests normal
- Hepatitis C exposure but blood tests normal
- Hepatitis B
- Hepatitis C
- Leukemia
- Lymphoma
- None of these
- Other: _____

Neurological History:

- Stroke
- Migraines or other severe headaches
- Pseudotumor cerebri
- Tumors
- None of these
- Other: _____

Musculoskeletal History:

- Joint pains in neck & shoulders related to being overweight
- Back pain related to being overweight
- Hip, knee or foot pains related to being overweight
- Diagnosed with early arthritis
- Severe arthritis or joint loss requiring orthopedic surgery
- History of orthopedic surgeries
- I have been told that my weight prevents me from having necessary orthopedic surgery
- None of these
- Other: _____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations?
Answer considering how you have felt over the past week or so.

- 0 = Would never doze
- 1 = Slight chance of dozing
- 2 = Moderate chance of dozing
- 3 = High chance of dozing

1. Sitting and reading	<input type="text"/>
2. Watching TV	<input type="text"/>
3. Sitting inactive in a public place (e.g., theater or meeting)	<input type="text"/>
4. As a passenger in a car for an hour without a break	<input type="text"/>
5. Lying down to rest in the afternoon when able	<input type="text"/>
6. Sitting and talking to someone	<input type="text"/>
7. Sitting quietly after a lunch without alcohol	<input type="text"/>
8. In a car while stopped for a few minutes in traffic	<input type="text"/>

My Sleep Score:

STOP/BANG OBSTRUCTIVE SLEEP APNEA ASSESSMENT:

STOP

S (snore) Have you been told that you snore?

T (tired) Are you often tired during the day?

O (obstruction) Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep?

P (pressure) Do you have high blood pressure or on medication to control high blood pressure?

BANG

B (BMI) Is your body mass index greater than 28?

A (age) Are you 50 years old or older?

N (neck) Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greater than 16 inches.

G (gender) Are you a male?

PERSONAL MEDICAL HISTORY (cont.):

Other History:

- Skin cancers or precancerous lesions
- Hair loss
- Psoriasis
- Eczema
- Nearsightedness
- Farsightedness
- Blindness in one eye
- None of these
- Other: _____

Surgeries:

DATE	SURGERY

Recent Hospitalizations:

DATE	ILLNESS	TREATMENT

PERSONAL MEDICAL HISTORY (cont.):

Prescription Medications:**

MEDICATION	DOSE	FREQUENCY

Non-Prescription, Over the Counter, or Herbal Medications/Supplements:**

MEDICATION	DOSE	FREQUENCY

**If your list of surgeries or medication exceeds the given amount of space, there is more space for you to fill out at the last page of this application form.

Are you opposed to blood transfusions for cultural or religious reasons? YES NO

PERSONAL MEDICAL HISTORY (cont.):

ALLERGIES:

- Food
- IV dye allergy (i.e. for CT scans or other x-ray tests)
- No drug or food allergy
- Allergies to medications or chemicals (Please list below)

1. _____
2. _____
3. _____

SOCIAL / FAMILY HISTORY:

Family History:

- | | | |
|--|---|---|
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Blood clots and embolism | <input type="checkbox"/> Neurological disorders (i.e. Parkinsons, Alzheimers) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypderlipidemia | |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Strokes | |

Current alcohol history:

	None	Less than 5 drinks/week	More than 6 drinks/week
Beer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other liquor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I have a history of alcohol abuse in the past. Yes No

If past user and have quit, please indicate year/age _____

Current tobacco/nicotine history:

	None	Less than a pack/roll/box per day	More than a pack/roll/box per day
Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cigar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chewable tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If past user and have quit, please indicate year/age _____

Do you currently use drugs including medical marijuana? Yes No

If yes, please elaborate on the type and amount. _____

I have a history of drug abuse in the past. Yes No

If past user and have quit, please indicate year/age _____

Do you exercise regularly? Yes No If so, what do you do: _____

Do you have any physical restrictions that keep you from exercising? Yes No

Reason? _____

SOCIAL / FAMILY HISTORY (cont.):

Having a support system before and after surgery is vital to successful and safe outcomes. The UCLA program believes that patients should not pursue surgery unless this issue is firmly addressed and confirmed prior to surgery. Please mark all that apply.

- | | | |
|--|---|---|
| <input type="checkbox"/> No support system | <input type="checkbox"/> Relatives | <input type="checkbox"/> Groups (i.e. overeaters anonymous) |
| <input type="checkbox"/> Spouse | <input type="checkbox"/> Friends | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Children | <input type="checkbox"/> Religious organization | |
| <input type="checkbox"/> Siblings | | |

A history of exposure to various forms of abuse is common in morbidly obese patients. If you have been a victim of any form of mental or physical abuse, please elaborate in the space below.

What are your primary goals and reasons to pursue weight loss surgery?

What are your greatest fears and concerns about weight loss surgery?

PROGRAM POLICY:

1. Prior to a consultation visit, the UCLA Bariatric Program requires the following:
 - Complete application
 - You may either attend seminar in person, view it live on line or look at the slides posted on our website(please refer to [www. bariatrics.ucla.edu](http://www.bariatrics.ucla.edu) or call 310-206-7163 for more information).

Unfortunately, there are no exceptions to these prerequisites.

2. If we are unable to contact you, our assumption will be that you are no longer interested in participating in the UCLA Bariatric Surgery Program. The office will attempt to contact the patient 3 times before their application and file is deactivated.
3. The office must be given at least a 24 hour notice for appointment reschedules. Rescheduling or canceling less than 24 hours before your appointment will be considered a “No Show”. Patients who chronically reschedule or have 3 No Shows signify a lack of dedication to the surgical weight loss process and for that reason, will be deemed an inappropriate surgical candidate.

By submitting this application, I confirm my interest in pursuing bariatric surgery at UCLA and will comply with the program’s policy and regulations.

Sign or type: _____ **Date:** _____

Congratulations on completing the New Patient Application!

Please attach a copy of the **front and back of your insurance card** and send the completed application by one of the methods below.

1. Email the application form and your insurance card to UCLABariatrics@mednet.ucla.edu
2. Fax completed application to (310) 267-4632
3. Mail to: UCLA Bariatric Surgery Department
10833 Le Conte Ave. 72-266 CHS
Los Angeles, CA 90095

Please call our office at (310) 825- 7163 three business days after submitting to follow up. We thank you for your interest in the UCLA Bariatric Surgery Program and look forward to hearing from you.

ADDITIONAL SURGERIES/MEDICATIONS: