David Geffen School of Medicine | UCLA Health System

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

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
- ◻ 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)
- ◻ Dr. Phil/ Dr. Ornish or similar programs
- ◻ Weight loss boot camps or 'farms'
- ◻ Personal trainer supervised weight loss program
- ◻ 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	◻	◻	◻	◻	◻	◻
Nutri-systems	◻	◻	◻	◻	◻	◻
Weight watchers	◻	◻	◻	◻	◻	◻
Opti-fast	◻	◻	◻	◻	◻	◻
Lindora	◻	◻	◻	◻	◻	◻
Fen/Phen Redux	◻	◻	◻	◻	◻	◻
Meridia	◻	◻	◻	◻	◻	◻
Xenical	◻	◻	◻	◻	◻	◻
Over the counter diet aids	◻	◻	◻	◻	◻	◻
Atkins Diet	◻	◻	◻	◻	◻	◻
Other:_____	◻	◻	◻	◻	◻	◻
Other:_____	◻	◻	◻	◻	◻	◻
Other:_____	◻	◻	◻	◻	◻	◻

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	□	□	□	□	□
Diet Soda	□	□	□	□	□
Juice	□	□	□	□	□
Crystal Lite or similar artificially sweetened drink	□	□	□	□	□
Sports drink (i.e. Gatorade)	□	□	□	□	□
Energy Drinks (i.e. Red bull)	□	□	□	□	□
Coffee	□	□	□	□	□
Decaffeinated coffee	□	□	□	□	□
Coffee drink (i.e. latte, cappuccino)	□	□	□	□	□

PERSONAL MEDICAL HISTORY:

PLEASE MARK ALL THAT APPLY

Cardiac History:

□ High blood pressure (including medication controlled)
□ Heart attack
□ Congestive heart failure
□ Abnormal heart rhythms
□ I have or have had a pacemaker
□ Murmurs
□ Pulmonary hypertension
□ Known abnormal EKGs
□ Swelling of the legs during the day
□ None of these
□ Other:_____

PERSONAL MEDICAL HISTORY (cont.):

Endocrine history:

- ☐ Insulin treated diabetes
- ☐ Oral medication treated diabetes
- ☐ Hyperlipidemia (cholesterol/other lipids)
- ☐ **Hyper**thyroidism
- ☐ **Hypo**thyroidism
- ☐ Endocrine cancers (thyroid, adrenal, pituitary, etc)
- ☐ Hypo**para**thyroidism
- ☐ 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	
2. Watching TV	
3. Sitting inactive in a public place (e.g., theater or meeting)	
4. As a passenger in a car for an hour without a break	
5. Lying down to rest in the afternoon when able	
6. Sitting and talking to someone	
7. Sitting quietly after a lunch without alcohol	
8. In a car while stopped for a few minutes in traffic	

My Sleep Score: 0

STOP/BANG OBSTRUCTIVE SLEEP APNEA ASSESSMENT:

STOP

S (snore) Have you been told that you snore?	No
T (tired) Are you often tired during the day?	No
O (obstruction) Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep?	No
P (pressure) Do you have high blood pressure or on medication to control high blood pressure?	No

BANG

B (BMI) Is your body mass index greater than 28?	No
A (age) Are you 50 years old or older?	No
N (neck) Are you a male with a neck circumference greater than 17 inches, or a female with a neck circumference greaterthan 16 inches.	No
G (gender) Are you a male?	No

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:

- □ Obesity
- □ Cancer
- □ Diabetes
- □ Heart disease
- □ Blood clots and embolism
- □ High blood pressure
- □ Hypderlipidemia
- □ Strokes
- □ Neurological disorders (i.e. Parkinsons, Alzheimers)
- □ Other:_____

Current alcohol history:

	None	Less than 5 drinks/week	More than 6 drinks/week
Beer	□	□	□
Wine	□	□	□
Other liquor	□	□	□

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	□	□	□
Cigar	□	□	□
Chewable tobacco	□	□	□

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.

- □ No support system
- □ Spouse
- □ Children
- □ Siblings
- □ Relatives
- □ Friends
- □ Religious organization
- □ Groups (i.e. overeaters anonymous)
- □ Other:_____

A history of exposure to various forms of abuse is common in morbidly obsess 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 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: