

UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS

Adult Bariatric Surgery Program

**Health History Questionnaire –
Medical / Nutritional**

NAME:

REG #:

BIRTHDATE:

Please also fill out the upper right hand corner on all pages.

SURGICAL PROCEDURE YOU ARE INTERESTED IN: **LAPAROSCOPIC GASTRIC BYPASS (ROUX-EN-Y)**
 LAPAROSCOPIC GASTRIC BANDING
 LAPAROSCOPIC SLEEVE GASTRECTOMY **UNDECIDED**

PERSONAL INFORMATION

LAST NAME: FIRST: M.I.: MAIDEN: AGE:

ADDRESS:

CITY: STATE: ZIP CODE:

PHONE NUMBER WHERE CAN YOU BE REACHED OR RECEIVE A MESSAGE AT DURING THE DAY?

HOME: _____ CELL: _____ WORK: _____ OTHER: _____

E-MAIL ADDRESS:

DO YOU WISH TO RECEIVE COMMUNICATION VIA E-MAIL? YES NO

SPOUSE

LAST NAME: FIRST:

YOUR PRIMARY CARE PHYSICIAN

PHYSICIAN NAME:

ADDRESS:

CITY: STATE: ZIP

PHONE:

REFERRING PHYSICIAN (IF DIFFERENT FROM PRIMARY CARE PHYSICIAN)

PHYSICIAN NAME:

ADDRESS:

CITY: STATE: ZIP:

PHONE:

PRIMARY INSURANCE COMPANY

INSURANCE COMPANY NAME:

POLICY HOLDERS NAME: RELATIONSHIP TO PATIENT:

POLICY NUMBER: GROUP/PLAN NUMBER:

CUSTOMER SERVICE PHONE NUMBER: CONTACT PERSON:

PROVIDER INQUIRY/PRE-CERTIFICATION PHONE NUMBER:

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YOU WILL NEED TO CALL YOUR INSURANCE COMPANY TO ASK THE FOLLOWING QUESTIONS BEFORE YOUR FIRST APPOINTMENT.

PROCEDURE CODES:

LAPROUX-EN-Y GASTRIC BYPASS: CPT CODE: 43644

LAP ADJUSTABLE BANDING: CPT CODE: 43770

LAP SLEVE GASTRECTOMY: CPT CODE: 43775

DIAGNOSIS CODE:

MORBID OBESITY: ICD-9 CODE: 278.01

1. REPRESENTATIVE AT INSURANCE COMPANY (NAME): _____
2. DO I HAVE BENEFIT COVERAGE FOR MEDICALLY NECESSARY WEIGHT LOSS SURGERY FOR MORBID OBESITY FROM MY INSURANCE COMPANY? YES NO
3. IS IT COVERED IF I HAVE SURGERY AT THE UNIVERSITY OF MICHIGAN? YES NO
4. WHAT IS MY INSURANCE BENEFIT OR EXCLUSION

5. DOES MY WEIGHT LOSS SURGERY BENEFIT REQUIRE A MEDICALLY SUPERVISED WEIGHT LOSS TRIAL PROGRAM? YES LENGTH OF PROGRAM? _____ NO SKIP NEXT QUESTION.
6. IS A PRIMARY CARE PHYSICIAN REQUIRED TO COMPLETE THE WEIGHT LOSS DOCUMENTATION OR CAN A SPECIALTY DOCTOR RECOMMEND AND FOLLOW THE WEIGHT LOSS TRIAL PROGRAM?

7. WHAT IS MY CO-PAY FOR A PRIMARY CARE OFFICE VISIT? \$ _____
8. WHAT IS MY CO-PAY FOR A SPECIALIST CARE OFFICE VISIT (EXAMPLE: LAP BAND ADJUSTMENT)?
\$ _____ (*ADJUSTMENTS FOR THE LAP BAND: CPT CODE: HCPCS S2083*)
9. WILL THE NUTRITION EVALUATION APPOINTMENT BE COVERED IF THE DIAGNOSIS IS MORBID OBESITY? (DIAGNOSIS CODE: 278.01) YES NO
10. WHEN IS THE EFFECTIVE DATE OF THE POLICY? _____ (MM/DD/YYYY)
11. WHEN IS THE RENEWAL DATE? _____ (MM/YYYY)
12. DO I HAVE A PRE-EXISTING CLAUSE? YES NO SKIP TO QUESTION # 14
13. WHEN IS THE END DATE OF THE PRE-EXISTING CLAUSE? _____ (MM/DD/YYYY)
14. IS A REFERRAL REQUIRED FROM MY INSURANCE COMPANY? YES NO
15. WHAT IS MY DEDUCTIBLE PER CALENDAR YEAR? \$ _____
HOW MUCH HAS BEEN MET? \$ _____
16. WHAT IS THE MAXIMUM OUT-OF-POCKET COST PER CALENDAR YEAR? \$ _____
HOW MUCH PAID TO DATE? \$ _____
17. WHAT IS THE CO-INSURANCE FOR MY POLICY? _____
18. WHAT IS MY IN-PATIENT SURGICAL CO-PAY TO THE DOCTOR? \$ _____
19. WHAT IS MY OUT-PATIENT SURGICAL CO-PAY TO THE DOCTOR? \$ _____
20. WHAT IS MY IN-PATIENT SURGICAL CO-PAY TO THE HOSPITAL? \$ _____
21. WHAT IS MY OUT-PATIENT SURGICAL CO-PAY TO THE HOSPITAL? \$ _____

EMPLOYER: _____

OCCUPATION OR TYPE OF WORK PERFORMED: _____

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SUPPORT SYSTEM / SOCIAL HISTORY

GENDER: MALE FEMALE MARITAL STATUS: SINGLE MARRIED DIVORCED OTHER
 DO YOU HAVE CHILDREN? YES NO AGES: _____

Please list any family, friends, organizations, etc. who have offered to help you with household duties, child care, emotional, physical, needs after your surgery.

Name:	Relationship to you:

Tobacco Products: Do you use, or have you ever used any tobacco products? Yes No Quit

If yes: cigarettes chew pipe How much used per day? _____
 Year you started? _____ If you quit, year you quit? _____

Alcohol: Do you drink any alcoholic beverages? Yes No

How many alcoholic drinks do you consume per day? _____ per week? _____
 What type of alcohol do you drink? Beer Wine Liquor If you quit, when? _____

History of Drug Abuse? Yes No If you quit, when? _____

Type of drug(s) if yes: _____

FAMILY HISTORY: Please check the box and write in family members affected

Be sure to identify if the family member is from your father or mother's side of the family, such as:

- | | | | |
|----------------------|-----------------|----------------------|-----------------|
| Father | Paternal Aunt | Mother | Maternal Aunt |
| Paternal Grandmother | Paternal Uncle | Maternal Grandmother | Maternal Uncle |
| Paternal Grandfather | Paternal Cousin | Maternal Grandfather | Maternal Cousin |

Check if Applicable	Family member affected:	Check if Applicable	Family member affected:
<input type="checkbox"/> Heart Disease		<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Stroke		<input type="checkbox"/> Obesity	
<input type="checkbox"/> Blood Clot		<input type="checkbox"/> Blood Disorder	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Kidney disease	
<input type="checkbox"/> Cancer (Type): _____ _____		<input type="checkbox"/> Thyroid Disease	

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MEDICAL INFORMATION Do you have, or have you had, any of the following conditions? Circle **Y** for Yes and **N** for No

Y	N	Diabetes: Type 1 <input type="checkbox"/>	Type 2 <input type="checkbox"/>	Y	N	Crohn's Disease, Colitis
Y	N	High blood pressure		Y	N	Irritable Bowel Syndrome
Y	N	High cholesterol		Y	N	Stomach Ulcers (Peptic)
Y	N	Chest pain, angina		Y	N	Heartburn, indigestion, GERD
Y	N	Heart failure		Y	N	Headaches, how often: _____
Y	N	Heart attack, when: _____		Y	N	Thyroid disease (specify): _____ Hypothyroidism <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/>
Y	N	Emphysema		Y	N	Lupus
Y	N	Asthma		Y	N	Kidney Disease
Y	N	Sleep Apnea Do you use (circle): CPAP BiPAP		____ hrs	How many hours of sleep do you average each night?	
Y	N	Arthritis, joint pain: knees <input type="checkbox"/> hips <input type="checkbox"/> ankles <input type="checkbox"/> wrist <input type="checkbox"/> hands <input type="checkbox"/> back <input type="checkbox"/> Other: _____		Y	N	Hernia, what kind: _____ Has it been repaired? Yes <input type="checkbox"/> No <input type="checkbox"/>
Y	N	Chronic low back pain		Y	N	Urinary incontinence
Y	N	Gallbladder disease Has it been removed? Yes <input type="checkbox"/> No <input type="checkbox"/>		Y	N	Polycystic ovarian syndrome
Y	N	Fatty liver disease		Y	N	Have you ever had Blood Clot, Deep Vein Thrombosis, or Pulmonary Embolism? (Bring lab works and other tests from that time) <input type="checkbox"/> DVT: When? _____ What was the cause? _____ _____ <input type="checkbox"/> Pulmonary Embolism: When? _____ What was the cause? _____ _____
Y	N	Do your religious beliefs allow blood transfusions if medically necessary?				
Y	N	Have you ever had Blood transfusion(s)? Date(s): _____				
Y	N	Hepatitis (please circle): A B C				
Y	N	HIV				
Y	N	If female, last monthly cycle: Date: _____ Menopause: _____		Y	N	Dependent on wheelchair, except when: _____
Y	N	Cancer: What kind: _____ When: _____ Treatment received & completed: _____ _____ Surgery: _____ Radiation: _____ Chemo: _____		Y	N	Do you participate in any form of physical activity on a regular basis? What? _____ How often? _____ How many minutes? _____
Y	N	Psychological Diagnosis (Current or Past): <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Other: _____		How many flights of stairs can you climb and blocks can you walk without experiencing shortness of breath? How many stairs can you climb? _____ How many blocks can you walk? _____		

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Record **all Weight Loss Medications** taken (over the counter and prescription).

Please check the one that applies	Name of the Medication	Dosage or Strength	How often did you take it?	When did you last take it (date)?
Over the Counter <input type="checkbox"/> Prescription <input type="checkbox"/>				
Over the Counter <input type="checkbox"/> Prescription <input type="checkbox"/>				
Over the Counter <input type="checkbox"/> Prescription <input type="checkbox"/>				

Current weight in pounds: _____
Height in inches: _____

At what age were you when your weight became a problem?

Highest weight in pounds: _____

Your goal (desired) weight in pounds: _____

Best Effort at Weight Loss:

Lost _____ pounds on _____ (Diet or program)

Eating Habits and Practices: Please check **all** the boxes which apply.

I eat:

- | | | |
|---|---|--|
| <input type="checkbox"/> to make me happy | <input type="checkbox"/> when I'm frustrated or upset | <input type="checkbox"/> out of habit |
| <input type="checkbox"/> to reward myself | <input type="checkbox"/> to comfort myself | <input type="checkbox"/> because I'm bored |
| <input type="checkbox"/> to make me feel "better" | <input type="checkbox"/> any other reasons (specify): _____ | |

I currently, or have at any time in the past, practiced the following to control my weight:

- binge eating; describe: _____
- purging (vomiting, use of laxatives, "water pills", or excessive exercise)
- eating past the feeling of being full
- getting up in the middle of the night & eating
- eating the majority of your calories in the evening
- skipping meals; if yes which meal(s) breakfast lunch dinner
- other (specify): _____

Record **ALL** weight loss **Attempts**, especially professionally supervised (physician, and/or registered dietitian) programs.

Date Month/Year (Most recent first)	Amount of time on diet	Weight lost on diet	Amount of time weight loss maintained	Name of diet, program used	Doctor or dietitian who supervised

If you need more space, please attach an additional page

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Use the following scale to choose the most appropriate answer for each situation. If you have a CPAP or BiPAP machine please answer the questions based on when you are using the machine.

Epworth Sleepiness Scale:

- 0 = would *never* doze or sleep
- 1 = *slight* chance of dozing or sleeping
- 2 = *moderate* chance of dozing or sleeping
- 3 = *high* chance of dozing or sleeping

SITUATION	CHANCE OF DOZING OR SLEEPING			
	(CIRCLE THE NUMBER WHICH BEST DESCRIBES YOUR ANSWER)			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place	0	1	2	3
Being a passenger in a motor vehicle For an hour or longer	0	1	2	3
Lying down in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (no alcohol)	0	1	2	3
Stopped for a few minutes in traffic while driving	0	1	2	3

TOTAL SCORE **(THIS BOX IS FOR OFFICE USE ONLY)**

PLEASE CIRCLE THE ANSWER WHICH BEST DESCRIBES YOUR RESPONSE TO THE FOLLOWING QUESTIONS.

If you have a CPAP or BiPAP machine please answer the questions based on using your machine.

Do you snore extremely loud so that you may be heard from another room?	YES	NO
Has anyone ever told you that you pause in your breathing when you sleep?	YES	NO
Do you find yourself falling asleep at inappropriate times? (during conversation at work / school)	YES	NO
Do you drift off while driving?	YES	NO
Do you wake up feeling un-refreshed?	YES	NO
Do you suffer from unexplained daytime fatigue ?	YES	NO

Signature of Patient or Legally Authorized Representative (if patient is unable to sign)

____/____/_____
Date (mm/dd/yyyy)