Patient Name_______________________________________________

HonorHealth Bariatric Center

(The patient completes all information requested except when indicated.)

HonorHealth Bariatric Center

Mail completed packet to:
10210 North 92nd Street, Suite 101
Scottsdale, Arizona 85258
480-882-7460

Or Email to:
weightloss@honorhealth.com

Seminars are available online and in-person at the HonorHealth Shea Medical Center location.
Visit Honorhealth.com/events to register.
Congratulations!
By considering the option to undergo weight loss surgery, you have taken the first step necessary to change your health...and your life. Please read the following information carefully.

Please do not print the packet double sided.

Steps in the Process:

1. You must attend one of our free public educational seminars. A list of our current seminars is located on our website Honorhealth.com/events or call 623-580-5800.

2. Confirm your insurance coverage for weight loss surgery.

Patients Paying Cash:

Patients who have decided to pay cash either because they have no insurance benefit or because they do not want or are not able to meet the requirements of their insurance company go directly to #3 below.

If you are going to use insurance to pay for your surgery:
Contact your insurance carrier to determine whether you have a weight loss benefit as part of your insurance coverage.
Your insurance company may require a medically supervised weight loss program. You may opt to work within our system of care or with your primary care physician to complete your supervised weight-loss program.

OUT OF NETWORK:
If we are not a contracted provider for your insurance company, you may still choose to complete our program.
All charges would be subject to your out-of-network benefits.

3. Complete and submit your new patient packet.
You must completely fill out your new patient packet and sign it in order for us to determine whether you’re a candidate for surgery at the HonorHealth Bariatric Center. Please complete this packet in ink.
- Include a copy (front and back) of your insurance card with your completed packet.

4. Support documentation is now required by all insurance companies for HMO, POS and PPO type plans. You will need to provide:
- A letter from a physician supporting your decision to undergo weight loss surgery.
- The physician will refer to this as a letter of medical necessity. We have attached a copy of a sample letter that you can give to your primary care doctor to complete.
- If your insurance company requires a supervised medical weight loss period, we can help by having you work with our medical weight loss specialist.
- This program is covered by most insurance plans.

5. Submitting your completed packet:
   i. You can bring the packet, insurance information and supporting documentation to the public seminar, or
ii. **Mail** your completed packet and documentation to:

   HonorHealth Bariatric Center  
   10210 North 92nd Street, Suite 101  
   Scottsdale, Arizona 85258

iii. Or **Email** your completed packet and documentation to:  
   weightloss@honorhealth.com

Please do not fax your completed new patient packet

6. **When we have received your packet:**

   - We will verify your insurance benefit, co-pay and eligibility requirements. Our patient liaison will then call you to answer any questions you may have and help you develop a plan to complete the program.
   - For patients who are not using insurance to pay for the surgery, our patient liaison will call you to schedule your initial consultation and answer any remaining questions you may have.
   - All patient packets are evaluated for possible medical problems or special situations that might require a different pathway of care.

7. **Your initial consultation will include:**

   - A comprehensive health history and physical evaluation by the surgeon.
   - A nutritional evaluation by one of our staff Registered Dietitian. This is now required by all insurance companies in order to obtain an authorization for surgery.
   - All patients must complete a comprehensive psychological evaluation and testing by a Licensed Clinical Psychologist specializing in Bariatric surgery prior to surgery
     - You will be given a list of psychologists that we work with in order to complete this requirement.
   - An exercise consultation by our staff Exercise Physiologist.
   - Your initial appointment at HonorHealth Bariatric Center will last approximately 2 hours.

We will email you the confirmation of your appointment and a map to our office. If you cancel or reschedule an appointment please give several days’ notice.

PLEASE REMEMBER: If you did not submit a letter of medical necessity from your Primary Care Physician supporting your application for surgery, or your medically supervised weight loss documentation, you **MUST bring it with you** to your initial consultation.

**AUTHORIZATION** for surgery cannot be submitted without these documents.

*That’s it! You’re now on your way to better health. While it’s understandable that you may be anxious to schedule this life-changing event, we thank you for your patience during the process. At HonorHealth Bariatric Center, we take every precaution to ensure your health, safety and long-term success.*
New Patient Registration Form – Demographics and Insurance

Patient: Name: First_____________________Middle___________________Last_____________________
Aliases (other names you may go by): ______________________________________________________
SSN: (_____-_____-______) Date of Birth: (_____/_____/____) Sex: M | F
Patient street address and number: _______________________________________________________
Patient address additional: ______________________________________________________________
City: ______________________, State: _________, ZIP: _____________-_________ 
Primary Phone Number: (_____) _______-__________ Mobile | Home | Work
Secondary Phone Number: (_____) _______-__________ Mobile | Home | Work
Email address: ________________________________________________
What is your preferred language? ______________ Interpreter Required? Yes | No

Marital Status:
Divorced | Legally Separated | Married | Other | Sig. Other | Single | Widowed
Religious preference: _________________________ □ I prefer to not answer
Mother’s Maiden Name: _________________________ □ I prefer to not answer

The government requires that we ask the following 2 questions:

1) How do you identify your ethnicity?
   ____Hispanic or Latino, ___ Not Hispanic or Latino,
   ____ I prefer to not answer.
2) How do you identify your race?
   ____American Indian or Alaska Native  ___Black or African American,
   ____Native Hawaiian  ___Other Pacific Islander  ___White or Caucasian
   ____Asian  ____I prefer to not answer
Who is your Primary Care Physician? ________________________________
Contact information of the Primary Care Practice: ________________________________
____________________________________
____________________________________
Phone #: ______________________________

Employment Status: Full-Time | Part-Time | Retired | Disabled | Student | Unemployed
Employer Name: _________________________________
Occupation: _________________________________
How many employees work at your company?
   ____ 1-19   ____ 20-99   ____ 100+   ____ Don’t know
Who would you like to list as an emergency contact?

Name: _______________________________
Address: __________________________________________________________________
Relationship to you: ______________________________________________________
Phone Number: (_____ ) _______ - ________ Mobile | Home | Work

Who is the guarantor of your account? (Who is financially responsible for any amount not paid by the insurance company?) Please write “self” if it is you.

Guarantor: Name: First_____________________Middle___________________Last_____________________
SSN: (____-____-______) Date of Birth: (_____/_____/______) Sex: M | F
Address: __________________________________________________________________
Phone Number: (_____ ) _______ - ________ Mobile | Home | Work

Primary Insurance:

Medical Insurance Company Name: __________________________________________________________________
Member/Subscriber Identification #: ___________ Group #: ________________
Medical Insurance Company Address: __________________________________________________________________
Medical Insurance Customer Service Phone #: (_____ ) _______ - ________

Relationship of the insurance subscriber to the patient:
Self | Parent | Spouse | Other: ____________

Subscriber: Name: First_____________________Middle___________________Last_____________________
SSN: (____-____-______) Date of Birth: (_____/_____/______) Sex: M | F
Address: __________________________________________________________________
Phone Number: (_____ ) _______ - ________ Mobile | Home | Work
Employer Name: __________________________________________________________________
Occupation: _______________________________________
How many employees work at your company?
_____ 1-19 _____ 20-99 _____ 100+ _____ Don’t know

Do you have any additional insurance? Yes | No

Secondary Insurance:

Medical Insurance Company Name: __________________________________________________________________
Member/Subscriber Identification #: ___________ Group #: ________________
Medical Insurance Company Address: __________________________________________________________________
Medical Insurance Customer Service Phone #: (_____ ) _______ - ________

Relationship of the insurance subscriber to the patient:
Self | Parent | Spouse | Other: ____________

Subscriber: Name: First_____________________Middle___________________Last_____________________
SSN: (____-____-______) Date of Birth: (_____/_____/______) Sex: M | F
Address: __________________________________________________________________
Patient Name_______________________________________________

Phone Number: (_______) _______ - _______ Mobile | Home | Work

Employer Name: _________________________________

Occupation: _________________________________

How many employees work at your company?

_____ 1-19   _____ 20-99   _____ 100+   _____ Don’t know

Please present all insurance cards for copying.

How did you hear about HonorHealth Bariatric Center? (Please check one)

□ Electronic Newspaper     □ Physician referral
□ Family                   □ Radio
□ Friend                   □ Search Engine
□ Magazine                 □ T.V.
□ Newspaper                □ Website
□ Other (please explain) __________________________________________________________________________

Have you attended a HonorHealth Bariatric Center Informational Seminar?

□ No
□ Yes
□ When and Where? _________________________________

Have you had a previous bariatric surgery or procedure?    Yes | No

Type of Surgery: _________________________________ Date Performed: ______________________

Current Complications with the surgery? _________________________________

What procedure are you interested in?

Bypass | Sleeve | LapBand | Revision | Gastric Balloon | Other: _________________________________

Clinical Study Participation:

HonorHealth Bariatric Center strives to provide our patients with various methods of achieving weight loss and is currently participating in clinical trials of new devices being tested for use in overweight/obese patients. If you are interested in participating in one of these clinical trials or want to discuss participation, check this box.

□  Yes, I am interested in learning more about the clinical studies being performed at HonorHealth Bariatric Center.
□  No, I am not interested at this time.
Please fill out if you are over the age of 65 or on Medicare Disability only

Please check box ONLY if the answer is “YES”

☐ Are you receiving Black Lung Benefits?

☐ Are the services to be paid by a government research program?

☐ Are you entitled to benefits through the Dept of Veterans Affairs?

☐ Was the illness/injury due to a work-related accident/condition?
  - Date of Accident: ______ Location: _________ Time: ______

☐ Was the illness/injury due to a non-work-related accident?
  - Date of Accident:_______ Location:__________   Time:_______

☐ Are you entitled to Medicare based on End Stage Renal Disease?
  - Transplant Received? ______ Dialysis tx? _______ Dates_____ 

☐ Are you currently employed? If yes, place of employment__________
  - Employer coverage? _________ Plan:_________________

☐ Do you have a spouse who is currently employed?

☐ Retirement Dates (if applicable) or last date employed___________
  - Never worked Y/N
New Patient Registration Form – Medical Information

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<tr>
<th>Who are your current medical providers?</th>
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<tr>
<td>Name</td>
<td>Specialty, or condition for which they treat you</td>
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**Contact information for your pharmacy:**

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<th>Name:</th>
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<tr>
<td>Phone #</td>
<td>Cross Streets:</td>
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<tr>
<th>Preventive Care</th>
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<td><strong>Test</strong></td>
<td><strong>Year</strong></td>
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<tr>
<td>Annual Physical</td>
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<td>Colonoscopy</td>
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<td>Bone Density</td>
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<td>Dental Exam</td>
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**Allergies or intolerances to medications?**

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<th>Name</th>
<th>Reaction</th>
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**Please list all medications, supplements, over the counter drugs, creams and inhalers.**

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<tr>
<th>Name</th>
<th>Dose/Strength</th>
<th>Frequency taken</th>
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</table>
**Weight Related Illnesses**

Have you had, or do you have, any of the following illnesses or symptoms?

1. **Heart Disease**
   - Yes ☐ No ☐ Year diagnosed ______
   - Taking medications for heart disease [Check all that apply: ASA  Coumadin  Plavix]
     - ☐ Angina
     - ☐ M.I. (myocardial infarction)
     - ☐ Abnormal EKG
     - ☐ CABG (coronary artery bypass graft)
     - ☐ Palpitations
     - Stress test to rule out cardiac problems

2. **High Cholesterol**
   - Yes ☐ No ☐ Year diagnosed ______
   - High triglycerides ☐ Taking medication for high cholesterol

3. **High Blood Pressure**
   - Yes ☐ No ☐ Year diagnosed ______
   - Taking medications for high blood pressure
   - Average pressure: ________________________________
   - List dietary restrictions: ________________________________

4. **Pre-Diabetes**
   - Yes ☐ No ☐ Year diagnosed ______
   - Taking medications for pre-diabetes

5. **Diabetes**
   - Yes ☐ No ☐ Year diagnosed: ______
   - How Diagnosed? ☐ FBG  ☐ HgA1c  ☐ Glucola Test
   - What type? ☐ Type I  ☐ Type II  ☐ Don’t know
   - Gestational .......... ☐ Yes  ☐ No
   - Controlled with ............. ☐ Diet  ☐ Medications  ☐ Insulin
   - Last fasting blood sugar: ______ Date: _____________
   - Last HgA1c: _____________ Date: _____________
   - Complications of T2DM:
     - ☐ Neuropathy  ☐ Kidney Disease  ☐ Vascular Disease  ☐ Amputation

6. **Asthma**
   - Yes ☐ No ☐ Year diagnosed ______
   - ER visits in the last 2 years: ________________________________
   - Hospitalizations in last 2 years: ________________________________
   - Steroids used in last 2 years ☐ Yes  ☐ No

7. **Reactive Airway Disease (RAD)**
   - Yes ☐ No ☐ Year diagnosed ______
   - Age at diagnosis ________________ ☐ Taking medications for RAD
   - What exacerbates RAD? ________________________________
   - Take which inhaler for RAD? ________________________________
   - Take which steroids for RAD? ________________________________
8. **Sleep Apnea Syndrome**
   (Check all that apply to you regardless if you have been diagnosed with sleep apnea or not)
   - Morning headaches .............. □ Yes □ No
   - Daytime drowsiness............. □ Yes □ No
   - Restless sleep .................. □ Yes □ No
   - Snoring ........................ □ Yes □ No
   - Awakenings at night .......... □ Yes □ No
   (Including choke or gasp)
   - Observed apnic episodes ......... □ Yes □ No
   - Last sleep study (month/year) ____________________________
   Have you been diagnosed with sleep apnea? ........ □ Yes □ No
   Year diagnosed ________________
   CPAP used ........................ □ Yes □ No
   Setting ________________________

9. **Barrett’s esophagitis** □ Yes □ No Year diagnosed ______

10. **Hiatus hernia** □ Yes □ No Year diagnosed ______
    - Upper GI series .................. □ Yes □ No
    - Endoscopy ........................ □ Yes □ No

11. **Gastroesophageal reflux (GERD)** □ Yes □ No Year diagnosed ______
    □ Taking medication for GERD

12. **Gallbladder disease** □ Yes □ No
    How was it diagnosed? .............. □ Ultrasound □ Physical exam
    Year diagnosed __________
    Did you have your gallbladder removed? □ Yes □ No
    If yes, was it removed: □ Laparoscopically □ Open procedure □

13. **Stress incontinence** □ Yes □ No
    (Leakage of urine with laughing/coughing/sneezing)
    - Wear pads frequently ............ □ Yes □ No

14. **Diagnosis of Chronic Joint Disease** □ Yes □ No
    How was it diagnosed? _____________________________ Year: __________
    What treatments have been prescribed to you by a medical doctor (check all that apply):
    □ Physical therapy □ Lifestyle modification
    □ Medication Type of medication: _____________________________
    □ Surgery Type of surgery: _____________________________
15. Can you walk unassisted?  □ Yes  □ No
   If no, do you use a: cane ....... □ Yes  □ No
   walker ....... □ Yes  □ No
   wheelchair . □ Yes  □ No

16. Weight related injuries and trauma ______________________________________________________

17. Swelling in legs  □ Yes  □ No

18. Thyroid disease  □ Yes  □ No
   □ Taking medication for thyroid disease

19. Have you ever been on a blood thinner to prevent or treat the formation of blood clots?  □ Yes  □ No

20. Do you have a personal history of blood clots in your arms, legs or lungs?  □ Yes  □ No
   □ Warfarin  □ Coumadin  □ Lovenox  □ Heparin  □ Other _________________________________

21. Do you have a personal history of problems with your blood being too thin or too thick?  □ Yes  □ No

22. Deep Venous Thrombosis  □ Yes  □ No  Year Diagnosed: ______

23. Pulmonary Embolism  □ Yes  □ No  Year Diagnosed: ______

24. Hepatitis  □ Yes  □ No  Year Diagnosed: ______
   Which type (circle one):  A  B  C  Unknown

25. Cancer  □ Yes  □ No  Year Diagnosed: ______
   Type: __________________________________________________________
   Treatment: _____________________________________________________

26. Irregular period of infertility (for female patients only)  □ Yes  □ No
   If yes, please explain: ________________________________________________
<table>
<thead>
<tr>
<th>Condition</th>
<th>Date</th>
<th>Comments</th>
<th>Condition</th>
<th>Date</th>
<th>Comments</th>
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**Please circle or add all major operations or surgeries**

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<tr>
<th>Surgery</th>
<th>Date</th>
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<tbody>
<tr>
<td>None</td>
<td>Colon</td>
<td>Joint Replacement</td>
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<td>Appendectomy</td>
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<td>Coronary Artery Stent</td>
<td>Spine</td>
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<td>Breast Augmentation</td>
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<td>Cosmetic Surgery</td>
<td>Thyroid Surgery</td>
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<td>Breast Surgery</td>
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<tr>
<td>Cesarean Section</td>
<td>Fracture Repair</td>
<td>Tubes Tied</td>
<td>Heart Valve Surgery</td>
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<td>Heart Bypass</td>
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<td>Other:</td>
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**Hospitalizations**

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Family Medical History

<table>
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<tr>
<th>Age</th>
<th>Status: Alive or Deceased</th>
<th>Cancer</th>
<th>Depression</th>
<th>Diabetes</th>
<th>High Blood Pressure</th>
<th>Heart Disease</th>
<th>Obesity</th>
<th>Alcohol/Drug Abuse</th>
<th>Arthritis</th>
<th>Asthma</th>
<th>Birth Defects</th>
<th>COPD</th>
<th>High Cholesterol</th>
<th>Hearing Loss</th>
<th>Kidney Disease</th>
<th>Mental Illness</th>
<th>Miscarriages</th>
<th>Stroke</th>
<th>Vision Loss</th>
<th>Alzheimer's</th>
<th>Early Death</th>
<th>Other:</th>
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<td>Maternal Grandmother</td>
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<td>Paternal Grandmother</td>
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<tr>
<td>Other:</td>
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</tr>
</tbody>
</table>

Adopted | Family History Unknown

Social History

<table>
<thead>
<tr>
<th>Alcohol Use</th>
<th>□ YES □ NO</th>
<th>If NO, date of last drink: <strong>/</strong>/____</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glasses of wine per week</td>
<td>1 2 3 4 5 6 7 8 9 10+</td>
<td></td>
</tr>
<tr>
<td>Cans of beer per week</td>
<td>1 2 3 4 5 6 7 8 9 10+</td>
<td></td>
</tr>
<tr>
<td>Shots of liquor per week</td>
<td>1 2 3 4 5 6 7 8 9 10+</td>
<td></td>
</tr>
<tr>
<td>Mixed drinks with 0.5 ounces alcohol per week</td>
<td>1 2 3 4 5 6 7 8 9 10+</td>
<td></td>
</tr>
</tbody>
</table>

Sexual Activity

<table>
<thead>
<tr>
<th>Sexually active?</th>
<th>Currently</th>
<th>Never</th>
<th>Not Currently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Partners?</td>
<td>Men</td>
<td>Women</td>
<td>Both</td>
</tr>
</tbody>
</table>

| Birth control used: | |

Drug Use

<table>
<thead>
<tr>
<th>Amphetamines</th>
<th>Benzodiazepines</th>
<th>&quot;Crack&quot; Cocaine</th>
<th>Cocaine</th>
<th>Heroin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana</td>
<td>Methamphetamine</td>
<td>PCP</td>
<td>Huff Gasses</td>
<td>None</td>
</tr>
</tbody>
</table>
### Tobacco Use

<table>
<thead>
<tr>
<th>□ YES</th>
<th>□ NO</th>
<th>Quit Date: <em><strong>/</strong></em>/____</th>
</tr>
</thead>
</table>

**Type of Product:**

- □ Cigarettes
- □ Cigar
- □ E-Cigarettes
- □ Other: ____________________________

<table>
<thead>
<tr>
<th>Smoke every day</th>
<th>Smoke some days</th>
<th>Former smoker</th>
<th>Heavy smoker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Light smoker</td>
<td>Never smoked</td>
<td>Second-hand exposure</td>
<td></td>
</tr>
</tbody>
</table>

If ever smoked:

<table>
<thead>
<tr>
<th>How many packs/day average</th>
<th>½ 1 1½ 2 3+</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many years smoked?</td>
<td></td>
</tr>
</tbody>
</table>

- □ YES
- □ NO

You ever chewed?

- □ YES
- □ NO

If you currently use any tobacco product, are you ready to quit?

- □ YES
- □ NO

### Advanced Directives (Living will and medical power of attorney)

<table>
<thead>
<tr>
<th>□ YES</th>
<th>□ NO</th>
</tr>
</thead>
</table>

Do you have an advanced directive?

- □ YES
- □ NO

Would you like information or a copy of advanced directive forms?

- □ YES
- □ NO

### Patient Measurement

<table>
<thead>
<tr>
<th>Patient Measurement</th>
<th>Weight History</th>
<th>Age</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height</td>
<td>Birth Weight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Body Weight</td>
<td>After Undergoing Puberty</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ideal Body Weight</td>
<td>High School Graduation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excess Body Weight</td>
<td>Marriage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10% Pre-Op Excess Body Weight Loss Goal</td>
<td>Lowest Weight in the Past 5 Years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target Weight</td>
<td>Highest Weight in the Last 5 Years</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Body Frame (circle one)</th>
<th>Small</th>
<th>Medium</th>
<th>Large</th>
</tr>
</thead>
</table>

In your own words, please describe what you hope to accomplish and how you believe your life will change by losing weight.

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
Patient Name_______________________________________________

Dietary History
Approximate age when you first seriously dieted. ________________________________________________
List any physician-supervised and documented weight loss attempts. ________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

List the diets and diet programs you have tried:

<table>
<thead>
<tr>
<th>Diet</th>
<th>Date(s)</th>
<th>Duration</th>
<th>MD Supervised (circle one)</th>
<th>Max Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jenny Craig</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Nutri-System</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Weight Watchers</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Opti/Medi Fast</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Atkins</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

List the Medications and Treatments you have tried:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Date(s)</th>
<th>Duration</th>
<th>MD Supervised (circle one)</th>
<th>Max Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fen/Phen/Redux</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Meridia</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Topamax/Topiramate</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Bontril/Phendimetrazine</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Alli/Xenical</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>HcG</td>
<td></td>
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<td>Yes</td>
<td>No</td>
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<tr>
<td>Acupuncture</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Exercise
If you are able to exercise, what kinds of exercise do you do?

<table>
<thead>
<tr>
<th>Type of Exercise</th>
<th>Duration (how long each time)</th>
<th>Frequency (times per week)</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
Initial Nutrition Assessment

Please fill out the following information for your appointment with the wellness coach/dietitian. Answer the questions based on the past month of eating habits.

Please check the circle that describes your weight over the past 6 months
- I’ve gained weight (If so how much? __________)
- I’ve lost weight (If so how much? __________)
- My weight hasn’t changed

Please place a check in the column below that best describes how often you eat the following foods:

<table>
<thead>
<tr>
<th>FOOD</th>
<th>Daily</th>
<th>2-3 x week</th>
<th>1 x week</th>
<th>Monthly</th>
<th>Less than monthly</th>
<th>Dislike/Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meat (Beef/Pork)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Poultry (Chicken/Turkey)</td>
<td></td>
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<tr>
<td>Fish</td>
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<tr>
<td>Eggs</td>
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<tr>
<td>Vegetables</td>
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<tr>
<td>Fruit</td>
<td></td>
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<tr>
<td>Bread/Tortillas</td>
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<tr>
<td>Pizza</td>
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<tr>
<td>Pasta/Rice</td>
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<tr>
<td>Cheese</td>
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<tr>
<td>Yogurt</td>
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<td>Ice Cream</td>
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<td>Crackers</td>
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<td>Chips</td>
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<tr>
<td>Fried Foods</td>
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<td>Fast Foods</td>
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<td>Soda</td>
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<tr>
<td>Coffee</td>
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<tr>
<td>Juice/Gatorade</td>
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<tr>
<td>Energy Drinks</td>
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</table>

Please check the circle that describes your daily water intake
- I drink more than 64 oz of water
- I drink 32-64oz of water
- I drink less than 32 oz of water

Are you currently taking a daily multivitamin supplement?
- Yes
- No

Please check the circle that describes how many times you eat meals per day
- 4 or more
- 2-3
- 2 or less

Please check the circle that describes how many times you eat snacks per day
- 4 or more
- 2-3
- 2 or less
System Review

Please check all symptoms that you currently have. Write in any additional problems.

**Head, Eye, Ear, Nose, and Throat**

- □ No Complaints
- □ Vertigo
- □ headache
- □ sinus problems
- □ balance disturbances
- □ Pain in/around ears
- □ nasal congestion
- □ double vision
- □ decreased night vision
- □ Dizziness
- □ nasal drainage
- □ lump in throat
- □ dysphasia
- □ Rhinitis
- □ hoarseness
- □ ringing in ears
- □ ear drainage
- □ Sore throat
- □ blurred vision
- □ hearing loss
- □ visual aura
- □ Uvulectomy
- □ buzzing in ears
- □ pain with swallowing

**Respiratory**

- □ No Complaints
- □ cough
- □ bronchitis
- □ blood in sputum
- □ wake up at night short of breath
- □ asthma
- □ emphysema
- □ out of breath with exertion
- □ wake up at night coughing or choking
- □ wheezing
- □ use two pillows
- □ shortness of breath at night

**Cardiovascular**

- □ No Complaints
- □ cold feet
- □ heart attack
- □ heart murmur
- □ squeezing of chest
- □ blue toes
- □ pain in neck
- □ loss of pulses
- □ skipping of heartbeat
- □ blue finger
- □ pains in arms
- □ pounding of heart
- □ high blood pressure
- □ palpitations
- □ pains in chest
- □ irregular heartbeat
- □ abnormal electrocardiogram
- □ pain in legs

**Gastrointestinal**

- □ No Complaints
- □ colitis
- □ vomiting
- □ irritable colon
- □ burning in stomach
- □ cramps
- □ heartburn
- □ acid stomach
- □ food sticking in chest
- □ nausea
- □ gassiness
- □ blood in stools
- □ belching fluid in throat
- □ fissures
- □ constipation
- □ burning in throat
- □ pain with bowel movement
- □ diarrhea
- □ hemorrhoids
- □ pains in stomach

**Genitourinary**

- □ No Complaints
- □ nephritis
- □ kidney stones
- □ pain with urination
- □ trouble stopping urine
- □ blood in urine
- □ bladder stones
- □ small urine stream
- □ urinary tract infections
- □ kidney failure
- □ frequent urination
- □ trouble starting urine
- □ leakage of urine with cough or sneeze

**Men**

- □ No Complaints
- □ loss of erection
- □ painful erection
- □ discharge from penis
- □
Women

□ No Complaints

□ irregular periods  □ vaginal bleeding  □ vaginal discharge  □ pain with intercourse

□ ________________________________

Endocrine (Glandular)

□ No Complaints

□ goiter  □ hyperthyroid  □ grave’s disease  □ adrenal gland tumor

□ diabetes  □ x-ray to thyroid  □ frequent flushing  □ frequent heavy sweating

□ low thyroid  □ thyroid nodules  □ ________________________________

Musculoskeletal

□ No Complaints

□ flatfeet  □ foot pain  □ slipped disk  □ broken bones

□ sprains  □ knee pain  □ fluid in joints  □ herniated disk

□ arthritis  □ ankle pain  □ pain in joints  □ swelling of joints

□ sciatica  □ warm joints  □ low back pain  □ redness of skin over joints

□ hip pain  □ ________________________________

Neurological

□ No Complaints

□ fits  □ fainting  □ convulsions  □ twitching of muscles

□ tremor  □ dizziness  □ falling at night  □ loss of consciousness

□ vertigo  □ shakiness  □ falling to the side  □ pins & needles feelings

□ tingling  □ numbness  □ weakness of grip  □ weakness of any muscles

□ ________________________________

Psychological

□ No Complaints

□ major depression (once)

When? ________________________________  □ drug abuse/dependency

□ major depression (twice or more)

When? ________________________________  □ psychotic disorder

□ posttraumatic stress disorder  □ generalized anxiety disorder

□ borderline personality disorder  □ panic disorder

□ schizophrenia  □ panic attacks

□ bipolar disorder  □ obsessive compulsive disorder

□ manic depression  □ inpatient hospitalization

□ dissociative disorder

□ dissociative identity disorder

□ multiple personality disorder

□ alcohol abuse/dependency

□ psychotherapy

When: ________________________________  Condition: ________________________________
HonorHealth Bariatric Center
Diagnostic Questionnaire

The following questions are to help us determine a well suited program for your success. Please answer questions accurately to the best of your ability.

1. Are you normally a large-volume eater at mealtimes?  
   Yes  No

2. In a typical week, how frequently do you engage in *unplanned* snacking?  
   Many times per day  Once per day  3-6 times per week  1-2 times per week  Never

3. In a typical month, how frequently do you respond to stress or emotions (sadness, boredom, anger, etc.) by eating or snacking?  
   Daily  A few times per week  A few times per month  Less than monthly

4. Name the triggers or sources of stress that may cause inappropriate eating.  
   __________________________  __________________________  __________________________  __________________________

5. Name your top three favorite foods.  
   a. __________________________, b. __________________________, c. __________________________

6. Do you regularly eat after 7:00 p.m.?  
   Yes  No

7. Do you typically consider yourself well-disciplined and focused?  
   Yes  No

8. Have you achieved weight loss through dieting & exercise in the past?  
   Yes  No
   a. If so, what was your maximum weight loss?  
      __________ pounds
   b. How long did it take to achieve?  
      __________ months
   c. How long did you maintain it prior to regaining weight?  
      __________ months

9. Do you have either diabetes or insulin resistance?  
   Yes  No

10. Can you refrain from drinking alcohol?  
    Yes  No

11. In which bariatric services are you interested?  
    □ Medical Weight Loss Program  □ Adjustable Gastric Band  □ Sleeve
    □ Lap Gastric Bypass  □ Revision  □ Other: __________________________
Date

HonorHealth Bariatric Center
10210 N. 92nd St. #101
Scottsdale, AZ 85258

Re: [insert patient name]
DOB: [insert the patient's date of birth]

Letter of Medical Necessity
(For patients with Cigna, Medicare or Medicare Advantage plans, a Letter of Medical Clearance must be submitted to obtain authorization for Bariatric Surgery)

To whom it may concern:

[Patient name] is a [age] year-old male/female with a current weight of [weight] and a BMI of [BMI]. He/She has suffered from obesity for the past [# of years] years. He/She has the following co-morbid conditions: [insert co-morbidities and any treatments being used]. He/She has tried many diets in the past including: [insert any formal weight loss programs the patient has tried including diets, medication, behavior modifications, and exercise programs].

I recommend bariatric surgery be performed at HonorHealth Bariatric Center, which is a Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) Accredited Comprehensive Center with Adolescents.

Sincerely,

(Signature)
Self-Pay Pricing

Additional Procedure(s) Only if Deemed Medically Necessary - Billed Postoperatively

The need for an additional surgical procedures cannot always be predicted prior to surgery. Some examples are: Hernia Repair, Liver Biopsy, Removal of Gallbladder, Revisions, etc. These are billed separate and due upon receipt of invoice.

INITIALS: ____________________________

I _____________________ have agreed to the stated fees and wish to move ahead with consultation.

Payment of Bariatric package(s):

50% up front to reserve a surgery date. The balance will be due in full by your pre-operative visit;

INITIALS: ____________________________

Patient/Guarantor Signature: ______________________________

Date: ___________________________

Effective Date: 04/04/2014
Additional Procedure(s) Only if Deemed Medically Necessary

The need for an additional surgical procedure cannot always be predicted prior to surgery. Some examples are: Hernia Repair, Liver Biopsy, Removal of Gallbladder, Revisions, etc. These are billed separate and due upon receipt of invoice.

INITIALS: __________

I _____________________ have agreed to the stated fees and wish to move ahead with consultation.

Payment of Bariatric package(s):
50% up front to reserve a surgery date. The balance will be due in full by your pre-operative visit;

INITIALS: __________

Patient/Guarantor Signature: ____________________ Date: ___________________________