UNIVERSITY of MARYLAND MEDICAL CENTER

Date: ____/ _____/_____

HEALTH QUESTIONNAIRE (Pre-Bariatric Surgery)

Last Name	First Name	Maiden Name
Address		
City	State	Zip
Social Security Number	Date of Birth	
Preferred Pharmacy	Pharmacy Phone Number	
Gender: ☐ Male ☐ Female ☐ Non-binary		
Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Never Married		
Employer	Occupation	

Please check your preferred method of contact:

☐ Email		
☐ Home Phone	*Can we reach you at this number during the day?*	☐ Yes ☐ No
☐ Work Phone	*Can we reach you at this number during the day?*	☐ Yes ☐ No
☐ Cell Phone	*Can we reach you at this number during the day?*	☐ Yes ☐ No
May we leave a voicemail? ☐ Yes ☐ No		

Other persons we are allowed to speak to regarding your care (if applicable):

Name	Phone Number	Relation to you
Name	Phone Number	Relation to you

Vitals

What is your current weight? pounds	What is your current height? feet inches

Primary Care Physician

Physician's Name		
Address		
City	State	Zip
Phone Number:	Fax Number:	

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How did you hear about us?

☐ Referred by a Physician

Physician's Name

Address

City State Zip

Phone Number: Fax Number:

☐ Self-Referred

☐ Google Search ☐ Obesity Help ☐ Center for Weight Management and Wellness Website

☐ Facebook ☐ Ethicon ☐ Billboard

☐ Television ☐ Radio ☐ Another Patient

☐ Employee of UMMS ☐ Other:

Primary Insurance Company

Insurance Company Name

Insurance Company Address

City State Zip

Policy Holder's Name

Relationship to Patient

Policy Number Group/Plan Number

Customer Service Phone Number

Provider Inquiry/Pre-Certification Phone Number

Contact Person

Is Gastric Bypass for 'Morbid Obesity' a covered benefit? ☐ Yes ☐ No ☐ I don't know

Is Gastric Sleeve for 'Morbid Obesity' a covered benefit? ☐ Yes ☐ No ☐ I don't know

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Secondary Insurance Company

Insurance Company Name		
Insurance Company Address		
City	State	Zip
Policy Holder's Name		
Relationship to Patient		
Policy Number	Group/Plan Number	
Customer Service Phone Number		
Provider Inquiry/Pre-Certification Phone Number		
Contact Person		
Is Gastric Bypass for 'Morbid Obesity' a covered benefit?	☐ Yes ☐ No ☐ I don't know	
Is Gastric Sleeve for 'Morbid Obesity' a covered benefit?	☐ Yes ☐ No ☐ I don't know	

Spouse or Significant Other

Last Name	First Name	Maiden Name
Social Security Number	Date of Birth	
Employer		

Self-Pay Option

If Weight Loss Surgery is not a '**covered benefit'** or is an '**exclusion'** under your insurance plan, the insurance company **will not pay** for this procedure. Please be certain that your policy covers this surgery **before** returning this questionnaire. If your policy does not cover weight loss surgery, any costs will be your responsibility.

Would you like information about the self-pay option? Yes ☐ No ☐

Authorization for Release of Information

I authorize the physicians and outpatient staff in attendance on this case to release medical information to the pertinent insurance company(s) or third party carriers and request payment to be made directly to the billing entity. I understand that I am financially responsible for any balance not covered by the insurance carrier(s). I also request that payment of benefits from my policy _____ be paid directly to the billing entity until otherwise notified.

Signature _____

Center for Weight Management and Wellness
22 S. Greene St. Suite 100B, Baltimore, MD, 21201

Office: 410-328-8940
Fax: 410-328-8997

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Date: ____/ _____/_____

HEALTH QUESTIONNAIRE (Pre-Bariatric Surgery)

Social History

Did you ever use any products that contain **tobacco**? ☐ Yes ☐ No
If yes, what kind?
If yes, how often?
If yes, what year did you start?
If yes, did you quit? ☐ Yes: If so, when: _____ ☐ No
Do you do any other types of **illicit drugs**? ☐ Yes ☐ No
If yes, what kind?
If yes, when was the last time?
How much of the following **alcoholic drinks** do you drink per week)?
Mixed Drinks:
Beer:
Wine:

Education

What is the highest level of education you have completed?

☐ Some High School ☐ High School/GED ☐ College ☐ Post-Graduate

Family Medical History

Please complete the following information on the medical history of your immediate family (parents and siblings).

Family Member	Age	Alive? (Y/N)	Heart Disease (Y/N)	Stroke (Y/N)	Diabetes (Y/N)	Cancer (Y/N)	Blood Clots (Y/N)	Obesity/ Overweight (Y/N)	Other Health Problems
Father									
Mother									

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Medical Conditions

Please indicate which of the following medical conditions you have, or have ever been treated for:

☐ Diabetes	☐ GERD
☐ Gestational Diabetes	☐ Heartburn/Acid Reflux
☐ High Cholesterol	☐ Celiac Disease
☐ High Blood Pressure	☐ Ulcerative Colitis
☐ Chest Pain/Angina	☐ Crohn's Disease
☐ Heart Attack	☐ Frequent Diarrhea
☐ Heart Failure	☐ Irritable Bowel Syndrome
☐ Stroke	☐ Ulcer(s)
☐ Asthma	☐ Liver Disease/Hepatitis
☐ Emphysema /COPD	☐ Cancer – Type:
☐ Sleep Apnea	☐ Lupus
☐ Arthritis	☐ HIV/AIDS
☐ Joint Pain	☐ Renal Disease/Kidney Dysfunction
☐ Back Pain	☐ Bladder Incontinence
☐ Infertility/PCOS	☐ Eating Disorder
☐ Gout	☐ Hypothyroidism

Other Health Problems

Please list all other health problems not included above.

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Prior Operations

Have you had weight loss surgery before? ☐ Yes ☐ No	
If yes, when	Type of surgery
Please list all other surgeries you have had.	
Date	Surgery
Date	Surgery
Date	Surgery
Date	Surgery

Allergies

Are you allergic to any drug, food, or substance? ☐ Yes ☐ No	
If yes, please list and explain what the reaction is (swelling, hives, rash, etc.)	
Allergy	Reaction
Allergy	Reaction
Allergy	Reaction
Allergy	Reaction

Blood Transfusion

Would you accept a blood transfusion if medically necessary? ☐ Yes ☐ No
If no, please indicate why:

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Medications

Please indicate all prescribed or over-the-counter medications you are currently taking.

Medication	Dosage (e.g. "mg")	Frequency (times per day)	Reason

Vitamins, Minerals, and Herbal Supplements

Please indicate all prescribed or over-the-counter vitamins, minerals, and herbal supplements you are currently taking.

Vitamin/Mineral/Herbal Supplement	Dosage (e.g. "mg")	Frequency (times per day)	Reason

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