

# RMAP Patient Information Form (Please Fill Out Completely)

**Surgeon Selected :** Sherman C. Smith, MD    Steven C. Simper, MD    Rodrick D. McKinlay, MD

**Please check one:**  Self Pay    Insurance Pay   **Procedure:**   Gastric Bypass   Gastric Banding   Duodenal Switch   Other

Name (First) (Middle) (Last)			Date of Birth	Sex	Marital Status
Address			Phone (include area code) ( )	Cell Phone (include area code) ( )	
City	State	Zip	Race	Social Security #	
Occupation	Employer		Employment Status (Full/Part Time)		Drivers License #
Employment Address			Phone (include area code) ( )	Patient Email	

**Spouse/Guardian Information**

Name (First) (Middle) (Last)			Relationship	Date of Birth	Social Security #
Address		City	State	Zip Code	Phone (include area code) ( )
Employment Address		Occupation	Employer		Phone(include area code) ( )

Name of nearest relative/friend not living with you		Relationship	Phone (include area code) ( )	
Address		City	State	Zip

**How did you hear about our clinic?**

Physician    Hospital    Patient    Magazine    Internet    Insurance Company    Yellow Pages    Other \_\_\_\_\_

Primary Care Physician	Address	City, State and Zip	Phone (include area code) ( )
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<p><b><u>PRIMARY HEALTH INSURANCE COMPANY</u></b> (fill in completely)</p> <p>Name of Insured (employee) _____</p> <p>Name of Insurance Company _____</p> <p>Address of Insurance Company _____</p> <p>_____</p> <p>Phone Number of Insurance Company ( ) _____</p> <p>Pre-certification Phone Number ( ) _____</p> <p>Employer's Name _____</p> <p>Policy or ID Number of Employee _____</p> <p>Group Number _____</p> <p>Effective date of Coverage _____/Copay_____</p>	<p><b><u>SECONDARY HEALTH INSURANCE COMPANY</u></b> (fill in completely)</p> <p>Name of Insured (employee) _____</p> <p>Name of Insurance Company _____</p> <p>Address of Insurance Company _____</p> <p>_____</p> <p>Phone Number of Insurance Company ( ) _____</p> <p>Pre-certification Phone Number ( ) _____</p> <p>Employer's Name _____</p> <p>Policy or ID Number of Employee _____</p> <p>Group Number _____</p> <p>Effective date of Coverage _____/Copay_____</p>
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It is my responsibility to pay any deductible amount, co-insurance or any other balance not paid by my insurance. Finance charges (at an annual rate not to exceed 18%) will be added when my account becomes 90 days past due. If it becomes necessary for my account to be turned over to a collection agency, I understand that a collection fee up to an additional 50% may be added to my balance. I understand I will be responsible to pay all collection fees, attorney fees and court costs. Confidential Record: Information contained here will not be released except when you have authorized us to do so. Note: This form will be submitted to your insurance company with the letter of medical necessity and your medical records.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to: **Sherman C. Smith, M.D., Steven C. Simper, M.D. or Rodrick D. McKinlay, M.D.** This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information, including medical history and medical records, to my insurance company and immediate family.

Signed \_\_\_\_\_ Date: \_\_\_\_\_ Date Revised or Updated: \_\_\_\_\_  
Patient/ Responsible Party

# Medical History

**Surgeon You Have Selected:**

**Dr. Smith**

**Dr. Simper**

**Dr. McKinlay**

**Date:** \_\_\_\_\_

Date Revised or Updated: \_\_\_\_\_

**Name:** \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Height \_\_\_\_\_

Weight \_\_\_\_\_

Describe your present symptoms briefly:

\_\_\_\_\_

\_\_\_\_\_

**Chief Complaint:** \_\_\_\_\_

## Past Medical History

Previous Surgeries

Procedure

Date

Procedure

Date

1.		4.	
2.		5.	
3.		6.	

**Hospitalizations:** List diseases you have had that required hospitalization (approximate date).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Allergies: Drugs**

**Other**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Current Medication:**

\_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_ Condition \_\_\_\_\_

\_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_ Condition \_\_\_\_\_

\_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_ Condition \_\_\_\_\_

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\_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_ Condition \_\_\_\_\_

\_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_ Condition \_\_\_\_\_

**Family History:**

	Age	Health (good, fair, poor)	If deceased Cause	Age
Father				
Mother				
Brothers				
Sisters				
Husband/ Wife				
Sons				
Daughters				

Do you know of any blood relative who has or had: (Circle and give relationship)

Stroke	Cancer
High blood pressure	Tuberculosis
Diabetes	Bleeding tendency
Heart attack	Overweight (20-99 lbs)
Morbid obesity: (100 lbs over ideal weight)	

**REVIEW OF SYSTEMS**

**Musculoskeletal**

- |   |     |    |                              |     |    |
|---|-----|----|------------------------------|-----|----|
| Pain in calves when walking?.....   | Yes | No | Swelling in the ankles?..... | Yes | No |
| Pain in big toe?.....   | Yes | No | Knee pain?.....              | Yes | No |
| Phlebitis or inflamed leg veins?.....   | Yes | No | • Arthritic?.....            | Yes | No |
| Cramps in legs at night?.....   | Yes | No | • Under physician care?..... | Yes | No |
| Varicose veins?.....  | Yes | No | Hip pain?.....               | Yes | No |
| Do you have problems with your back?.....   | Yes | No | • Arthritic?.....            | Yes | No |
| • Under physician care?.....  | Yes | No | • Under physician care?..... | Yes | No |
| Have you ever had a problem with bleeding from a minor cut or tooth extractions?..... |     |    |                              | Yes | No |

**Cardiovascular**

- |   |     |    |                                       |     |    |
|---|-----|----|---------------------------------------|-----|----|
| Have you ever had chest pain or tightness.... |     |    | Does the chest pain.....              |     |    |
| • When exerting yourself?.....                | Yes | No | • Radiate down the arm?.....          | Yes | No |
| • When excited or upset?.....                 | Yes | No | • Occur only at rest?.....            | Yes | No |
| • After heavy meals?.....                     | Yes | No | • Disappear if you rest?.....         | Yes | No |
| Do you have palpitations?.....                | Yes | No | Describe the chest pain _____         |     |    |
| Do you have heart problems?.....              | Yes | No | Do you have high blood pressure?..... | Yes | No |
| • Under a physicians care?.....               | Yes | No | • For how many years? .....           |     |    |
| • For how many years?.....                    |     |    | • Under a physicians care? .....      | Yes | No |

**Pulmonary**

Have you had shortness of breath:			Do you need more than one pillow to sleep?.....	Yes	No
• Doing normal work?.....	Yes	No	Do you cough up sputum?.....	Yes	No
• Which awakens you at night?.....	Yes	No	Experience Asthma? .....	Yes	No
• Climbing a flight of stairs?.....	Yes	No	• For how many years? .....	_____	
• Accompanied by wheezing?.....	Yes	No	• Under a physicians care? .....	Yes	No
• For how many years? .....	_____		Experience Obstructive Sleep Apnea?.....	Yes	No
• Under a physicians care? .....	Yes	No	• For how many years? .....	_____	
Do you have a chronic cough?.....	Yes	No	• Under a physicians care? .....	Yes	No

**Gastrointestinal**

Have you ever had pain in the stomach which...			Do you have.....		
• Occurs one or two hours after a meal?....	Yes	No	• Abdominal cramps?.....	Yes	No
• Is brought on by eating fried, greasy foods?..	Yes	No	• Alternating diarrhea and constipation?.....	Yes	
• Awakens you at night?.....	Yes	No	• Pain during or after bowel movement?.....	Yes	
• Is relieved by eating?.....	Yes	No	• Mucous in the stool?.....	Yes	No
• Is relieved by antacid medications?... ..	Yes	No	• Blood in the stool?.....	Yes	No
• Occurs while eating or immediately after?Yes	No		• Ribbon-like stools?.....	Yes	No
• Is relieved by a bowel movement?.....	Yes	No	• Black stools?.....	Yes	No
Do you have Acid reflux? .....	Yes	No	• Need for laxative or enemas? Yes	No	
• For how many years? .....	_____		o How often?.....	_____	
• Under a physicians care? .....	Yes	No			

**Genitourinary**

Have you ever had....			Trouble staring to urinate?.....	Yes	No
Burning when urinating?.....	Yes	No	Trouble holding the urine?.....	Yes	No
Loss of control of bladder?.....	Yes	No	Frequency/awakening at night?.....	Yes	No
Blood in the urine?.....	Yes	No	Passed a kidney stone?.....	Yes	No
Dark colored urine?.....	Yes	No			

**Reproductive**

**Men:** Have you ever had.....

Prostate problems?.....	Yes	No
Prostate cancer?.....	Yes	No
Loss of sexual function?.....	Yes	No

**Women:**

Are you still having monthly menstrual periods? Yes	No	When was your last Pap Smear?.....		
Are your periods: Irregular___Heavy___Painful___		Number of pregnancies ___ Live births ___ Miscarriages ___		
Have you ever had bleeding between periods? Yes	No	• C- sections ___ Stillbirths ___ Premature births___		
Date of last period _____		Complications?.....		
Have you had discharge from the nipples?Yes	No	Have you ever taken birth control pills? .....	Yes	No

**Neurological**

Have you ever fainted? .....	Yes	No	Do you have severe headaches?.....	Yes	No
Have you ever had a convulsion?.....	Yes	No	• Do they cause visual problems?.....	Yes	No
Double vision?.....	Yes	No	• Do they occur on one side of the head?...	Yes	No
Ringing in ears?.....	Yes	No	• Do they awaken you at night?.....	Yes	No
Weakness in arms or legs? .....	Yes	No	• Does Aspirin relieve them?.....	Yes	No

**General**

Do you have diabetes? ..... Yes No  
 • For how many years? ..... \_\_\_\_\_  
 • Under physicians care?..... Yes No  
 • Is it controlled with medication?..... Yes No

Do you experience extreme weakness or fatigue?..... Yes No  
 • For how many years? ..... \_\_\_\_\_  
 • Under a physicians care? ..... Yes No

Hernia:

• Hiatal..... Yes No  
 • Umbilical..... Yes No  
 • Inguinal..... Yes No  
 • Untreated..... Yes No

**Psychosocial**

Do you experience any of the following conditions?  
 Bipolar disorder ..... Yes No  
 Anxiety/panic disorder ..... Yes No  
 Personality disorder ..... Yes No

Psychosis ..... Yes No  
 Depression ..... Yes No  
 • Under a physicians care? ..... Yes No  
 • Controlled with medication? ..... Yes No

**Personal Habits: (Check)**

**Tobacco Use**

None  Rare  Occasional  Frequent  
 How many years did/have you smoked? \_\_\_\_\_  
 If so when did you quit? \_\_\_\_\_

**Alcohol Use**

None  Rare  Occasional  Frequent  
**Substance Abuse (Prescription/Illegal)**  
 None  Rare  Occasional  Frequent

**WEIGHT MANAGEMENT HISTORY:** This form is submitted to your insurance company with your letter of medical necessity. Approval or denial of your request for surgery depends on meeting the criteria put forth by your insurance company. Failure of multiple attempted dietary programs is a standard requirement. **Please fill out in detail.**

**Please Indicate Approximate Weights – How many years have you been morbidly obese? \_\_\_\_\_**

	Normal	Obese	Morbidly obese (100 pounds over ideal weight)
Childhood 1-10 years			
Adolescence 11-18 years			
Young Adult 18-30 years			
Adult 30-60 years			

Number of visits yearly to your physician for medical problems (asthma, hypertension, heart problems, joints, arthritis, respiratory, circulation, etc.) related to obesity. \_\_\_\_\_

Drs who are following, or have followed, your weight problems: <i>NAME</i>	<i>Diet programs your doctor has you trying, or has had you try:</i>	WT LOST	WT REGAINED	LENGTH OF PROGRAM	Est. Cost

Please provide to the best of your knowledge any Weight Loss Program you have tried over the years. This information is key to surgery authorization. Do your best to provide as much info as possible.

PROGRAM	YEAR	WT. LOSS	WT. REGAINED	LENGTH OF PROGRAM	EXPENCE
WEIGHT WATCHERS					
TOPS					
OVEREATERS ANONYMOUS					
DIET CENTERS					
Jenny Craig Nutri System					
Quick Weight Loss Center					
LA Weight Loss					
BEHAVIOR MODIFICATION					
JAWS WIRED					
APPETITE SUPPRESSANT PILLS					
SHOTS					
HYPNOSIS					
HOODIA					
SET FOR LIFE					
200 PLUS – DANA THORNOCK					
HOW TO LOWER YOUR FAT THERMOSTAT					
HERBAL LIFE					
SLIM FAST					
AMERICAN HEART ASSOCIATION DIET					
SLIM FOR LIFE					
RICHARD SIMMONS					
ACUPUNCTURE					
FAD DIETS					
SELF IMPOSED DIET ATTEMPTS					
OTHER					

### Physical Exercise

PROGRAM	TIME SPENT	WT. LOSS	WT. REGAINED	LENGTH OF PROGRAM	EXPENSE
Bicycling					
Jogging					
Walking					
Swimming					
Spa Memberships					
Aerobic					
Video tapes					
Health Rider					
Home gym equip.					
Curves					
Other					

