



# THE QUEEN'S MEDICAL CENTER

## COMPREHENSIVE WEIGHT MANAGEMENT PROGRAM

1380 Lusitana Street, POB 1, 3rd Floor ■ Honolulu, Hawaii 96813 ■ (808) 691-7546 ■ FAX: (808) 691-7807 ■ [www.queens.org](http://www.queens.org)

### What to Ask Your Health Insurer

Insurance plans vary in the services that they cover; therefore, it is your responsibility to speak with your insurer to determine what services your specific plan covers. **In general, most insurers will cover bariatric surgery if the insured meets specific criteria.**

The most common criteria require:

- BMI > 40 kg/m<sup>2</sup>
- BMI > 35 kg/m<sup>2</sup>, with at least one of the following:
  - Type 2 Diabetes Mellitus
  - Hypertension, on three antihypertensive medications
  - Obstructive Sleep Apnea

The following information may be useful when speaking with your insurer:

- The code your insurer will need is called a CPT code. The CPT code will depend on which surgical procedure you and your surgeon choose. The CPT codes for bariatric surgery are:
  - **43644 Laparoscopic Roux-en Y Gastric Bypass**
  - **43775 Laparoscopic Sleeve Gastrectomy**
- You may want to ask what portion of the hospital, surgeon and anesthesiologist's bill will be covered. Some plans will cover 90%, others 80%. With some plans, you may have a fixed deductible that you must pay each year.
- Some plans require the patient work with a registered dietitian or physician monthly for 3-6 consecutive months before they will authorize surgery.
- If you are traveling from the neighbor island for visits or for surgery, you may want to inquire about covered benefits that can be coordinated through your Primary Care Physician.

### What is Not Covered?

- **Enrollment Fee**
- **Co-payments and Deductibles**
- **Facility Fee (if being seen at Punchbowl)**
- **Vitamin and Mineral Supplements**
- **Cosmetic Surgery to remove excess skin**



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### Your Initial Consultation and Evaluation

Thank you for registering with The Queen's Medical Center Comprehensive Weight Management Program. Congratulations for taking the next steps to improve your health and change your life! In an effort to make your first visit with us as efficient and pleasant as possible, please review this document and the contents of this folder. They include important reminders and a checklist of items we would like you to bring.

If you are enrolling in our **Medically Managed Weight Loss Program**, your initial consultation will include:

- An individual visit with the Bariatrician (1 hour). You may request visits with the Registered Dietitian and a Behavioral Health Specialist at your following clinic visit.

If you are enrolling in our **Surgical Weight Loss Program**, please note that the total time of your visit will take approximately four hours. For this reason we ask that you do not bring young children who will need supervision. Your initial consultation will include:

- Individual visits with the Bariatrician and Psychologist (1 hour each)
- Dietician Education Video (34 minutes)
- Psychological testing (45 to 60 minutes)

These appointments can be completed on the same day or scheduled on different days, if that is more convenient.

#### Initial Visit Instructions:

- Wear loose fitting clothes. You will be asked to remove your shoes and socks.
- Arrive 30 minutes before your scheduled appointment time.
- Bring your parking ticket, so that we can validate it for you.
- Inform the staff if you have an implanted cardiac pacemaker or defibrillator.

#### Please be sure to bring the following items with you:

- Photo ID
- Health Insurance Card(s)
- Completed Health Questionnaire
- Completed Food Log
- Signed Important Financial Information and Patient Agreement Forms

Should you have any questions, please call us at 808-691-7546. We look forward to seeing you soon. Thank you for selecting Queen's for your care!

# Registration Form

COMPREHENSIVE WEIGHT  
MANAGEMENT PROGRAM



THE QUEEN'S  
MEDICAL CENTER

Queen's Physicians Office Building 1 ■ 1380 Lusitana Street, Suite 300 ■ Honolulu, HI 96813  
Ph: 808-691-7546 ■ FAX: 808-691-7802 ■ www.queens.org

Date Completed _____	<input type="checkbox"/> Surgical
	<input type="checkbox"/> Medically Supervised
	<input type="checkbox"/> Undecided

**FOR OFFICE USE** MRN \_\_\_\_\_

Full Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Height (ft) \_\_\_\_\_ (in) \_\_\_\_\_ Weight (lbs) \_\_\_\_\_ **For Office Use**  
BMI \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Email Address\* \_\_\_\_\_

Home Address \_\_\_\_\_

Ethnicity \_\_\_\_\_ Part Hawaiian?  Yes  No

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Married?  Yes  No Veteran?  Yes  No Religious preference: \_\_\_\_\_

## ■ Health Care Information

Insurance Provider \_\_\_\_\_ Insurance Type:  PPO  HMO  Quest  Medicare

Primary Care Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

### Known Health Issues: ( Check all that apply)

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Diabetes Mellitus                      | <input type="checkbox"/> Hyperlipidemia   | <input type="checkbox"/> Chronic Back Pain    | <input type="checkbox"/> Polycystic Ovarian Syndrome (PCOS) |
| <input type="checkbox"/> Dyslipidemia                           | <input type="checkbox"/> Hypertension   | <input type="checkbox"/> Foot Pain            | <input type="checkbox"/> Pre-diabetes                       |
| <input type="checkbox"/> Dyspnea on Exertion                    | <input type="checkbox"/> Hypothyroidism   | <input type="checkbox"/> Hip Pain             | <input type="checkbox"/> Pseudotumor Cerebri                |
| <input type="checkbox"/> Fatty Liver Disease                    | <input type="checkbox"/> Metabolic Syndrome   | <input type="checkbox"/> Knee Pain            | <input type="checkbox"/> Psychological Factors              |
| <input type="checkbox"/> Gastroesophageal Reflux Disease (GERD) | <input type="checkbox"/> Obstructive Sleep Apnea (OSA)  | <input type="checkbox"/> Lower Extremity Pain |   |
| <input type="checkbox"/> Hypercholesterolemia                   | <input type="checkbox"/> Prior bariatric surgery? Type: _____ Year: _____ Place of surgery: _____ |   |   |

Spouse's Information Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact's Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about our program? Check One (Add check boxes)

Television  Google  Website  Radio  Friend  Doctor's Office  Other \_\_\_\_\_

\*By providing your email address, you are giving CWMP permission to send support group updates and/or program information.  
CWMP will not disclose the email address to outside entities.

### FOR OFFICE USE ONLY

Date \_\_\_\_\_ Time \_\_\_\_\_ Provider \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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### Important Financial Information

1. It is important that you check with your insurance carrier to determine whether or not your insurance plan covers **Bariatric Surgery** or **Weight Management** benefits. If you have an HMO or Quest plan, you must obtain a referral from your primary care physician and get approval from your insurance carrier before your visit. Any charges not covered by your insurance will be your responsibility.
2. Nutrition counseling is an important aspect of our program. If your health plan does not cover nutrition counseling, you will be offered a 30% discount. Please be prepared to pay for the dietitian charges on the day of your visit to receive an additional 10% discount.
3. **The QMC Comprehensive Weight Management Program** is a hospital outpatient department of The Queen's Medical Center- Punchbowl (QMC-PB). Depending on your insurance coverage, you may incur a coinsurance fee for your outpatient visit to our **Punchbowl Clinic** (facility fee) in addition to each provider professional coinsurance fee.
4. Please check with your insurance carrier to determine your co-pay outpatient services and be prepared to make payment on the day of your visit.

#### For our surgical program:

1. The non-refundable program enrollment fee of \$100 must be received prior to your initial clinic visit.
2. Nutrition counseling is a critical component for success with bariatric surgery. Visits with the dietitian will include: a minimum of three visits prior to surgery, a mandatory pre-op class and six visits in the year after surgery.
3. Psychological testing is required in preparation for bariatric surgery. The cost of testing may or may not be covered by your insurance. If your insurance does not cover the psychological testing, you will be billed. It is your responsibility to check with your insurance carrier to determine what services are covered.
4. Please check with your insurance carrier to determine your co-pay for surgery and inpatient services. The Queen's Medical Center will provide you with an estimate of your hospital cost share at the time you are pre-registered for your surgical procedure. You will be expected to pay this cost prior to surgery as part of the pre-registration process.
5. Diagnostic testing is an important part of pre and postsurgical care. Insurance plans may not cover the cost of all diagnostic testing. You may be asked to sign an Advanced Beneficiary Notice of Noncoverage (ABN) prior to your test. If your plan declines coverage, you may receive an invoice for payment due. Please be advised that you will be responsible for any amounts due, but may qualify for a discount by contacting the Queen's or DLS billing department.
6. Bariatric Vitamins are critical to maintaining health after surgery and are not covered by insurance. Please be prepared to purchase your vitamins ahead of surgery and plan for this monthly expense. Estimated cost ranges from \$35 to \$80 per month depending on where you purchase the supplements.

I certify that I have read and understand this financial information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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### **Patient Agreement**

Welcome to the Queen's Comprehensive Weight Management Program. To ensure effective patient care and efficiency, we ask that you review the following key points and sign in agreement prior to your initial visit.

#### **Clinic appointments:**

- Our staff will call to confirm appointments one week ahead of your visit. Please note that if you do not confirm with us, your appointment may be given away.
- You are required to check-in **before** your scheduled appointment time. This is to ensure that your vitals can be obtained ahead of visits with your provider(s). Please arrive 30 minutes early for your very first visit with us, and 15 minutes early for any follow-up visits.
- If you need to reschedule a visit, please contact us at least **48 hours** prior to your appointment.
- Late rescheduled visits (less than 48 hours of notice) and/or failure to attend scheduled visits are a detriment to the efficiency of our clinic and ability to offer timely appointments. Therefore, if you have more than **two** incidents, you may be dismissed from our program.
- At each visit, please sign and be sure to notify us of any changes to your address, phone number, insurance or primary care physician. Please be sure to schedule your next appointment before leaving.
- Parking validation for the POB parking garages will be provided to patients who have scheduled appointments.
- If you are traveling from the neighbor island, please be sure to coordinate any insured benefits through your Primary Care Physician.

#### **Program guidelines:**

- If enrolled in our surgical program, please be aware that all patients must meet program requirements which include being approved by our patient selection committee and being cleared for surgery by each discipline (Bariatrician, Registered Dietitian and Behavioral Health).
- Please be aware that your insurance company may have specific requirements that must be met in addition to our program guidelines. This may include a minimum length of time in our program or number of consecutive monthly visits.
- Some equipment at the facility has size and weight limitations, which may not be able to accommodate the size of all patients in the program, so it is possible that some services (e.g., nuclear medicine) may be limited.

**I have read, understand and agree to all of the above.**

Patient's Signature: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

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

# Weekly Food Log

**Instructions:** Please track your diet for one week before your initial appointment with the dietitian. Include details like your food and drink choices, time eaten, portions, and how food was prepared.

COMPREHENSIVE WEIGHT  
MANAGEMENT PROGRAM



	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
BREAKFAST							
SNACK							
LUNCH							
SNACK							
DINNER							
SNACK							

# THE QUEEN'S MEDICAL CENTER

## CONSENT FOR PHOTO, VIDEO OR AUDIO RECORDING

\_\_\_\_\_  
PATIENT'S NAME (PRINT)

By signing this form below, I confirm that this consent has been explained to me in terms I understand. Please read the following consent carefully.

- I consent for photo/video/audio recordings to be made of me for the purposes of my medical care and treatment. Refusal to consent will in no way affect the medical care that I receive. Photos that are taken will be used by my healthcare providers for the purpose of diagnosis and treatment. Photos will be retained as part of my medical record. I understand that I may withdraw my consent at any time. If I have any questions or I wish to withdraw my consent I will notify my attending doctor.

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
TIME

AM  
PM

\_\_\_\_\_  
SIGNATURE OF PATIENT'S REPRESENTATIVE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
TIME

AM  
PM

\_\_\_\_\_  
PRINT NAME OF REPRESENTATIVE

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

Reference: Administrative Policy #610-15-325-B "The Use of Photo/Video/Audio recording Devices"



**THE QUEEN'S MEDICAL CENTER**  
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## Health Questionnaire

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

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

### I. WEIGHT HISTORY

**What type of weight loss are you considering?**

Roux-en-Y Gastric Bypass

Sleeve Gastrectomy

Non-surgical Weight Loss

Undecided

**How did you hear about the program?**

**Why do you want to lose weight?**

**Do you have a goal weight, if so what is it?** \_\_\_\_\_

**When did you first become overweight/obese?**

Childhood

Teenager

Adult

**What was your lowest adult weight?** \_\_\_\_\_

What age were you? \_\_\_\_\_

**What was your heaviest adult weight?** \_\_\_\_\_

What age were you? \_\_\_\_\_



**What triggers you to eat or causes you to gain weight? Circle all that apply.**

Nutrition	Life Events	Emotional Eating	Activity
Large portions	Pregnancy	To feel emotionally full	Lack of exercise
High-fat foods	Stopped smoking	Stress/ Anxiety	Increasing sedentary life
High-carbohydrate foods	Stopped drinking	Anger/Frustration/Guilt	
High-sugar foods or drinks	Stopped drugs	Loneliness	
Low vegetable intake	Family gatherings	Depression	<b>Other</b>
Low water intake	New/Loss/Change of job	Sadness	Financial strain
Skipping meals	Moving/ Relocation	Boredom	Time management
Grazing	Marriage	To protect self	
Night eating	Divorce	Happiness	
Convenience	Accident/ Injury	Times of joy	
Limited cooking ability	Death of close person	To reward self	

Other: \_\_\_\_\_

**Please tell us about your weight loss attempts:**

✓	Program	When	Amount of Weight Lost	How long did you keep the weight off?	Comments
<input type="checkbox"/>	"On Own": Diet Exercise				
<input type="checkbox"/>	Fasting or deliberate limitation				
<input type="checkbox"/>	Weight Watchers				
<input type="checkbox"/>	Jenny Craig				
<input type="checkbox"/>	NutriSystems				
<input type="checkbox"/>	Shintani Diet				
<input type="checkbox"/>	Ornish				
<input type="checkbox"/>	Liquid Diets: Optifast, Medifast, Slimfast, etc.				
<input type="checkbox"/>	Other (please specify):				

What are your greatest challenges with weight loss? \_\_\_\_\_

**Have you ever taken medication to lose weight? Check all that apply.**

- |  |                                     |                                       |   |  |
|--|-------------------------------------|---------------------------------------|---|--|
| <input type="checkbox"/> Phentermine (Adipex)      | <input type="checkbox"/> Meridia    | <input type="checkbox"/> Xenecal/Alli | <input type="checkbox"/> Phen/Fen       | <input type="checkbox"/> Ozempic (semaglutide) |
| <input type="checkbox"/> Phendimetrazine (Bontril) | <input type="checkbox"/> Topiramate | <input type="checkbox"/> Saxenda      | <input type="checkbox"/> Diethylpropion | <input type="checkbox"/> Wegovy                |
| <input type="checkbox"/> Bupropion (Wellbutrin)    | <input type="checkbox"/> Belviq     | <input type="checkbox"/> Qsymia       | <input type="checkbox"/> Contrave       |  |

Other (including supplements): \_\_\_\_\_

What worked? \_\_\_\_\_

What didn't work? \_\_\_\_\_

Why or why not? \_\_\_\_\_

## II. NUTRITION AND PHYSICAL ACTIVITY

Do you follow a special diet? Circle any that apply.

None    Diabetic    Low-Sodium    Low-Fat    Kosher    Vegetarian/Vegan

Other: \_\_\_\_\_

Do you have any food allergies or food sensitivities? \_\_\_\_\_

Which meals do you usually eat?    Breakfast    Lunch    Dinner

Which meals, if any, do you skip?    Breakfast    Lunch    Dinner    None

If you snack, when do you eat?    Morning    Afternoon    Evening    None

What are some of your favorite foods to eat? \_\_\_\_\_

What beverages do you drink and how much (ounces)? \_\_\_\_\_

In a typical week, how are your meals prepared?

Home-cooked:	Most	Some	All
Pre-made or Frozen:	Most	Some	All
Restaurant or Take-out:	Most	Some	All

What do you do for physical activity?

How many days in the past week have you participated in physical activity? 0 1 2 3 4 5 6 7

Duration: \_\_\_\_\_ hours \_\_\_\_\_ minutes per session

Does anything limit you from exercising?

What types of activities would you like to be able to do?

### III. PSYCHOLOGICAL & SOCIAL HISTORY

What is/was your occupation? \_\_\_\_\_

Shift work? Yes No

Are you currently employed? Yes No

Does your weight limit your ability to work or be active? Yes No

If yes, please explain:

Who are your main sources of social support? \_\_\_\_\_

Who lives with you? \_\_\_\_\_

Do those close to you support your decision to lose weight and improve health? Yes No Unsure

Who does the grocery shopping for the household? \_\_\_\_\_ Cooking? \_\_\_\_\_

Will those in the household change the way the shopping and cooking are done to support your weight loss efforts? Yes No Unsure

Have you ever smoked, vaped, or chewed nicotine? Yes No

If Yes: Are you still using nicotine? Yes No

How long have/did you use nicotine?

How much do/did use nicotine a day?

If No: When did you quit?

Have you ever drunk alcohol? Yes No

If Yes: Do you still drink alcohol? Yes No

How much do you drink?

Did you ever drink to excess? Yes No

If No: When and why did you quit?

Have you ever used "street" drugs, marijuana, or abused prescription drugs? Yes No

If Yes: Are you still using/abusing? Yes No

What are/were your drugs of choice?

Has your doctor ever diagnosed you with, or do you think you suffer from, any of the following?

Circle all that apply:

- Depression
- Anxiety
- Panic attacks
- Bipolar
- Anorexia nervosa
- Bulimia
- Binge eating disorder
- Compulsive overeating

Have you ever been a victim of any of the following? Circle all that apply:

Sexual abuse      Emotional abuse      Physical violence      Verbal abuse

If you checked a history of abuse/violence, it happened when you were: Child      Adult      Both

Is the abuse ongoing? Yes No

Do you feel safe now? Yes No

#### IV. FAMILY HISTORY

Does anyone in your immediate family suffer from an addiction (i.e. alcohol, drugs, food, gambling)? Yes No

Whom and what substance?

Is the addiction ongoing? Yes No

Please refer to your <u>biological</u> family only.  Do not include step-parents.	Age	Living		If not alive, what was the cause of death and age at time of death?	Health Conditions, check all that apply								
		Yes	No		Overweight	Obese	Heart disease	Diabetes	High blood pressure	Cholesterol	Stroke	Cancer	
Mother													
Father													
Brother/ Sister													
Brother/ Sister													
Brother/ Sister													
Brother/ Sister													

Other significant family illness/ history: \_\_\_\_\_

#### V. MEDICAL HISTORY

**Allergies** Do you have any Drug Allergies? Yes No

If Yes, please list: \_\_\_\_\_

**Surgeries** Have you ever had excessive bleeding after surgery or dental procedures? Yes No

Have you had prior surgery? Yes No

If Yes, please list all prior surgeries and the year: \_\_\_\_\_

\_\_\_\_\_

**Has a Doctor or Health Professional ever diagnosed you with or treated you for any of the following?** Circle all that apply:

- Asthma
- Chronic lung disease/COPD
- Emphysema
- Pulmonary embolus (blood clot in lungs)
  - Requiring medications? Yes No
- Pulmonary hypertension
- Obesity hypoventilation syndrome
- Obstructive sleep apnea (OSA)
- Oxygen use
- High blood pressure
- High cholesterol
- Congestive heart failure (CHF)
- Heart valve abnormalities
- Abnormal heart rhythms
- Atrial fibrillation
  - Requiring medications? Yes No
- Aneurysms
- Heart attack (MI)
- Idiopathic intracranial hypertension (Pseudotumor Cerebri)
- Deep Vein Thrombosis (DVT, blood clot in legs)
  - Requiring medications? Yes No
- Venous ulcers on your legs
- High sugars, but not diabetes
- Diabetes
- Hypothyroidism
- Hyperthyroidism
- GERD/Acid Reflux
- Heartburn
- Irritable bowel syndrome
- Gastroparesis
- Ulcers
- Hiatal hernia
- Gallstones
- Cirrhosis
- Hepatitis
- Fatty liver
- Elevated liver functions tests
- Urinary incontinence/Leaky urine
- Kidney stones
- Kidney disease
- End Stage Kidney Disease on Dialysis
  - Plans for an organ transplant? Yes No
- Joint pain or Arthritis
- Gout (List joints: \_\_\_\_\_)
- Stroke
- Seizures
- HIV/AIDS
- Psoriasis
- Glaucoma

What other medical problems do you have?

## Review of Systems: Circle Yes or No

### General

Previous obesity surgery: Yes No  
Cancer in the past 5 years? Yes No

### Neuro

Numbness/tingling in hands, arms, legs, feet Yes No  
Memory problems Yes No

### Pulmonary

Morning headaches: Yes No  
Cough: Yes No  
Wheezing: Yes No  
Allergy symptoms: Yes No  
Sleep: Hours of sleep per night: \_\_\_\_\_ Quality: Good Fair Poor  
Have you ever been diagnosed with obstructive sleep apnea? Yes No  
If Yes, date and place of study \_\_\_\_\_  
If Yes, do you use CPAP, BiPAP? Or, have you had a UPPP? Yes No  
Snoring - Do you snore loudly? Yes No  
Tired - Do you often feel tired, fatigued, or sleepy during daytime? Yes No  
Observed - Has anyone observed you stop breathing during your sleep? Yes No  
Blood Pressure - Do you have or are you being treated for High Blood Pressure? Yes No

### Cardiac

Heart attack or stroke in the past 6 months? Yes No  
Chest pain? Yes No  
Exertional Shortness of Breath (when walking)? Yes No  
Shortness of Breath when Laying flat? Yes No  
Leg swelling? Yes No  
Palpitations (feeling your heart race or skip a beat)? Yes No  
Dizziness or passing out? Yes No  
Can you climb a flight of stairs or walk up a hill without stopping? Yes No  
When was your last stress test? \_\_\_\_\_  
When was your last angiography? \_\_\_\_\_

### Vascular

Cramping or pain in legs with walking? Yes No

### Heme/Onc

Abnormal bruising/bleeding? Yes No  
Use of blood thinners? Yes No  
Blood in stool? Yes No  
Have you ever had a cancer or tumor? Yes No  
If Yes, what type? \_\_\_\_\_  
Treatment (circle all that apply): Surgery Chemo Radiation Other  
How long since last treatment? \_\_\_\_\_  
How often are you seeing your oncologist? \_\_\_\_\_  
How long have you been in remission? \_\_\_\_\_  
Have you had any recurrence? \_\_\_\_\_

Have you had Colon Cancer Screening (i.e. colonoscopy)? Yes No If Yes, date: \_\_\_\_\_  
Have you had Breast Cancer Screening (i.e. mammogram)? Yes No If Yes, date: \_\_\_\_\_  
Have you had Cervical Cancer Screening (i.e. PAP smear)? Yes No If Yes, date: \_\_\_\_\_

**Rheumatology/MSK**

Joint pain? Yes No

Back pain? Yes No

Activity is limited by pain? Yes No

Requiring daily medication? Yes No

What kind of medication, including over-the-counter: \_\_\_\_\_

Surgical Intervention performed or planned? Yes No

**Endocrine**

If you are diabetic: How often do you check your sugars at home? \_\_\_\_\_

What do your sugars run, at home? \_\_\_\_\_

What was your last HA1C? \_\_\_\_\_

**G/U (Females)**

Are you planning to get pregnant within 18-24 months? Yes No

Birth control? Yes No

Do you/ did you have a "regular" menstrual cycle? Yes No

Polycystic ovaries? Yes No

Estrogen or hormone replacement therapy? Yes No

Undergone Hysterectomy? Yes No

Tubal ligation? Yes No

**GI**

GERD/Acid Reflux: Yes No

If Yes, how long have you had these symptoms (weeks, months, years)? \_\_\_\_\_

How would you rate your symptoms? Mild Moderate Severe

Do you take medications for it? Yes No

Abdominal pain: Yes No

Vomiting: Yes No

Diarrhea: Yes No

Constipation: Yes No

Difficulty swallowing food/liquids: Yes No

**Skin**

Skin infections/rashes/wounds Yes No





**Aside from your Primary Care Physician, please list your other health care providers, mental health providers or specialists that you see on a regular basis.**

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

Specialty: \_\_\_\_\_

Reason you see them: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

Specialty: \_\_\_\_\_

Reason you see them: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

Specialty: \_\_\_\_\_

Reason you see them: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

Specialty: \_\_\_\_\_

Reason you see them: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_