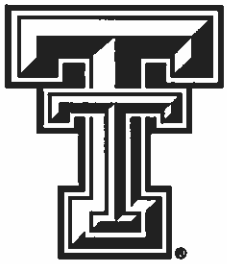

Texas Tech Physicians

of LUBBOCK

DEPARTMENT OF SURGERY/BARIATRICS

Adult Bariatric Surgery Program

Health History Questionnaire – Medical / Nutritional

Texas Tech Physicians
of LUBBOCK
DPARTMENT OF SURGERY/BARIATRICS

Adult Bariatric Surgery Program

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NAME:

MRN:

BIRTHDATE:

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

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

PERSONAL INFORMATION

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

ADDRESS:

CITY: STATE: ZIP CODE:

PHONE NUMBER WHERE YOU CAN BE REACHED OR RECEIVE A MESSAGE 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 CODE:

PHONE:

REFERRING PHYSICIAN (IF DIFFERENT FROM PRIMARY CARE PHYSICIAN)

PHYSICIAN NAME:

ADDRESS:

CITY: STATE: ZIP CODE:

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:

Texas Tech Physicians
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DPARTMENT OF SURGERY/BARIATRICS

Adult Bariatric Surgery Program

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NAME:

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BIRTHDATE:

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, and 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 ❑ LIQUOR ❑ If you quit, when? _____

HISTORY OF DRUG ABUSE? YES ❑ NO ❑ If you quit, when? _____

What 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:
❑ Heart Disease		❑ High Blood Pressure	
❑ Stroke		❑ Obesity	
❑ Blood Clot		❑ Blood Disorder	
❑ Diabetes		❑ Kidney Disease	
❑ Cancer (Type): _____ _____		❑ Thyroid Disease	

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NAME:

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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 ❑ Type 2 ❑	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 ❑ Hyperthyroidism ❑
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 ❑ Hips ❑ Ankles ❑ Wrist ❑ Hands ❑ Back ❑ Other: _____	Y	N	Hernia: What kind?: _____ Has it been repaired? Yes ❑ No ❑
Y	N	Chronic Low Back Pain	Y	N	Urinary Incontinence
Y	N	Gallbladder Diseases: Has it been removed? Yes ❑ No ❑	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) ❑ DVT: When? _____ What was the cause? _____ ❑ 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): Anxiety ❑ Depression ❑ Panic Attacks ❑ Bipolar Disorder ❑ 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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SURGERIES: Please include the dates

Date	Surgery	Date	Surgery

MEDICATIONS: What medications do you take on a regular basis? Include any over-the-counter herbal, vitamin-mineral, and prescription drugs.

Medication	Dosage (mg/IU/gm, etc.)	How Often (times/day)	Why do you take it?

ALLERGIES: Are you allergic to any drug, food or substance? (Example: Latex)
If yes, What happens when you take or are exposed to it?

Drug/Food/Substance	Reaction

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BIRTHDATE:

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 ❑ Prescription ❑				
Over the Counter ❑ Prescription ❑				
Over the Counter ❑ Prescription ❑				

Current weight in pounds: _____ At what age were you when your weight became a problem?

Height in inches: _____ _____

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:

❑ to make me happy ❑ when I'm frustrated or upset ❑ out of habit
❑ to reward myself ❑ to comfort myself ❑ because I'm bored
❑ to make me feel "better" ❑ 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 point 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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BIRTHDATE:

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 loudly, 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)

Texas Tech University Health Sciences Center

Confidential Communication Request
And
Identity Theft Protection Questions

Patient Name: _____

MRN: _____

DOB: _____

TTUHSC values the privacy of its patients and is committed to operating our practice in a manner that promotes patient confidentiality while providing high quality patient care. TTUHSC will accommodate reasonable requests.

If you need copies of medical records, you will need to complete a different authorization form. Please ask a staff member for the required form.

☐ Permission to give verbal protected health information or leave messages with the following person(s): **Example: family members, friends, personal caregivers, etc. You do not need to list any medical providers who are involved in your care.**

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

☐ Permission to call the following numbers to leave messages (without disclosing protected health information): **Please note that TTUHSC cannot leave specific test results or details of treatment plan on answering machines or voice mail due to our concern for your privacy.**

Phone #: _____ Phone #: _____

☐ Permission to use e-mail address for the purpose of providing information about on-line patient portal and general information about TTUHSC.

E-mail address: _____

Security and Identity Theft Protection Questions: Please provide a minimum of two answers.

1. What was the name of the elementary school you attended? _____
2. What is your mother's maiden name? _____
3. What model was your first car? _____
4. What town were you born in? _____

Date	Print Name	Signature (Patient or Other Legally Authorized Person)
Time	Witness/Translator	Relationship to Patient

Texas Tech University Health Sciences Center Ambulatory Clinics Consent to Treatment/Health Care Agreement	Patient Label (Name, DOB, SIRN)

CONSENT TO TREATMENT: I voluntarily consent to receive medical and health care services provided by Texas Tech University Health Sciences Center physicians, employees and such associates, assistants, and other health care providers (otherwise referred to as "TTUHSC"), as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations, and treatment. I understand photographs, videotapes, digital and/or other images may be made/recorded for treatment and payment purposes only. I understand that TTUHSC is a teaching institution. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I acknowledge that TTUHSC may use health information exchange systems to electronically transmit, receive and/or access my medical information which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history, and other health care information.

I understand that this Consent to Treatment/Health Care Agreement will be valid and remain in effect as long as I attend or receive services from the TTUHSC Ambulatory Clinics, unless revoked by me in writing with such written notice provided to each clinic I attend or from which I receive services.

RELEASE OF MEDICAL INFORMATION: I acknowledge that "protected health information" pertains to my diagnosis and/or treatment at TTUHSC including, but not limited to, information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs, or communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, prescriptions, medical history, prescription history, treatment progress or any other such related information.

I acknowledge that the "Notice of Privacy Practices" provides information about how TTUHSC and its workforce may use and/or disclose protected health information about me for treatment, payment, health care operations, and as otherwise allowed by law. I understand TTUHSC cannot be responsible for use or re-disclosure of information by third parties.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, I hereby assign to TTUHSC physicians and providers and/or the TTUHSC Medical Practice Income Plan my right, title, and interest in all insurance, Medicare/Medicaid, or other third-party payer benefits for medical or health care services otherwise payable to me. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third-party payer, up to the total amount of my medical and health care charges, to TTUHSC physicians and/or Medical Practice Income Plan. I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct.

I agree to pay all charges for medical and health care services not covered by, or which exceed, the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer, and agree to make payment as requested by TTUHSC.

ADVANCE DIRECTIVE:

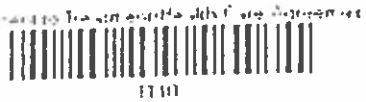
Has an Advance Directive been signed?	____ YES	____ NO
If yes, is it still in effect?	____ YES	____ NO
Has a signed copy been provided to TTUHSC?	____ YES	____ NO

NOTICE OF PRIVACY PRACTICES:

I have received a paper copy of TTUHSC's Notice of Privacy Practices. _____ (Patient's Initials)

I certify that I have read this form or it has been read to me*.

Date	Print Name	Patient/Other legally authorized person
Time	Witness/Translator*	Relationship to Patient



TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER

NOTICE OF PRIVACY PRACTICES

EFFECTIVE: APRIL 14, 2003
REVISED: SEPTEMBER 23, 2013

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

ABOUT THIS NOTICE:

Texas Tech University Health Sciences Center (TTUHSC) is dedicated to maintaining the privacy of your Protected Health Information (PHI). TTUHSC provides health care services and items through its Schools of Medicine, Nursing, Pharmacy and Allied Health Sciences. TTUHSC provides services at its main community hospitals, ambulatory care clinics, ambulatory surgical centers, pharmacies, research units and several community service outreach centers throughout West Texas. TTUHSC is required by law to maintain the privacy of your PHI and provide you with notice of its legal duties and privacy practices. This notice of privacy practices describes how TTUHSC may use or disclose your PHI. PHI includes any information that relates to (1) your past, present, or future physical or mental health or condition; (2) providing health care to you; and (3) the past, present, or future payment for your health care. For TTUHSC at Lubbock, University Medical Center (UMC), and UMC Physicians Network Services (PNS) participate in a clinically integrated health care setting which is considered an organized health care arrangement under HIPAA. This arrangement involves participation of three legally separate entities in the delivery of health care services in which no entity will be responsible for the medical judgment or patient care provided by the other entities in the arrangement. Each entity within this arrangement (TTUHSC, UMC, and PNS) will be able to access and use your PHI to carry out treatment, payment, or health care operations. The terms of this notice shall apply to TTUHSC's privacy practices until it is changed by TTUHSC.

YOUR PRIVACY RIGHTS:

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- **Get an electronic or paper copy of your medical record.** You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, within 14 days of your request. We may charge a reasonable, cost-based fee.
- **Ask us to correct your medical record.** You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- **Request confidential communication.** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- **Ask us to limit what we use and share.** You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- **Get a list of those with whom we've shared information.** You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide accounting once a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **Get a copy of this privacy notice.** You can ask for a paper copy of this notice at any time, even if you have agreed to receive this notice electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you.** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- **File a complaint if you feel your rights are violated.** You may file a complaint in one of the following ways:
  - Contact the TTUHSC privacy official at the address indicated below
  - Use our confidential website at www.Ethicspoint.com
  - Contact The Office for Civil Rights:
    United States Department of Health and Human Services
    1301 Young Street, Suite 1169, Dallas, Texas 75202
    www.hhs.gov/ocr/privacy/hipaa/complaints/

  We will not retaliate or take action against you for filing a complaint.

YOUR CHOICES:

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- **In these cases, you have both the right and choice to tell us to:**
  - Share information with your family, close friends, or others involved in your care.
  - Share information in a disaster relief situation.
  - Include your information in a hospital directory
  - Contact you for fundraising efforts, but you can tell us not to contact you again.
  - If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- **In these cases we never share your information unless you give us written permission:**
  - Marketing purposes
  - Sale of your information
  - Most sharing of psychotherapy notes

TTUHSC USES AND DISCLOSURES:

How do we typically use or share your health information? We typically use or share your health information in the following ways.

- **Treat you.** We can use your health information and share it with other professionals who are treating you. For example: a doctor treating you for an injury asks another doctor about your overall health condition.
- **Run our organization.** We can use and share your health information to run our practice, improve your care, and contact you when necessary. For example, we use health information about you to manage your treatment and services.
- **Bill for your services.** We can use and share your health information to bill and get payment from health plans or other entities. For example, we give information about you to your health insurance plan so it will pay for your services.
- **How else can we use or share your health information?** We are allowed or required to share you information in other ways-usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html
    - **Help with public health and safety issues.**
        - We can share health information about you for certain situations such as:
            - Preventing disease
            - Helping with product recalls
            - Reporting adverse reactions to medications
            - Reporting suspected abuse, neglect, or domestic violence
            - Preventing or reducing a serious threat to anyone's health or safety
    - **Conducting Research.** We can use or share your information for health research.
    - **Comply with the law.** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
    - **Respond to organ and tissue donation requests.** We can share health information about you with organ procurement organizations.
    - **Work with a medical examiner or funeral director.** We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
    - **Address workers' compensation, law enforcement, and other government request.**
        - We can use or share health information about you:
            - For workers' compensation claims
            - For law enforcement purposes or with a law enforcement official
            - With health oversight agencies for activities authorized by law
            - For special government functions such as military, national security, and presidential protective services
    - **Respond to lawsuits and legal actions.** We can use or share health information about you in response to a court or administrative order, or in response to a subpoena.

TTUHSC RESPONSIBILITIES:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

CHANGE IN NOTICE OF PRIVACY PRACTICES:

TTUHSC reserves the right to change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

QUESTIONS:

If you have any questions about this notice or would like additional information, please contact the privacy official at the address and telephone number listed below or you may visit our web site at www.ttuhsc.edu/hipaa

PRIVACY OFFICIAL CONTACT INFORMATION

SONYA CASTRO
INSTITUTIONAL PRIVACY OFFICER
3601 4TH STREET, STOP 8165
LUBBOCK, TX 79430
(806) 743-3949

ALICIA KRIZAN
REGIONAL PRIVACY OFFICER
AMARILLO
1400 COULTER RD, ROOM B903
AMARILLO, TX 79106
(806) 354-5588

YVETTE QUINTANA-CHAVEZ
REGIONAL PRIVACY OFFICER
EL PASO
4800 ALBERTA AVENUE
EL PASO, TX 79905
(915) 215-4456

MELISSA CASTRACANE
REGIONAL PRIVACY OFFICER
AT THE PERMIAN BASIN
800 WEST 4TH STREET
ODESSA, TX 79763
(432) 703-5160

www.Ethicspoint.com

TTUHSC Provides For Program Accessibility To Members Of The Public. Those Who Need Materials In Braille, Large Print, Tape Format, Or Who Need An Interpreter Or Telecommunications Device For The Deaf Are Asked To Contact The Clinic Manager.