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 _____

❑ Surgical
❑ Medically Supervised
❑ 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)

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

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. 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.

2. 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.

3. 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.

4. 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.

5. 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.

Appointments:

- You will receive automated & MyChart reminders to confirm appointments 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 office or virtual appointment time. This is to ensure that your data can be obtained ahead of visits with your provider(s). Please check in 30 minutes before your initial visit with us, and 15 minutes before for any follow-up visits. For virtual visits, please call our office to check in at 808-691-7546.
- **Virtual Visits:** For safety reasons, we cannot have your visit if you are driving. Your visit will be rescheduled.
- 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 **one incident for New Patients**, **two incidents for Established Patients**, you may be dismissed from our program.
- At each visit, please 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: _____

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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	**Other**
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
☐ "On Own": Diet Exercise				
☐ Fasting or deliberate limitation				
☐ Weight Watchers				
☐ Jenny Craig				
☐ NutriSystems				
☐ Shintani Diet				
☐ Ornish				
☐ Liquid Diets: Optifast, Medifast, Slimfast, etc.				
☐ Other (please specify):				

What are your greatest challenges with weight loss? _____

_____

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

☐ Phentermine (Adipex) ☐ Meridia ☐ Xenecal/Alli ☐ Phen/Fen ☐ Ozempic (semaglutide)
☐ Phendimetrazine (Bontril) ☐ Topiramate ☐ Saxenda ☐ Diethylpropion ☐ Wegovy
☐ Bupropion (Wellbutrin) ☐ Belviq ☐ Qsymia ☐ 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 <u>past</u> 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

		Living			Health Conditions, check all that apply							
Please refer to your biological family only. Do not include step-parents.	Age	Yes	No	If not alive, what was the cause of death and age at time of death?	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
Daily Headaches Yes No
Vision loss, blurriness or flashes of light Yes No
Do you hear your heartbeat? 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
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

Please list the names of all medications and the doses that you are currently taking. Include over the counter medications (i.e. aspirin, ibuprofen, glucosamine, vitamins, etc.)

Medication Name	Dose (mg)	# Tablets/Dose	Route (Oral, IM)	# Times Daily

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: _____

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