Madison Surgical Associates
General Surgery • Weight Loss Surgery Center

Ravindra Mailapur, MD, FACS

207 Longwood Drive Sw • Huntsville, Alabama 35801 • (256) 265-1890 • fax (256) 265-1891 • msahsv.com

BARIATRIC SURGERY WELCOME LETTER

Dr. Ravindra Mailapur and the staff at Madison Surgical Associates would like to extend a warm welcome to you and your family and congratulate you on your decision to learn more about weight loss surgery. Thank you for giving us the opportunity to share with you some vital information regarding weight loss surgery and our team.

Severe or morbid obesity is a condition that is debilitating and places an individual at increased risk for several co-morbidities and a shorter life expectancy. We have a multidisciplinary program to aid individuals suffering from morbid obesity and to help them overcome this condition.

Morbid obesity is increasingly recognized as a major health threat. It is defined as being at least 80-100 pounds over ideal body weight or having a body mass index (BMI) of 40 or greater. Approximately five percent or nine million of the U.S. adult population suffer from this condition. Rarely has diet and exercise been effective in controlling this problem.

Surgical treatment of morbid obesity is gaining increased acceptance. I feel that the Roux-en-Y Gastric Bypass, laparoscopic Adjustable Gastric Banding, and laparoscopic Sleeve Gastrectomy are effective weight loss surgery options.

We feel that we have a program that will be very distinguished for North Alabama and Southern Tennessee. We will offer pre and post-operative education and support. We will help you through the steps necessary to have surgery as well as provide you with support essential for postoperative success for years to come. The resources which will be available to you will include nutrition, exercise consultation, support groups, and psychological counseling.

Once again, we are delighted in having this opportunity to share our program with you. We look forward to helping you achieve a successful and positive weight loss experience.

Sincerely,

Ravindra Mailapur, M.D., F.A.C.S.

PATIENT INFORMATION SHEET

Personal Details

Date: _____

Name: _____ DOB/Age: _____

Address

Street:
City, State and Zip Code:

Home Tel: _____ Work Tel: _____ Mobile Tel: _____

Fax Number: _____ Preferred Method of contact: _____

Gender: ☐ Male ☐ Female Social Security # _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Ethnic Group**:** ☐ Caucasian ☐ Hispanic ☐ Asian ☐ African American ☐ Other

Employment Status**:** ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Other

Current Occupation: _____ Current Employer: _____

Current Employer Address: _____

Email 1: _____ Email 2: _____

Spouse's Name: _____ Spouse's DOB/Age: _____

Spouse's Employer: _____ Spouse's Social security Number: _____

Spouse's Work Tel: _____ Spouse's Mobile Tel: _____

Emergency Contact (Preferably someone not living with you)

Name: _____ Relationship: _____

Home Tel: _____ Work / Mobile Tel: _____

Referral Information (Please let us know, how did you hear about us)

Referred by: ☐ Physician ☐ Friend ☐ TV ☐ Radio ☐ Patient ☐ Internet ☐ Other

Details of referral source: _____

Billing Information

Primary Insurance Company**:** _____

Policy Number #**:** _____ Group Number #: _____

Name of insurance Holder: _____ Date of Birth of Insured: _____

Relationship to Insurance Holder: _____

Secondary Insurance Company**:** _____

Policy Number #**:** _____ Group Number #: _____

Name of insurance Holder: _____ Date of Birth of Insured: _____

Relationship to Insurance Holder: _____

BARIATRIC SURGERY HEALTH QUESTIONNAIRE

Patient Name: _____ DOB: _____ Age: _____

Gender: Male Female | Primary Care Physician: _____

DIETARY AND WEIGHT LOSS HISTORY

The information requested in this questionnaire is very important. To give you the best care, and to obtain your insurance approval, we must have complete answers:

(PLEASE Fill Height and Weight Only. We will calculate the BMI)

Height	Weight	BMI		

Please check the appropriate boxes and add notes as needed:
My obesity started: ☐In childhood ☐at puberty ☐as an adult ☐after pregnancy ☐after a traumatic event

Family History of Obesity: Yes ☐ No ☐ If YES, who: _____

How long have you been around the present weight for: _____ Years
Highest Adult Weight: _____ Date: _____ Lowest Adult Weight in the past 3 years: _____ Date: _____

Most weight lost on any program: ___ Program? _____ Weight loss sustained for: _____

Taste preferences (please check all that apply) ☐ Sweets ☐ Salty ☐ Fast food ☐ Comfort foods ☐ _____

Eating Habits (please check all that apply) ☐Binge eater ☐Stress ☐Boredom ☐Loneliness ☐ _____

Weight Loss Programs/Diets/Medications attempted in the past:

Program	Dates	Duration	Max Wt Lost	MD Supervised
Jenny Craig				
Nutri-system				
Weight Watchers				
Opti-fast, Medi Fast				
O.A. or TOPS				
Fen/Phen Redux				
Meridia				
Xenical				
Over the counter diet aids				
Atkins Diet				
Other:				
Other:				
Other:				
Other:				

Personal Medical History (Do you have or have you ever had? Check all that apply)

Cardiovascular	**Yes**	**No**	**Don't know**	**Reproductive**	**Yes**	**No**	**Don't know**
High Blood Pressure				Polycystic Ovarian Syndrome			
Congestive Heart Failure				Mennorhagia (Painful Periods)			
Heart Attack				Amenorrhea (No Periods)			
Angina (Chest Pain)				Partial Hysterectomy			
Peripheral Vascular Disease				Complete Hysterectomy			
Lower Extremity Edema				Others:			
DVT/PE (Blood Clot in Legs or Lungs)				**Psychosocial**			
Others:				Psychosocial Impairment			
				Depression			
Metabolic				Bipolar Disorder			
Diabetes Mellitus Type I				Personality disorder			
Diabetes Mellitus Type 2				Psychosis			
Hyperlipidemia (High Cholesterol)				Schizophrenia			
Gout Arthritis				Alcohol Use			
Others:				Tobacco Use			
				Substance Abuse			
Pulmonary				Past Alcohol or Substance Abuse			
Obstructive Sleep Apnea				Previous Eating Disorder			
Obesity Hypoventilation Syndrome				**General**			
Pulmonary Hypertension				Leakage of Urine			
Asthma				Pseudotumor Cerebri			
COPD				Abdominal Wall Hernia			
Home Oxygen				Functional Status			
Others:				• No Impairment			
				• Walk 200 ft with cane			
Gastro-Intestinal				• Cannot walk 200 ft with cane			
GERD				• Wheelchair			
Cholelithiasis (Gallstones)				• Bedridden			
Liver Disease				Abdominal Skin Infection			
Crohn's Disease							
Ulcerative Colitis				**Neurological**			
Others:				Epilepsy			
				Stroke			
Musculoskeletal				TIA (Transient Stroke)			
Back Pain							
Musculoskeletal Disease				**Others:**			
Fibromyalgia				Kidney Failure			
Rheumatoid Arthritis				AIDS			
Others:							

Cancer history:

Have you ever been diagnosed with cancer: Yes: ☐ No: ☐

What kind of cancer have you been diagnosed with:

When were you diagnosed with cancer: Cancer free since:

What treatment have you received since diagnosis: Chemotherapy:☐ Surgery:☐ Radiation Therapy:☐ Other:☐

Type of Surgery	Year of surgery. Open or Laparoscopic?

Have you had weight loss surgery before like gastric bypass, gastric stapling, etc. If so, give details:

Please list all **Previous Hospitalizations within the past 2 years:**

Reason for Hospitalization	Date and Year	Name of Hospital

Please list any **medications (prescription and over the counter, eye drops, creams), vitamins and/or herbal supplements** you are presently taking:

Name of Medication	Dosage / Frequency	Reason for taking the medicine

Family History

	Health problems if alive. Age of father	If dead, at what age did they die.	Cause of death.
Father			
	Health problems if alive. Age of Mother	If dead, at what age did they die.	Cause of death.
Mother			
Brothers: (Please give ages and major health problems in them)			
Sisters: (Please give ages and major health problems in them)			

List any allergies you have to food and medications. Please list the nature of your allergic reaction:

Do you have an allergy to any latex products? Yes: ☐ No: ☐

Social Profile:

Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Do you have a support person? Yes: ☐ No: ☐

Does the support person live with you? Yes: ☐ No: ☐

Employment Status: Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐

Are you a smoker? Yes: ☐ No: ☐ Packs/day: _____

Have you smoked in the past? Yes: ☐ No: ☐ Age started:_____ Age Quit:_____ Packs/day: _____

Do you consume alcohol: Yes: ☐ No: ☐ Drinks/day: _____

Have you ever consumed alcohol: Yes: ☐ No: ☐ Drinks/day: _____

Do you use recreational drugs? Yes: ☐ No: ☐ Type/frequency: _____

Education: 8th Grade or less ☐ High school graduate: ☐ College Graduate: ☐ Any Postgraduate Work: ☐

Screening for Sleep Apnea:

Have you ever been diagnosed with Sleep Apnea: Yes ☐ No ☐
Do you use a C-Pap: Yes ☐ No ☐
Do you use a Bi-Pap: Yes ☐ No ☐
Please complete the following even if you have sleep apnea:

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation		Chance of Dozing
	Sitting and reading	
	Watching TV	
	Sitting, inactive in a public place (i.e. a theater)	
	As a passenger in a car for an hour without a break	
	Lying down to rest in the afternoon when circumstances Permit	
	Sitting and talking to someone	
	Sitting quietly after lunch without alcohol	
	TOTAL SCORE	

Review of systems (Please indicate any personal history below):

• ***CONSTITUTIONAL SYMPTOMS***			• ***GENITOURINARY***		
Fever	No	Yes	Frequent Urination:	No	Yes
Chills	No	Yes	Painful Urination:	No	Yes
Fatigue	No	Yes	Blood in Urine:	No	Yes
Lightheadedness	No	Yes	Urinary Infections:	No	Yes
• ***EYES***			• ***MUSCULOSKELETAL***		
Eye Glasses	No	Yes	Muscle Cramps:	No	Yes
Eye Discharge	No	Yes	Joint Swelling:	No	Yes
Eye Pain	No	Yes	Joint Pain:	No	Yes
Blurred Vision	No	Yes	Back Pains	No	Yes
• ***EARS/NOSE /MOUTH/THROAT***			• ***INTEGUMENTARY (skin, breast)***		
Nose Discharge	No	Yes	Rash:	No	Yes
Hoarseness of voice	No	Yes	Dry Skin:	No	Yes
Decreased hearing	No	Yes	Breast Mass:	No	Yes
Ringing in ears	No	Yes	Nipple Discharge:	No	Yes
Bleeding from nose	No	Yes			
			• ***NEUROLOGICAL***		
• ***CARDIOVASCULAR***			Dizziness:	No	Yes
Chest Pain:	No	Yes	Headache:	No	Yes
Palpitations:	No	Yes	Strokes:	No	Yes
Edema:	No	Yes	Seizures	No	Yes
Shortness of Breath:	No	Yes			
Coronary Artery Disease:	No	Yes	• ***HEMATOLOGIC/LYMPHATIC***		
			Easy Bruising:	No	Yes
• ***RESPIRATORY***			Prolonged Bleeding:	No	Yes
Asthma:	No	Yes	Enlarged Lymph Nodes:	No	Yes
Cough:	No	Yes	Deep Vein Thrombosis:	No	Yes
Spitting up blood:	No	Yes			
Shortness of breath:	No	Yes	• ***OTHERS***		
• ***GASTROINTESTINAL***					
Change in Bowel habit:	No	Yes			
Nausea/ Vomiting:	No	Yes			
Rectal Bleeding:	No	Yes			
Constipation:	No	Yes			
Diarrhea:	No	Yes			
Heartburn:	No	Yes			

Please list the names of all the physicians you see:

Primary Care Physician:

Name: _____
Address: _____
_____

Office Tel: _____ Office Fax: _____

Cardiologist:

Name: _____
Address: _____
_____

Office Tel: Office Fax:

Psychiatrist / Psychologist:

Name: _____
Address: _____
_____

Office Tel: _____ Office Fax: _____

Pulmonary / Sleep Study Specialist:

Name: _____
Address: _____
_____

Office Tel: _____ Office Fax: _____

Gastroenterologist:

Name: _____
Address: _____
_____

Office Tel: Office Fax:

Other Physician:

Name: _____
Address: _____
_____

Office Tel: Office Fax:

Research and Support System

How long have you been contemplating bariatric surgery? _____

Have you done any research about bariatric surgery? YES ☐ NO ☐

If YES, What type of research was done: _____

Do you have a friend or family member who has had bariatric surgery? ☐ ☐

If YES, who? _____

Describe your present life stressors: _____

Describe the present support system you rely upon during and after surgery: _____

What are your goals expected from surgery:

What do you think is your greatest hope about the surgery: _____

What is your greatest fear about weight loss surgery:

What is the motivating factor making you seek this surgical intervention for weight loss: _____

Please write any other concerns that you have regarding your health or bariatric surgery:

I attended the public patient information seminar on: _____

_____ _____

Signature of the Patient Date of Signature

Please return the completed form along with a copy of your driving license and the front and back of insurance card to:

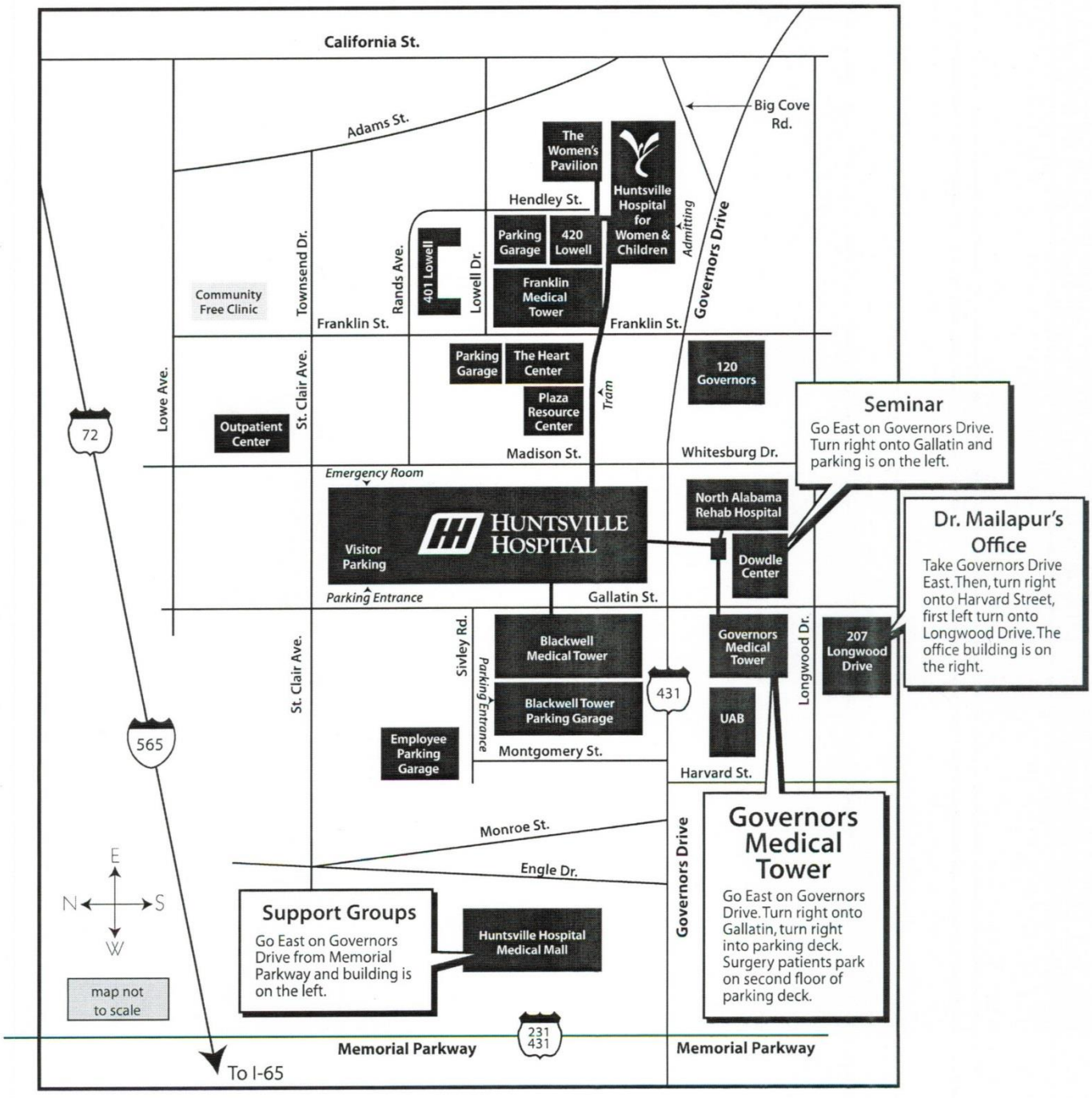
Ravindra V Mailapur, MD.
207 Longwood Drive SW
Huntsville, AL 35801

EXTREMELY IMPORTANT

Failure to fill this form completely may result in undue delay in having your information reviewed. Please take some time to fill this form as completely as possible to avoid delays in processing insurance approvals.

Huntsville Hospital / Dr. Mailapur's Office

Directions from the Parkway



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SEMINAR ATTENDANCE ACKNOWLEDGEMENT

I, _____, acknowledge that I have attended the education seminar on WEIGHT LOSS SURGERY (Bariatric Surgery). I have received detailed explanations on:

1. My role with bariatric surgery
2. Setting realistic expectations
3. Etiology, incidence and co-morbidities associated with morbid obesity
4. Different types of weight loss surgeries
5. Risks, benefits and alternatives of Roux-En-Y Gastric bypass surgery, Gastric Banding, Vertical Sleeve Gastrectomy, Duodenal Switch and Vertical Banded Gastroplasty.
6. Expected weight loss
7. Overview of the diet and post-operative follow-ups after weight loss surgery.
8. Overview of vitamin and mineral supplementation after surgery

I have been given the **Bariatric Patient Education Syllabus** to help me follow the lecture. The **Bariatric Patient Education Syllabus** is mine to keep. I am aware that the surgeon and staff are available to me by phone to answer questions I may have at any time. I will be able to discuss my specific medical concerns with the nurse and surgeon during my consultation appointment.

Patient's Signature: _____ Date: _____

Witness Signature: _____ Date: _____