Allina Health Weight Management

Thank you for choosing Allina Health Weight Management. The Weight Management Program offers comprehensive weight loss options for patients of all ages. Please review the following descriptions to assure we get you scheduled with the right program and providers.

Kids, Teens and Young Adults Weight Management Program - serving ages 25 and younger

The Kids, Teens and Young Adult program is a resource to achieve a healthier weight. Individuals and families work with medical doctors, dietitians, nurse practitioners, mental health providers, physical therapists, surgeons, and other specialists. If you are interested in the program, please complete a different intake form for that program. It can be found at AllinaHealth.org/kidswm.

Medical Weight Management Program

Individual Program – The individual program is a personalized, one-on-one non-surgical program. Patients meet with a weight loss physician or nurse practitioner to create a specialized treatment plan. A registered dietitian will develop a diet tailored to your specific needs. The focus is on portion control, healthy eating, and a moderately reduced calorie diet that will work for you. This plan may include medications. The individual program cost for provider and dietitian visits is covered by most insurers, with the exception of Medicare and Medicare replacement plans.

Allina Health Weight Management offers a cash pay option for dietitian visits for Medicare and Medicare replacement plan patients.

Optifast Meal Replacement Program

The Optifast program is a medically supervised complete meal replacement program. Patients are seen by a nurse practitioner or physician assistant during the active weight loss phase. Lifestyle and behavior change are key to success. The Optifast program includes weekly classes and visits with our registered dietitian. The weekly classes are taught by healthcare professionals (Registered Dietitian, Extercise Physiologist, Nurse Practitioner and Physician Assistant). Classes are 45 to 60 minutes in length and are not mandatory, but are highly encouraged as those who attend group sessions for weight management lose more weight.

Surgical Weight Management Program

The surgical program offers the sleeve gastrectomy, Roux-en-Y gastric bypass, and duodenal switch operations. Your decision to have weight loss surgery is personal and complex. The Surgical Weight Management team of surgeons, physician assistants, nurse practitioners, psychologists, nurses, dietitians, and support staff will provide support, assistance, and advice throughout your journey before and after weight loss surgery.

Please remember that with any clinic visit, co-pays, coinsurance and deductibles may apply.

PRINT

EMAIL RESET

Doc Type: Questionnaire
Descriptor: Bariatric

Office Use Only:
Date Rcvd: _____
MRN: _____
Approval: _____
EE: _____
Appts: _____
Excellian: _____
Ins: _____

Stop Bang _____

Allina Health Weight Management Health History Form

Please complete form using blue or black ink

Indicate which Weight Management Program you would like to enroll in. Refer to cover letter on page 1 for a description of the programs. **Select only one option.**

Kids, Teens and Young Adult Program this is a non-surgical and surgical program serving ages 25 and younger
Please use separate health history form located at allinahealth.org/kidswm or call 763-236-0940 for a copy.

Optifast Medical Program: this is the Optifast Meal Replacement Program that includes food products for purchase.

- ☐ Coon Rapids
- ☐ Hopkins
- ☐ Vadnais Heights
- ☐ Woodbury

Medical Program: this is the non-surgical program that may include medications

- ☐ Abbott Northwestern
- ☐ Coon Rapids
- ☐ Fridley
- ☐ Hopkins
- ☐ United
- ☐ Vadnais Heights
- ☐ Woodbury

Surgical Program: this is for weight loss surgery

- ☐ Abbott Northwestern
- ☐ Mercy
- ☐ St. Francis
- ☐ United

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email: _____

Weight History

What is your current height?	What is your current weight?
BMI (this will be calculated by staff)	
How long have you been this weight?	Years:
At what age did you first become overweight?	
Lowest adult weight	Highest adult weight (non-pregnant)
Average weight over the past 5 years	

PATIENT LABEL

Patient Name: _____

Patient Date of Birth: _____ / _____ / _____

Medical History

Cardiovascular	Respiratory	Musculoskeletal	Endocrine
☐ irregular heart beat	☐ asthma	☐ osteoarthritis	☐ diabetes type I
☐ heart block	☐ obstructive sleep apnea	☐ rheumatoid arthritis	☐ diabetes type II
☐ pacemaker/palpitations	☐ pulmonary hypertension	☐ degenerative disc disease (DDD)	☐ glucose intolerance / pre-diabetic
☐ chest pain (angina)	☐ emphysema/COPD	☐ degenerative joint disease (DJD) where: _____	☐ diabetic eye problems
☐ heart disease	☐ pulmonary embolism	☐ herniated disc	☐ diabetic ulcers
☐ congestive heart failure	**Liver/Stomach/Intestine**	☐ gout	☐ low thyroid (hypothyroid)
☐ heart attack (MI)	☐ gallstones	☐ carpal tunnel syndrome	☐ infertility
☐ high blood pressure	☐ inflamed gallbladder	☐ plantar fasciitis	☐ hypoglycemia
☐ coronary artery disease	☐ hepatitis	☐ joint pain	☐ metabolic syndrome
☐ carotid artery disease	☐ ulcer	☐ swelling	☐ morbid obesity
☐ edema	☐ h. pylori	☐ pain	☐ obesity
☐ high triglycerides	☐ colitis	☐ stiffness	☐ pancreatitis
☐ high cholesterol or low HDL	☐ spastic colon	**Neurological**	**Reproductive/Male**
	☐ irritable bowel	☐ seizures	☐ prostate cancer
☐ heart murmur / abnormal heart valve	☐ Crohn's disease	☐ migraines	☐ impotence
	☐ acid reflux or heartburn	☐ neuropathy/nerve pain	☐ penile deformity
☐ pass out or lose consciousness	☐ fatty liver (NASH or NAFLD)	☐ sciatica	☐ penile prosthetic device
			☐ erectile dysfunction
☐ blood clot or DVT	☐ increased LFT's	☐ pseudo tumor cerebri	☐ enlarged prostate
Kidneys / Genitourinary	☐ Cirrhosis	☐ narcolepsy/ drop attacks	☐ urinary symptoms due to enlarged prostate
☐ renal insufficiency	☐ pancreatitis	☐ paralysis	**Other**
☐ diabetic kidney disease	☐ trouble swallowing	☐ restless legs	☐ awaiting organ transplant – type: _____
☐ kidney failure	**Infectious Diseases**	☐ fibromyalgia	☐ glaucoma: open angle
☐ currently on dialysis	☐ VRE	☐ multiple sclerosis	☐ glaucoma: narrow angle
☐ stress incontinence	☐ MDRO	☐ stroke/CVA	☐ glaucoma: unknown
☐ kidney stones	☐ MRSA	☐ Charcot Marie Tooth Syndrome	☐ other eye problem
Skin	☐ C Diff		☐ history of cancer
☐ problems with healing of wounds/cuts/bruises	☐ HIV positive		

PATIENT LABEL

Patient Name: _____

Patient Date of Birth: _____ / _____ / _____

Review of Systems

Check off any symptoms you **currently** have:

General	**Cardiac**	**Musculoskeletal**	**Male Genital/Urinary**
☐ fatigue	☐ chest pain	☐ low back pain	☐ incontinence
☐ fevers	☐ fast heart rate	☐ neck pain	☐ blood in urine
☐ chills	☐ irregular heart rate	☐ muscle pain	☐ difficult urination
☐ insomnia	☐ lightheadedness	☐ fibromyalgia	☐ up at night to urinate
☐ excessive daytime sleepiness or drowsiness	☐ fainting or passing out	☐ joint pain – location:	☐ impotence
	☐ none of the above		☐ erectile dysfunction
☐ none of the above	**Gastrointestinal**	☐ muscle or joint stiffness	☐ none of the above
Head and Neck	☐ heartburn	☐ mobility problems	**Female Genital/Urinary**
☐ TMJ	☐ constipation	☐ use of cane or walker	☐ stress incontinence
☐ recent dental problems	☐ diarrhea	☐ none of the above	☐ menstrual irregularity
☐ none of the above	☐ IBS	**Skin**	☐ heavy menses
Eyes	☐ lactose intolerance	☐ acne	☐ blood in urine
☐ change in vision	☐ wheat intolerance	☐ recurrent skin infections	☐ excessive facial hair
☐ eye pain	☐ hemorrhoids	☐ skin tags	☐ none of the above
☐ none of the above	☐ stool incontinence	☐ stretch marks	**Neurological**
Respiratory	☐ abdominal pain	☐ none of the above	☐ seizures
☐ shortness of breath at rest	☐ Nausea/vomiting	**Vascular**	☐ tremors
☐ shortness of breath with activity	☐ none of the above	☐ swelling of lower extremities	☐ headaches
	Psychological		☐ migraines
☐ cough	☐ excessive worry	☐ ulcers of lower extremities	☐ tension headaches
☐ snoring	☐ anxiety		☐ balance problems
☐ waking up due to snoring or stopping breathing	☐ panic attacks	☐ none of the above	☐ walking problems
	☐ depression		☐ nerve pain
☐ none of the above	☐ feeling "up" or elated		☐ numbness/tingling
	☐ none of the above		☐ none of the above

STOP BANG

If you have already been diagnosed with sleep apnea and have been prescribed a CPAP or BiPAP, you do NOT have to complete this section.

Collar size of shirt ☐ S ☐ M ☐ L ☐ XL or _____ inches cm

Neck circumference _____ inches / cm (This will be measured by staff)

	Yes	No
Snoring – Do you ***s***nore loudly (louder than talking or loud enough to be heard through closed doors?		
Tired – Do you often feel ***t***ired, fatigued, or sleepy during the day?		
Observed – Has anyone ***o***bserved you stop breathing during your sleep?		
Blood Pressure – Do you have or are you being treated for high blood ***p***ressure?		
BMI – ***B***MI more than 35 kg/m^2?		
Age – ***A***ge over 50 years old?		
Neck circumference – ***N***eck circumference greater than 40 cm / 15.75 inches?		
Gender – ***G***ender male?		

PATIENT LABEL

Patient Name: _____

Patient Date of Birth: _____ / _____ / _____

Surgical History

List all previous surgeries

Surgery	Year	Incision location	Reason

	Yes	No	Comment
Have you had problems with anesthesia?	☐	☐	

Weight Loss Surgery – complete this section **ONLY** if you have had weight loss surgery before

	Comments
What year did you have weight loss surgery?	
Name of surgeon	Where:
Weight before surgery	Lowest weight after surgery
Any adverse events after surgery?	Describe:

Indicate which operation you had

☐ gastric bypass (Roux-en-Y)	☐ adjustable gastric band (Lap-band or Realize band)
☐ duodenal switch	☐ vertical banded gastroplasty (VBG)
☐ sleeve gastrectomy	☐ Other:

PATIENT LABEL

Patient Name: _____

Patient Date of Birth: _____ / _____ /_____

Family History

	Age now or at death	Cause of death	Cancer – Colon	Coronary Artery Disease – type and age of onset	Diabetes	High cholesterol	High blood pressure	Obesity	Bleeding or Clotting Disorder	Stroke
Mother										
Father										
Sister										
Brother										
Maternal GrandMa										
Maternal GrandPa										
Paternal GrandMa										
Paternal GrandPa										

Is there a family history of:	**Yes**	**No**	**Family member**
Substance Abuse Dependence	☐	☐	
Depression	☐	☐	
Anxiety	☐	☐	
Severe mental illness	☐	☐	

PATIENT LABEL

Patient Name: _____

Patient Date of Birth: _____ / _____ /_____

Substance Use

	Yes	No	Type/Amount/Frequency
Do you currently use tobacco?	☐	☐	
Have you ever used tobacco?	☐	☐	
How many years did you use?			
How much did you use?	Packs per day:		
When did you quit?			

	Yes	No	Type/Amount/Frequency
Do you consume alcohol?	☐	☐	
Last consumed alcohol?	When:		

	Yes	No	Type/Amount/Frequency
Have you ever used an illicit drug such as marijuana, cocaine, meth, or heroin?	☐	☐	
Last use?	When:		

	Yes	No	Type/Amount/Frequency
History of chemical dependency?	☐	☐	
History of chemical dependency treatment?	When:		

Social History

	Yes	No	Comment
Are you presently in a relationship?	☐	☐	If yes, for how long?
Do you have children?	☐	☐	What are their ages?
Are you currently employed?	☐	☐	If yes, how long have you been employed? Occupation:
Are you disabled?	☐	☐	Reason: Work status:
Are you sexually active?	☐	☐	If so, male or female partner?
Do you use birth control?	☐	☐	What method?

Female Reproductive

	Yes	No	Comment
Is there a **possibility that you are pregnant**?	☐	☐	
Are you planning future pregnancies?	☐	☐	
Are you **currently breast feeding**?	☐	☐	
Have you gone through menopause?	☐	☐	
Do you have a history of polycystic ovarian syndrome (PCOS)?	☐	☐	

Menstrual periods – check all that apply

☐ Regular	☐ Irregular	☐ Heavy flow/many clots
☐ Normal flow	☐ Peri-menopausal	☐ Not applicable

What is the date that your last pregnancy was complete / date of delivery?	Date:

PATIENT LABEL

Patient Name: _____

Patient Date of Birth: _____ / _____ / _____

Allergies

List allergies to medicine, food, dye, tape, metal, latex.

Allergy	Reaction

Medications

List **all current** medications you are taking including vitamins, over-the-counter medications, supplements, and intermittently used medications.

Name	Dose	How often taken	Purpose	Year started

Pharmacy of Choice – name the pharmacy you use to have your prescriptions filled.

Name of pharmacy	City/Location	Phone Number

Physical Activity

Indicate **past** exercise efforts:

☐ group exercise classes	☐ health club membership (YMCA, Curves, SNAP Fitness, etc.)
☐ use of a pedometer	☐ home exercise (videos, treadmill, etc.)
☐ personal trainer	☐ other – describe:

Describe **current** exercise program:

Type of exercise	
Frequency (number of days per week)	
Duration (number of minutes per session)	
If **not** exercising, what keeps you from exercising?	

Ability to Walk:

☐ no limitations	☐ Use of a brace	☐ Use of a cane	☐ Use of a walker	☐ Use of a Wheelchair
Are you able to walk 2 blocks?			☐ Yes ☐ No	
Are you able to go up and down a flight of stairs?			☐ Yes ☐ No	

PATIENT LABEL

Patient Name: _____

Patient Date of Birth: _____ / _____ /_____

Have you ever been diagnosed with:

	Yes	No	Date of diagnosis	Treatment
Depression				
Bipolar				
Anxiety / Panic attacks				
Schizophrenia				
Psychosis				
Personality disorder				
Compulsive overeating				
Anorexia Nervosa				
Binge eating disorder				
Bulimia				
Other / describe				

Check all that apply:

	Yes	No	Comment
Thoughts of self harm			
Past suicide attempt			
Under the care of a psychiatrist			
Under the care of a counselor or therapist			

Have you ever been prescribed:

	Yes	No	Date stopped
MAO inhibitor			
tranylcypromine (Parnate)			
phenelzine (Nardil)			
selegiline (Eldepryl, Emsam, Zelapar)			

PATIENT LABEL

Patient Name: _____

Patient Date of Birth: _____ / _____ /_____

Weight Loss History

Weight Loss Attempts – Indicate which diet programs you have tried in the past

Diet Program	Dates	Pounds lost
Atkins diet		
Cabbage soup		
Calorie counting		
Diabetic diet		
Exercise		
Grapefruit		
Jenny Craig		
LA Weight Loss		
Low fat / low cholesterol		
MD supervised program		
Medifast		
New Day		
Nutrisystem		
Other high protein / low carbohydrate		
Optifast		
Overeaters Anonymous		
Own reduced calorie / portions		
Registered Dietitian visits		
Slimfast		
Slimgenics		
South Beach		
TOPS		
Weight Watchers		
Zone		
Other		

Do you have a pattern or known causes of weight gain?

☐ Gradual over time

☐ Postpartum

☐ Depression or other significant life event Describe: _____

☐ Medication related. Name of medication: _____

☐ Sudden / unexpected Explain: _____

☐ Other: _____

PATIENT LABEL

Patient Name: _____

Patient Date of Birth: _____ / _____ /_____

Weight Loss Medications – Indicate which medications you have used to lose weight

Medication	Dates	Pounds lost
lorcaserin (Belviq)		
metformin (Glucophage)		
naltrexone HCL/Buproprion HCL (Contrave)		
orlistat (Alli, Xenical)		
phentermine		
phentermine / topiramate(Qsymia)		
sibutramine (Meridia)		
topiramate (Topamax or Trolandi)		
wellbutrin		
Other		
Fen-phen		
Redux (dexfenfluramine)		

	Yes	No
Did you take Fen-phen or Redux for longer than 3 months?	☐	☐
If yes, did you have an echocardiogram?	☐	☐

	Yes	No
Have you tried diet and exercise for a period of at least 3 months?	☐	☐
Have you tried diet and exercise for a period of at least 6 months?	☐	☐
Did you lose 1 pound or more a week while trying diet and exercise?	☐	☐

Dietary Assessment

What time do you:		Dietary recall:
Wake up?		How many meals do you eat each day?
Eat breakfast?		How many times do you snack each day?
Eat lunch?		How many cups of fruit do you eat each day?
Eat dinner?		How many cups of vegetables do you eat each day? Do not include corn and potatoes
Eat snacks?		
Go to bed?		

Describe what you typically eat for each of the following:

Breakfast	
Lunch	
Dinner	
Snacks	

PATIENT LABEL

Patient Name: _____

Patient Date of Birth: _____ / _____ /_____

Dining Out History:

How many times do you eat out each week?	
Where do you dine out?	
What foods do you order when you dine out?	

Describe what you typically consume for liquids:

	Type	Amount in ounces	per day	per week	per month
Alcohol					
Diet soda					
Regular soda					
Milk					
Juice					
Water					
Artificially sweetened water					
Other					
Coffee	☐ caffeine ☐ decaf				
Sugar	How much:				
Cream	How much:				
Tea	☐ caffeine ☐ decaf				
Sugar	How much:				
Cream	How much:				

Meal Activity:

How long does it take you to eat a meal?	
How often do you skip meals?	
Who does the grocery shopping?	
Who prepares the meals in your home?	
Describe your family dynamics around food (as a child and currently)	

	Yes	No	Comment
Do you do any binge eating?	☐	☐	
Do you eat until uncomfortably full?	☐	☐	How often?
Do you eat when not physically hungry?	☐	☐	
Do you worry that you have loss of control over how much you eat?	☐	☐	
Do you wake at night to eat?	☐	☐	

PATIENT LABEL

Patient Name: _____

Patient Date of Birth: _____ / _____ / _____

Global Health

Please respond to each question or statement by marking one box per row.

		Excellent	Very Good	Good	Fair	Poor
Global01	In general, would you say your health is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global02	In general, would you say your quality of life is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global03	In general, how would you rate your physical health?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global04	In general, how would you rate your mental health, including your mood and your ability to think?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global05	In general, how would you rate your satisfaction with your social activities and relationships?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global09	In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
		Completely	**Mostly**	**Moderately**	**A Little**	**Not at All**
Global06	To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
	In the past 7 days...	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
Global10	How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
		None	**Mild**	**Moderate**	**Severe**	**Very Severe**
Global08	How would you rate your fatigue on average?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Global07	How would you rate your pain on average?	☐ 0 No pain	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 Worst pain imaginable

22 August 2016

PATIENT LABEL

Patient Name: _____

Patient Date of Birth: _____ / _____ /_____

Medical Care Providers

List all providers you receive care from, starting with your primary care provider. Include their area of specialty, addresses, and phone numbers.

Primary Care Provider: _____ Clinic:_____

Address: _____ Phone:_____

Referring Provider Name: _____ Clinic: _____

Address:_____

Specialty:_____ Phone: _____

Mental Health Provider Name: _____ Clinic: _____

Address:_____

Specialty:_____ Phone: _____

Appointment Policy

We try to provide the best service possible to the clients we serve. To allow us to do this, it is important that you come for all of your scheduled appointments. If you need to cancel or reschedule, please contact our office at least 24 hours in advance. This allows us the opportunity to offer that appointment time to another patient who is waiting.

If you have three cancellations without 24 hours' notice or three no shows in one year, program services may be terminated. The Program Manager or Nurse Clinician will attempt to contact you to assess your ongoing interest and commitment to the program.

If you need to cancel or reschedule an appointment please contact the clinic where your appointment is scheduled.

SURGICAL PROGRAM
INSURANCE VERIFICATION FORM

Only complete this form if you are interested in weight loss surgery.

Medicare Patients: Be aware that Medicare and Medicare replacement plans do not cover dietitian visits. Medicare enrollees may be asked to sign a waiver acknowledging these visits may not be a covered service. The cost for the dietitian component of the program will be at least $620.00

Patient Initials _____

You must contact your insurance company to determine your coverage for weight loss services To do so, please call the customer service number on the back of your insurance card. Keep record of the date of your call as well as the name of the customer service representative who provided you the information.

If you are enrolling in the Surgical Program, we will contact your insurance carrier as well to verify your coverage and criteria for weight loss surgery. This is to ensure that all information provided to *you* and to *us* is accurate. In order to do this on your behalf, please complete the following:

Your Name: _____ Date of Birth: ____ /____ /_____

Have you had weight loss surgery in the past? ☐ Yes ☐ No

INSURANCE INFORMATION

Primary Insurance:

Company: _____/ID# _____ Group# _____

Secondary Insurance (If applicable):

Company: _____/ID# _____ Group# _____

If UCARE Insurance, what is the PMI number: _____

Are you the subscriber: ☐ Yes ☐ No

If not, Name of Subscriber, Date of Birth, and Relationship

_____ /_____ /_____

Social Security Number of Subscriber: _____ (Tricare and Veterans Insurance ONLY)

Provider Phone Number OR Customer Service Phone Number on the back of your insurance card: _____

We will document the information we receive in your Excellian Chart. This will be provided to your nurse clinician prior to your Initial Visit so that she can accurately determine a plan of care for you to meet your specific insurance criteria. If we determine that you **DO NOT have insurance coverage for weight loss surgery**, we will contact you. Please provide the best phone number to reach you and also indicate if we are able to leave a message for you at that phone number.

Phone: _____ Okay to Leave a Message: ☐ Yes ☐ No

For Office Use Only:

Location: ANW HOP MCY STF UTD

Provider: _____

Date of Visit: _____

Allina Health

Allina Health Weight Management Program Health History Form

59-01

SR-16301 (06/19)

PATIENT LABEL

Patient Name:

_____

Patient Date of Birth: _____ / _____ /_____