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MEDICAL ARTS BUILDING
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FREEHOLD, NJ 07728



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THE EXPERIENCE YOU WANT. THE CARE YOU DESERVE.

MORRIS WASHINGTON, MD, FACS
LISA DOBRUSKIN, MD
RAGUI SADEK, MD
JESSICA J. WOISKI, MS, PA-C

Hello _____,

We are looking forward to meeting with you at Endo-Surgical Associates of Central Jersey, L.L.C.
Your appointment is scheduled for _____ at _____.

Here are some reminders to keep in mind before you arrive for your evaluation:

1. First and foremost, you should contact your insurance provider to determine the extent of your coverage and any related issues of which you should be aware. Let them know the type of procedure you are contemplating.
2. Please fill out the attached patient assessment document and bring it with you the day of your evaluation. We will require this completed document prior to your appointment at Endo-Surgical Associates of Central Jersey.
3. Please bring with you a referral from your primary physician to see Dr. Washington, if required by your insurance provider.
4. You will be meeting with the Bariatric Coordinator. This meeting will take place at Endo-Surgical Associates of Central Jersey, L.L.C. located at the hospital. Valet parking is available at the front entrance for your convenience. Please enter the Medical Arts Building and proceed to suite 104.
5. You will meet the surgeon and staff.
6. On the day of your evaluation, please plan to spend approximately one hour with us.
7. Patients arriving late for their appointments will be rescheduled for another day.

Please do not hesitate to contact us if you have any questions at 732-761-1740.

Thank you for your cooperation.

ENDO-SURGICAL ASSOCIATES

Patient Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: (____) _____ Work Phone: (____) _____
Cell Phone: (____) _____ Sex: Male _____ Female _____
Date of Birth: _____ Age: _____ Social Security #: _____
Employer Name: _____ Occupation: _____
Work Address: _____
Emergency Contact: _____ Telephone #: _____
Relationship of Emergency Contact to Patient: _____
Insurance Carrier: _____
Insurance Address: _____
Insurance Phone: (____) _____ Effective Date: _____
Insured: _____ Insured's Date of Birth: _____
ID#: _____ Group #: _____ Copay: _____
Name of Spouse: _____
Referral: Yes _____ No _____
Secondary Coverage: _____
Referring Doctor: _____ Phone #: (____) _____
Address: _____
Other Doctors: _____

I request and authorize payment of benefits to be made on my behalf directly to ENDO-SURGICAL ASSOCIATES for services provided to me by ENDO-SURGICAL ASSOCIATES. I also authorize any holder of medical information about me to release to insurance carriers, government agencies or others who are financially liable for my medical care any information needed to determine these benefits and the benefits payable for related services.

Signature of Patient or Representative

Date

Bariatric Surgery Center

Today's Date: _____

Initial Evaluation Form (All questions MUST be answered to assure a rapid evaluation. Use additional pages as needed.)

Name _____ Date of Birth _____

Address _____

City _____ State _____ ZIP _____

Home Phone _____ Work Phone _____

Preferred Number: Home Work Other _____

Occupation (Optional) _____

Social Security No. _____ E-Mail Address _____

Insurance Information

Primary _____ Secondary _____

Primary Care Physician _____ Phone _____

Address _____

City _____ State _____ ZIP _____

Have you been referred for Bariatric Surgery? Yes No

If yes, by whom _____

What is your primary reason for making an appointment at this time? _____

Present Weight _____ Present Height _____

I would like more information about: Nonsurgical Weight Loss Surgical weight loss Treatment for obesity related illness

At what age did you begin to develop a significant weight problem? _____

In your opinion, what contributes to your excess weight?

- | | | |
|--|--|--|
| <input type="checkbox"/> Portion sizes | <input type="checkbox"/> Eating too much fat and sugar | <input type="checkbox"/> Stress eating |
| <input type="checkbox"/> Emotional eating | <input type="checkbox"/> Compulsive eating | <input type="checkbox"/> Lack of exercise |
| <input type="checkbox"/> Medications (please list below) | <input type="checkbox"/> Nervous eating | <input type="checkbox"/> Lack of knowledge about healthful eating and exercise |

Please describe any events you believe are related to your weight gain _____

Weight Loss History

Has your primary physician discussed weight loss options with you? Yes No

If yes, what treatment was recommended? Lifestyle Medication Surgery

Lifestyle (Diet and Exercise)

Name of Program	Year Started	How Long	Starting Weight	Number of Pounds Lost	Length of time weight stayed off	How much weight regained

Weight Loss Medications (Prescription, Over-the-counter, Herbal)

Name of Medication	Year Started	How Long	Starting Weight	Number of Pounds Lost	Length of time weight stayed off	How much weight regained

Have you previously had surgery for weight loss? Yes No

If yes, type of surgery, where, and when _____

Have you had nutrition counseling? Yes No

If yes, please describe _____

Are you currently on a diet for a medical reason? Yes No

Have you ever had surgery? Yes No

If yes, please list ALL surgical procedures with the approximate date _____

Are you receiving any psychiatric/ psychological services at this time? Yes No

If yes, by whom _____

Are you currently being treated for depression? Yes No

If yes, by whom _____

Have you ever been diagnosed with an eating disorder? Yes No

If yes, please describe _____

Current non-weight loss medications and supplements

Name	Dose	How Often	Starting Date	Prescription	Vitamin	Over-the-counter	Herbal

• Please list allergies to medications and your reaction _____

Family History

	Age	Approx. height/weight	Significant illnesses	Deceased?	Age and cause of death
Mother					
Father					
Maternal grandmother					
Maternal grandfather					
Paternal grandmother					
Paternal grandfather					
Siblings					

Are you adopted? Yes No

Current Lifestyle

Please check the appropriate box:

- Single Married Divorced Widow Significant Other
 Do you live alone? Yes No
 Do you have children? Yes No If yes, please list ages _____
 Do your children live at home? Yes No
 Is your family supportive of your weight loss? Yes No
 Do you smoke? Yes No
 If yes, number of packs a day _____ number of years _____ When did you quit? _____
 Do you drink alcohol? Yes No
 If yes, type of drink _____ how many drinks _____ how often _____
 Do you currently use or have you ever used illicit drugs? Yes No
 If yes, please describe drug, method, and frequency of use (e.g. smoke, snort, etc.) _____
 Do you currently exercise regularly? Yes No
 If yes, what exercise do you perform? _____
 How many times a week? _____ How long do you exercise each time? _____
 Do you feel sad most of the time? Yes No
 Has your appetite changed over the past six months? Yes No
 Has your interest in sex changed over the past six months? Yes No

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

	No chance	Slight	Moderate	High
Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting inactive in a public place (e.g. a theater or in a meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Review of Systems

Do you now, or have you recently had any of the following problems? (Please circle Y or N for EVERY problem)

Constitutional Symptoms

Fever Y N
 Chills Y N
 Headache Y N
 Weight loss/gain Y N
 Other _____

Eyes

Blurred Vision Y N
 Double Vision Y N
 Pain Y N
 Other _____

Neurological

Tremors Y N
 Dizzy spells Y N
 Numbness Y N
 Tingling Y N
 Other _____

Endocrine

Excessive thirst Y N
 Too hot/ cold Y N
 Tired/ sluggish Y N
 Other _____

Gastrointestinal

Abdominal Pain Y N
 Nausea/ vomiting Y N
 Diarrhea Y N
 Constipation Y N
 Other _____

Cardiovascular

Chest Pain Y N
 Swelling of feet Y N
 Circulatory prob Y N
 Other _____

Skin

Rash Y N
 Boils Y N
 Itching Y N
 Other _____

Musculoskeletal

Joint pain Y N
 Back pain Y N
 Weakness Y N
 Other _____

ENT

Ear Infections Y N
 Sore throat Y N
 Sinus problems Y N
 Hay fever Y N
 Other _____

Respiratory

Wheezing Y N
 Frequent cough Y N
 Shortness of breath Y N
 Other _____

Hematology

Swollen glands Y N
 Bleeding problem Y N
 Anemia Y N
 Other _____

Psychological

Depression Y N
 Anxiety Y N
 Obsessions Y N
 Hyperactivity Y N
 Alcoholism Y N
 Other _____

Personal Medical and Surgical History

- Heart Disease
 _____Heart Attack _____Heart Murmur
- High blood pressure
- High Cholesterol
- Sleep Apnea
- Asthma
- Thyroid disorder
- Arthritis
- Irregular Rhythm
- Thyroid Disease
- Cancer (list)

- Diabetes
- Hepatitis
- GI Disorder
- Gout
- Arthritis
- Osteoporosis
- Cirrhosis
- Depression
- Emphysema
- Urine Infections
- Glaucoma
- Kidney Stones
- Polycystic ovarian syndrome
- Hypertension
- Anemia
- Clotting/ bleeding disorder
- Gastritis/ Ulcer
- Multiple Sclerosis
- Parkinson's
- Phlebitis
- Seizures
- Vascular Disease
- Stroke
- Venereal Disease

• Allergies (please list) _____

For Women

What was the first day of your last menstrual period? _____

Is your cycle regular? Yes No

If no, please describe _____

Have you experienced any abnormal bleeding? Yes No

If yes, please describe _____

How many times have you been pregnant? _____ How many times have you delivered? _____

Do you use hormonal birth control? Yes No

Do you perform breast self-exams? Yes No

If yes, how often? _____

When was your last Pap smear? _____ When was your last mammogram? _____

Office Use Only

Assessment/Plan _____

Office Notes _____

1. What are your expectations of bariatric surgery? (check all that apply)

- Enable significant weight loss
- Allow you to increase your physical activity
- Make you feel better about yourself and your appearance
- Reduce medical problems associated with being nutritionally challenged
- Make you more attractive to your spouse/significant other/opposite sex
- Enhance your sex life
- Allow you to take part in activities confined to small places (i.e., driving a sports car, going on amusement park rides, etc.)
- Allow you to do your job more effectively
- Improve your overall quality of life

2. How much weight do you hope to lose through bariatric surgery?

- <50 lbs
- 50-100 lbs
- 100-150 lbs
- 150-200 lbs
- >200 lbs

3. How long do you think it will take you to reach your goal weight after bariatric surgery?

- <6 months
- 6 months- 1 year
- 1 year-18 months
- 18 months- 2 years
- >2 years

4. Do you think that if you do not reach your goal weight in the expected period of time that bariatric surgery has failed you?

- yes
- no

Please explain:

5. Do you have the support from family and/or friends regarding your decision to have bariatric surgery?

yes

no

If yes, who are these people? (check all that apply)

Spouse/ Significant other

Mother

Father

Son

Daughter

Sister

Brother

Other relative

Friend

Doctor or other health care provider

If no, who are these people? (check all that apply)

Spouse/ Significant other

Mother

Father

Son

Daughter

Sister

Brother

Other relative

Friend

Doctor or other health care provider

6. Have you decided to keep your decision to have bariatric surgery private and not tell family/friends?

Yes

No

Please explain your decision:

7. Have you told your employer/co-workers about your decision to have bariatric surgery?

Yes

No

Please explain your decision:

If yes, what response did you receive?

What is the response you expected to receive? (please explain)

8. Do you expect to have the support of your family and/or friends after you undergo bariatric surgery?

yes

no

If yes, from whom do you expect to receive support? (check all that apply)

Spouse/ Significant other

Mother

Father

Son

Daughter

Sister

Brother

Other relative

Friend

Doctor or other health care provider

If no, who are these people? (check all that apply)

Spouse/ Significant other

Mother

Father

Son

Daughter

Sister

Brother

Other relative

Friend

Doctor or other health care provider

9. In general, do you expect to receive positive or negative feedback from your family and/or friends following your surgery? (please rate the feedback you anticipate to receive on the scale below, where 7 is very positive feedback, 1 is very negative feedback, and 4 is no feedback).

1	2	3	4	5	6	7
very negative feedback			no feedback			very positive feedback

10. Have any of your personal relationships been damaged as a result of being nutritionally challenged?

Yes

No

If yes, please explain:

11. Do you feel that a psychological exam is necessary prior to your bariatric surgery?

Yes

No

Please explain:

12. Do you think undergoing any type of counseling prior to bariatric surgery is necessary?

A. Yes

B. No

Please explain:

13. Do you think counseling may be necessary after undergoing bariatric surgery?

Yes

No

Please explain: _____

If yes, what type of services do you think you would benefit from? (check all that apply)

Follow-up clinical appointments

Private therapy

Group Therapy

Access to a dietician

Psychological counseling

14. Have you been attending any type of bariatric surgery or weight loss support groups?

Yes

No

Please explain: _____

If yes, how are these groups conducted?

Locally

On-line (via the internet)

Other (please explain)

Who is running these programs?

Peers

Professional therapist

Social Worker

Other (please explain)

Have these programs been helpful to you? (Please rate how helpful they have been on the scale below, where 7 is very helpful and 1 is not helpful at all).

1	2	3	4	5	6	7
Not			somewhat			very
Helpful			helpful			helpful

Please explain: _____

15. What is your impression of how others currently see you as a nutritionally challenged individual?

16. How would you currently rate your self-esteem? (please rate your self-esteem on the scale below, where 7 represents very high self-esteem and 1 is very low self-esteem).

1	2	3	4	5	6	7
Very low			average			very high
Self-esteem			self-esteem			self-esteem

Please explain: _____

17. Are you currently self-conscious of your physical appearance? (please rate your level of self-consciousness on the scale below, where 7 represents feeling very self-conscious and 1 represents not feeling self-conscious at all).

1	2	3	4	5	6	7
not self-			somewhat			very self-
conscious			self-conscious			conscious
at all						

Please explain: _____

18. Did you lose a parent or someone very close to you early in life?

____ Yes

____ No

If yes, when? (please explain) _____

19. Are you currently in a satisfying relationship?

____ Yes

____ No

If no, what is it about your relationship that is not satisfying to you?

20. Are you sexually active with your spouse or significant other?

Yes

No

Please explain: _____

21. Have you ever been sexually abused?

Yes

No

If yes, at what age, and by whom? (please explain): _____

Did you seek and receive therapy at any point after the abuse?

Yes

No

Please explain: _____

Do you feel that these experiences still affect you today?

Yes

No

Please explain: _____

22. Are you, or have you ever been, in an abusive relationship?

Yes

No

If yes, who is, or was, the abuser?

spouse

significant other

friend

Are (were) you abused physically?

Yes

No

If yes, how frequently are (were) you abused? (please explain):

Are (were) you abused verbally?

Yes

No

If yes, how frequently are (were) you abused? (please explain):

23. Are you currently, or were you ever, a substance abuser?

Yes

No

If yes, please explain:

Do you, or did you, undergo therapy for substance abuse?

Yes

No

Please explain:

24. Have you learned anything new about yourself while completing this questionnaire?

____ Yes

____ No

Please explain:

25. Please feel free to add any additional comments below.

**Office of Endo- Surgical Associates of Central Jersey
L.L.C.**

Introduction to Privacy Notice

Dear Patient,

This is a summary of the ways in which medical information about you may be used and disclosed, and how you can get access to this information. Endo-Surgical Associates of Central Jersey, L.L.C., their associates and entire staff will use your medical information as part of rendering patient care. Your medical information may be used for treatment, payment, or health care operations. For example, your medical information may be used by health care professional treating you, by the office insurance coordinator to process your payment for the services rendered, by administrative personnel reviewing the quality and appropriateness of the care you receive. Your information may also be disclosed pursuant to applicable federal state law.

The complete Notice of Privacy Practices is located in the waiting area. We encourage you to read the entire Notice. Additionally, you are required to acknowledge in writing that you have received copy of the Consent for Release of Information form that is attached.

The attached notice is effective as of April 14, 2003

THIS IS A NEW FORM WHICH IS NECESSARY TO BE PART OF YOUR MEDICAL CHART MANDATED BY THE GOVERNMENT. IT ASSURES YOU THAT I WILL TRY TO PROTECT YOUR MEDICAL PRIVACY. IF YOU HAVE ANY QUESTIONS PLEASE FEEL FREE TO CALL.

Endo-Surgical Associates of Central Jersey

**CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT, AND
HEALTH CARE OPERATIONS**

I, _____ hereby authorize Endo-Surgical Associates of Central Jersey, LLC to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and healthcare operation. I understand that while this is voluntary, if I refuse to sign this consent, Endo-Surgical Associates of Central Jersey, LLC can refuse to treat me.

I have been informed that Endo-Surgical Associates of Central Jersey, LLC has prepared a notice ("NOTICE") which more fully describes the uses and disclosures that can be made individually identifiable health information for treatment, payment, and healthcare operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Endo-Surgical Associate of Central Jersey, LLC in writing, but if I revoke my consent, such revocation will not affect any actions that Endo-Surgical Associates of Central Jersey, LLC took before receiving my revocation.

I understand that Endo-Surgical Associates of Central Jersey, LLC has reserved the right to change his/her privacy practices and that I can obtain such change notice upon request.

I understand I have the right to request the Endo-Surgical Associates of Central Jersey, LLC restricts how many individually identifiable health information is used and/or disclosed carry out treatment, payment of health operations. I understand that Endo-Surgical Associates of Central Jersey, LLC does not have to agree to such restrictions are agreed to, Endo-Surgical Associates of Central Jersey, LLC must adhere to such restrictions

Signature from Patient or Patient's Representative

Date

Printed name of Patient or Patient's Representative

Relationship to the Patient

ADVANCED BENEFICIARY NOTICE

In the event that I lose my health insurance benefits and become a self-paying patient, I acknowledge and understand that I am responsible for payment of all medical services rendered to me by the physicians of Endo-Surgical Associates of Central Jersey, LLC, as well as for any unpaid cash balances on my account.

Patient

Signature of Patient / Guarantor

Date



**BARIATRIC SURGERY COMPREHENSIVE EDUCATION
AND SUPPORT PROGRAM- REGISTRATION FORM**

PLEASE PRINT

Date: _____ Circle one: **GBS** **SLEEVE** **LB** Insurance Co. _____

Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State/Zip Code: _____

Phone: Home: () _____ Work: () _____

Cell: () _____ E-mail: _____

(Please list only the phone numbers and the e-mail address that you permit us to use to contact you.)

Please list any existing health conditions: _____

Please list any medications/supplements you take now:

Prescription: _____

Over-the-Counter: _____

Vitamins/Herbs: _____

Have you ever been advised by a physician to lose weight? Yes No

Reason: _____ BMI: _____

Please list any physical limitations that would make increasing your activity level a challenge: _____

Are you currently on a diet? Yes No If yes, please specify: _____

Next page...

**BARIATRIC SURGERY COMPREHENSIVE EDUCATION
AND SUPPORT PROGRAM- REGISTRATION FORM**

Name: _____

Weight Loss History:

Method tried	When and for how long	Outcome

Family History

Chronic Diseases (Please circle those that apply):

Heart disease *Mother* *Father* *Grandparents* *Siblings*

High Blood Pressure *Mother* *Father* *Grandparents* *Siblings*

Cancer *Mother* *Father* *Grandparents* *Siblings*

Osteoporosis *Mother* *Father* *Grandparents* *Siblings*

Diabetes *Mother* *Father* *Grandparents* *Siblings*

Are you new to the area? Yes No

How did you hear about our program? _____