Doctor / Other ____________________ has referred patient: ____________________ for an evaluation
On Appointment Date: ____________________ Time: __________

Please fill out the **Bariatric Pre-Surgical Psychological Evaluation Form** before the appointment and bring that form to the appointment, along with your glasses (if needed) for reading and a sweater because the building is likely to be cold.

Pre-surgical assessments are commonly requested for individuals who are about to undergo bariatric surgery. Your assessment will be conducted by Dr. Richard L. Azrin or Dr. Cheryl Millsaps, Licensed Psychologists and does not involve a medical check-up.

The evaluation usually lasts from **3 to 5 hours**, depending on each patient. A good night’s sleep and breakfast are recommended. If you have difficulty reading or writing, please inform our office prior to the appointment so that accommodations may be made. Some psychological test will usually be given before meeting with the doctor.

If you have any questions, please call (205) 329 7815

**Directions:**

**Coming from I-59 toward Downtown Birmingham**, merge onto US-31 South via exit number 126A. Drive about 5 miles, then take Brookwood Medical Center Drive exit.

**Coming from I-65 toward Birmingham**, merge onto I-59 North/I-20 East (Exit 261A on left). Merge onto US-31 and take Brookwood Medical Center Drive Exit.

**Coming from I-459**, merge onto US-31 via exit 13. Take the Brookwood Medical Center Drive exit.

**Coming from Hwy 31**, take the Brookwood Medical Center Drive exit located between Vestavia and Homewood.

**Parking:**
Drive past the Hospital and look for the POB (Professional Office Bldg.) and parking lot on the left.

**Coming from Lakeshore Parkway**, go under Hwy 31 overpass, turn between the Shell gas station and the Compass Bank and drive to the stop sign at the top of the hill. Turn Right and then make the first right into the Parking lot of the POB (Professional Office Building).

**Take the elevator to the 3rd floor then go to your left to Suite 310.**
Bariatric Pre-Surgical Evaluation Form
CONFIDENTIAL
Richard L. Azrin, Ph.D.  ◆  Cheryl Millsaps, Ph.D.
Birmingham Neuropsychology, LLC
2018 Brookwood Medical Center Drive
Professional Office Building, Suite #310
Birmingham, AL 35209

Voice: (205) 329-7815       Fax: (205) 329-7816

Instructions: Please complete this form as accurately/completely as you can.
A doctor will discuss your responses with you during your appointment.

Patient’s Name: Mr /Ms /Mrs ________________________________ Evaluation Date: ___ / ___ / ____
Your Home Address: ___________________________________________ Zip: __________
Home Phone: ________________ Work/Other Phone: ________________ Soc Sec Num: ____________
Date of Birth: ____ / ____ / ____ Age: _______ Race: ___________ Gender (circle):  Male  Female
Marital Status (circle)    Single  /  Married  /  Divorced  /  Separated  /  Widow
Which surgeon (or doctor) referred you to this clinic?: Dr. __________________________________________________
Besides referral source, do any other doctors need a copy of your report? ________________________________
Which surgery are you interested in having? (circle) Gastric Bypass/ Lap band / gastric sleeve / other: __________

Weight Loss History / Surgery Knowledge
What is your approximate current weight? ______ Height? _____Your Goal Weight after surgery? ______
How long have you been considering surgery? ______________________________________________________
When was your first appointment with the surgeon? ____________________________________________________
What / who made you interested in the surgery? ______________________________________________________
What are your reasons for wanting the surgery? _______________________________________________________

Have you attended any Surgical Seminars?   (circle)   Yes   No    If Yes, # attended __________
Have you attended any Surgical Support Groups?   (circle)   Yes   No    If Yes, # attended __________
Do you feel you adequately understand the surgical procedure?   (circle)  Yes  No    If No, Questions: ______

Do you feel you adequately understand the lifestyle changes required after surgery? (circle)   Yes   No
If No, Questions: ________________________________________________________________________________
How do your family / friends feel about you having the surgery? ________________________________________
______________________________________________________________________________________________

Have you ever taken laxatives or vomited on purpose because you ate too much food? No  Yes
How much and how often do you exercise? __________________________________________________________________
______________________________________________________________________________________________
Exercise limitations (describe): ___________________________________________________________________

Notes / Comments: ________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Revised 9/29/2009
Medical History  (Please circle all that apply)

Joint Pain  Short of Breath  High Blood Pressure  High Cholesterol  Sleep Apnea  Arthritis
Diabetes  Heart Disease  Stroke  Cancer  Head Injury  Emphysema  COPD  Asthma
Incontinence  Thyroid disorder

Pain in:  back  hips  knees  feet  other  _______________  Swelling (where)  ___________

Past Surgeries:  back  knee  gallbladder  hysterectomy  Other:  ____________________________________

Other medical illnesses:  __________________________________________

Significant Symptoms:

Please indicate whether you have experienced any of the symptoms below, when, and briefly describe:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Circle Yes or No</th>
<th>When it began</th>
<th>Please briefly describe problem(s) and treatments, if any</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Consciousness</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Memory Difficulties</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Blurred/Double Vision</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Muscle Jerks or Twitches</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Bowel or Bladder Problems</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Speech Difficulties</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Sleep Difficulties</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Decreased Energy</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Decreased Motivation</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Decreased Happiness</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Social Isolation</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Frequent Headaches</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Dizziness</td>
<td>No</td>
<td>Yes</td>
<td></td>
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<tr>
<td>History of Anorexia</td>
<td>No</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Bulimia/vomiting/laxative</td>
<td>No</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Seizures</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Frequent Anxiety</td>
<td>No</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Persistently Depressed Mood</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Nightmares</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Angry Outbursts</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>Mental Confusion</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>Driving Difficulties</td>
<td>No</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Excessive Worry</td>
<td>No</td>
<td>Yes</td>
<td></td>
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<tr>
<td>Unusual/Frightening</td>
<td>No</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
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</tbody>
</table>

Current Medications:

<table>
<thead>
<tr>
<th>Name of Medicine</th>
<th>What is it for?</th>
<th>Name of Medicine</th>
<th>What is it for?</th>
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<tbody>
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</table>

Revised 9/29/2009
Please tell us about any Family History of Medical or Psychiatric Illness (circle all that apply):

Diabetes  High Blood Pressure  Heart problem  Obesity  Stroke  Cancer  Alcoholism  Drug abuse

Other (list)

Family history of Psychiatric Illness (list)

Your Psychiatric/Psychological History
Have you ever had any treatment for psychiatric/psychological difficulties (relationship counseling, psychological counseling, medicines for depression or anxiety, etc):  (circle) Yes  No  If yes, please describe below:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Date (From – To)</th>
<th>Describe Treatment received</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Have you ever considered or attempted suicide?  No  Yes (describe) ____________________________

Have you ever heard or seen things that others didn’t (hallucinations)?  No  Yes (describe) ____________________________

Substance Use
Are you currently drinking?  No  Yes  Total number of years drinking on a fairly regular basis: ______

Average amount you regularly drink (for example: 1 drink/week, 5 drinks/day, etc) ____________________________

What type of alcohol do you typically drink? (12 oz. can of beer, 6 oz cup of wine, shot of hard liquor) ______

Have you ever been addicted to any drugs?  No  Yes (describe) ____________________________

Have you ever failed at attempts to quit alcohol or drugs?  No  Yes (describe) ____________________________

Have people ever said you should quit drinking or using drugs?  No  Yes (describe) ____________________________

Have alcohol or drugs ever caused social or job problems?  No  Yes (describe) ____________________________

Have you been involved in any treatment for drinking alcohol (including A.A.) or Using drugs?  No  Yes

Cigarette Smoking:
Are you currently smoking?  No  Yes  If you smoked previously, when did you stop? __________

Briefly describe attempts to quit smoking: ________________________________________________

Approximately how many years smoked in lifetime: __________ Average number of packs/day: __________

Educational/Occupational History:
Education:  High school degree?  Yes  No  or  Years of college __________ Other __________

Occupation: ________________________________ Currently working?  No  Yes, Where? ______________________________

Social History  How many kids do you have? _____

Spouse or Partner Living with you? (# years ____ )  Children (# ____ ) and ages: ______________________________

Parents or others living with you: ______________________________

Relationship problems: ______________________________

Do you have someone who can take care of you after you are released from the hospital?  Yes  No

Name: ______________________________ Relation: ______________________________

Revised 9/29/2009
New Patient Information

Patient Name (Last)____________________________(First)____________________________(M.I.)______
Address_______________________________________City__________________State_______Zip________
Sex:   M   F

Patient’s Employer_______________________________________________________
Birth Date __________________ Age________ Social Security Number _____________________________
Home Phone (       ) Work (       ) Cell (___)_________________
Marital Status: __________ Driver License #: ___________
Spouse/Partner Name __________________  Spouse Soc Sec #:___________________________
Spouse place of Employment ________________________________  Spouse Phone #: _____________
Other Emergency Contact _________________________ Relationship to Patient _______________________

Insurance Information
1) Name of Primary Insurance: _____________________________________________________________
   Contract #________________________ Group #_______________________Effective Date_____________
   Policy Holder’s Name: __________________ DOB_________ Soc Sec Number __________________
   Relationship___________ Employer_______________ Phone #'s: _______________________________

2) Name of Secondary Insurance: _________________________________________________________
   Contract #________________________ Group #_______________________Effective Date_____________
   Policy Holder’s Name: __________________ DOB_________ Soc Sec Number __________________
   Relationship___________ Employer_______________ Phone #'s: _______________________________

Request for Confidential Handling of Health Information
Complete only if you want communications regarding your health care information sent to an alternate address or telephone other than listed above.  I request that my provider handle my confidential health information as described below.  All reasonable requests to receive communication of your health information by alternative means and/or locations will be granted. Please describe the alternative means below (e.g. US mail, telephone call, etc.) by which you prefer to receive your health information.

Alternate Address________________________________________________________________________________
Alternate Telephone_______________________________ Alternate Telephone_______________________________

Agreement
If your insurance company OR health plan requires pre-approval OR referral for your visit, it is your responsibility to obtain this referral or YOU will be personally responsible for the bill. I, the undersigned (patient or legal guardian), authorize medical treatment to be rendered by the provider and assume financial responsibility. In the event the account is not paid in full within 90 days*, the undersigned agrees to pay all costs of collection including reasonable attorney fees, and hereby waives all rights of exemption under the constitution and laws of the State of Alabama.  I also authorize the release of my medical records to my physicians and insurance carriers.  If the provider has a contractual arrangement with your insurance carrier, the balance refers only to the amount that you are required to pay. I understand that all of the providers in the offices at 2018 Brookwood Medical Center Drive, POB Suite 311 and POB Suite 310 are independent practitioners (not partners) although they are sharing office and staff. Your signature below also indicates you have received the Alabama Notice Form: Notice of Policies and Practices to Protect the Privacy of your Health Information and agree to its terms and serves as an acknowledgement that you have been given a copy of the HIPAA Notice Form. Informed Consent: I agree to participate in evaluation/treatment, and the purpose has been explained to me and/or my guardian/representative.

Signature of Patient or Responsible Party: ________________________ Date____________

If signed by a responsible party, describe that representative’s authority to act for the patient______________________________
Patient Name: ___________________________ Date of Birth: ________________
Social Sec. #__________________________ Date(s) of requested records: _________________

I hereby authorize the above providers to obtain and release the protected information specified below.
Please list any restrictions on this release of information__________________________________________________

Name____________________________ Phone_________________ Fax_______________
Address___________________________________________________________________
City                     State                   Zip

Name____________________________ Phone_________________ Fax_______________
Address___________________________________________________________________
City                     State                   Zip

Name____________________________ Phone_________________ Fax_______________
Address___________________________________________________________________
City                     State                   Zip

Name____________________________ Phone_________________ Fax_______________
Address___________________________________________________________________
City                     State                   Zip

Records to be Obtained: Please send copies of all EEG, MRI, CT, History and Physical, and the doctors last progress notes.
Release: This form when completed and signed by you, authorizes me to release, as well as obtain, protected information from your clinical record to and from the person(s) you designate. I hereby authorize Dr. Richard Azrin, Dr. Cheryl Millsaps, Margaret Smith, LCSW, Dr. Stuart Tieszen, Dr. Elena Herndon, Dr. Joel Melvin, Jeannie Briscoe, LCSW and/or his or her administrative and clinical staff to release any and all contents of my chart (including at least billing information, psychotherapy/progress notes, test results/data, reports, visit information, prescriptions, medical information, documents provided by patient, insurance/third party forms/reports, records received by others). This information should only be released to and/or obtained from the above individuals.

I am requesting my psychologist, psychiatrist, or social worker release this information to aid in treatment and/or assessment and/or provide information about me to others. This authorization shall remain in effect indefinitely. However, you have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule. I hereby release the above treatment/assessment providers and their respective medical staff and office from any and all liability and claims arising out of or relating to the disclosure and/or release of confidential and/or privileged information.

Informed Consent: I agree to participate in evaluation/treatment, and the purpose has been explained to me and/or my guardian/representative.

Name of patient and/or responsible party       Signature of patient or responsible party       Date

If signed by patient’s representative, a description of representative's authority to act for the patient is provided above.

*** Please fax records to Fax# (205) 329-7816 OR call Voice # (205) 329-7815