Jamshid Nazarian, M.D., F.A.C.S
DIPLOMATE, AMERICAN BOARD OF SURGERY
BARIATRIC SURGERY
Beverly Hills Institute for Bariatric Surgery

Fax to: 1-310-854-0121 when completed

(Please bring the completed original forms to your first office visit)

- Enclosed is a **Medical Release Form** (Page 2) so your Medical file can be released and faxed to us.

  1. We will use this information to guide your treatment.

  2. It will provide us with valuable information that will be needed for your insurance authorization.

- Every patient undergoes a **Psychological Evaluation** prior to surgery. Many insurance companies also require this before submitting for authorization. A charge of $200.00 will be billed to your insurance company (unless you are already under the care of a Psychologist or Psychiatrist)

Note: If your insurance company compensates the Psychologist less than $200.00 you will be billed for the balance.

If you have any questions as you fill out your patient chart, please call 877-558-5483 and we will get the answers you need.

Thank you so much for your understanding and cooperation. We look forward to helping you realize your healthy goals.

Jamshid Nazarian, M.D., F.A.C.S
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Beverly Hills Institute for Bariatric Surgery

Medical Records/Confidential Medical Information

I, _________________________, hereby authorize _________________________, his/her Director
(Patient Name) (Physician or Facility)
or designee, to release information contained in my medical records, including alcohol and drug abuse records protected under the regulations in Code 42 of Federal Regulations, Part 2, if any; psychological and/or social service records, if any, including communications made by me to a social worker or psychologist; and information relative to HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and ARC (Aids-Related Complex) if any, to the individuals or organizations listed below, only under the conditions listed below:

The information is to be released to ____
(Person or Organization Receiving Records)
for the purpose of ____.

Time Period/Date: ____

Information to be released:

______ Entire Record
______ History and Physical
______ Operative Reports
______ Emergency Room Record
______ X-ray(Please Specify Study):____
______ Discharge Summary
______ Lab Reports
______ EKG Reports
______ Pathology Reports

Other (Please specify): ____
____

________________________ (Date)

____ (Patient Signature)

____ (Parent or Guardian)

____ Other Signature (On Behalf of Patient)

________________________ (Date)

________________________________ (Witness)

**Authorization must be dated and signed by the patient. If the patient is a minor, or is physically or mentally incompetent, the authorizations must be signed by the nearest of kin. If patient has authorized someone else to pick up the records, this person signs on the Other Signature Line and must have a signed authorization from the patient.
AUTHORIZATIONS MORE THAN 6 MONTHS OLD WILL NOT BE HONORED.

Please forward all requested documents to:

Jamshid Nazarian, MD, F.A.C.S.
8920 Wilshire Blvd., Suite 501
Beverly Hills, CA 90211
310-854-1174 Phone
310-854-0121 Fax

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NOTE: Please Print

Today's Date: ________________

Name: ______________________________
Last First M.I.

SSN: ______________________

Address: ______________________

Daytime Phone: ________________
Cellular: ________________

____
City State Zip

Evening Phone: ______________________ E-Mail: ______________________________

Birthdate: ________ Age: ___ Gender (circle): M / F Martial Status: ________________

Driver License: State: ____________ Number: ____________ Smoker? (Circle) Yes / No

Employer: ______________ how long? _______ Occupation: ________________

Employers Address: ________________________ Work Phone: ____________________
City/State/Zip

Referred to Dr. Nazarian by: __________________ Religion: ______________________

Responsible Parties Information

Name: ______________________________ Phone: ____________________________

Address (if different): ____

SSN: ____________________ Relationship to Patient: ______________________

Employer: ______________ how long? _________ Occupation: __________________

Employers Address: ______________________ Phone: __________________________

Insurance Information

Name of Insurance Company: ____

Primary Policy: _________________ Policy ID: _____________________

Group Number: _________________ Employee: _____________________

Secondary Policy: _________________ Policy ID: _____________________

Group Number: _________________Employee:__________________

Contacts:

Primary Care Physician: ____
Name Address Phone

Emergency Contact: ____
Name Address Phone

Emergency Contact: ____
Name Address Phone

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The following is a statement of our Financial Policy that we require that you read, agree to and sign prior to any treatment.

YOUR CO-PAYMENT OR DEDUCTIBLE IS PAYABLE IN FULL AT THE TIME OF SERVICE. We accept checks or cash. **Recent Federal legislation has made it illegal for physicians to routinely write off co-payments and deductibles.**

We may accept assignment of insurance benefits. This means that we will accept the amount allowed by your insurance company; you will be responsible for co-payments and deductibles. The difference between the billed amount and what your insurance company pays is your responsibility (your co-insurance/co-payment). We cannot bill your insurance unless you bring in all insurance information and an original claim form (when required).

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some and perhaps all of the services provided may be “non-covered” services or not considered “reasonable and necessary” under your medical insurance. If your treatment or services are so determined by your insurance company any non-covered balance is your responsibility.

A fully completed Patient Information Sheet is necessary to insure efficient billing to your insurance carrier. Most of the information we request is for your protection in the event of an emergency. **A post office box is not an acceptable mailing address.**

Photocopies of the front and back of all insurance cards must be maintained in our office at all times. If you see the doctor and do not provide us with complete insurance information, your account will be assigned a Cash Status and payment in full will be required at the time of the visit.

Our office does not charge for missed appointments as a courtesy to you. We do, however, request that you give us at least 24 hours notice if you will not be able to make an appointment so that we may contact another patient who requires care.

Signature: ______________________________

Printed Name: ______________________________

Date: ____________________

I HAVE BEEN ADVISED THAT THE COST OF THE INITIAL VISIT WITH THE DOCTOR IS $350.00. THIS AMOUNT WILL BE BILLED TO MY INSURANCE COMPANY REGARDLESS OF WHETHER OR NOT I DECIDE TO HAVE THE SURGERY.

BY SIGNING THIS LETTER, I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR ANY DEDUCTIBLE OR CO-PAYMENTS REQUIRED BY MY INSURANCE COMPANY. FURTHERMORE, IF THIS AMOUNT IS NOT PAID BY MY INSURANCE COMPNAY FOR ANY REASON, I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT IN FULL.

Signature: ______________________________

Printed Name: ______________________________

Date: ______________________________

AUTHORIZATION TO RELEASE INFORMATION

The undersigned authorizes (to the extent necessary to determine liability for payment and obtain reimbursement), Jamshid Nazarian, M.D., to disclose all or portions of the patient's record to any person or corporation which is or may be liable, for all or any portion of the physician's charges, including but not limited to insurance companies, health care services plans, or worker's compensation carriers.

FINANCIAL AGREEMENT

The undersigned agrees, whether he/she signs as agent or as patient, that in consideration for the service to be rendered to the patient, he/she obligates himself/herself to pay any and all unpaid balances. Should the account be referred to collection, she/he understands and agrees to incur any/all additional expenses and attorney's fees.

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned consents to the procedure which may be performed by Jamshid Nazarian, M.D., which may include, but are not limited to: laboratory charges, and/or medical or surgical treatment or procedures.

The undersigned certifies that he/she has read the foregoing, received a copy, and is the patient, patient's legal representative, or is duly authorized by the patient to execute the above and accept its terms.

Patient Name ______________________ Signature ______________________

Date: ______________________

Witness Name ______________________ Signature ______________________

Date: ______________________

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Surgical Preference Form

Various forms of weight loss surgery are currently available to assist you in achieving your weight loss goals. At this time, which of the following procedures are you considering for your individual need?

- ☐ **Laparoscopic Gastric Bypass (Roux-en-Y)**
- ☐ **Silicon Adjustable Laparoscopic Banding (Lap Band)**
- ☐ **Open Gastric Bypass (Roux-en-Y)**
- ☐ **Vertical Ring Gastroplasty**
- ☐ **Duodenal Switch (Bilio-pancreatic Diversion)**

Each procedure possesses certain advantages, risks and personal adjustments, all of which will be addressed in detail in your discussions with Dr. Nazarian.

__________________________ ____________________

Patient Name **Date**

Name: ______________________________ Date: ____________________

Jamshid Nazarian, MD FACS
Diplomate, American Board of Surgery
BARIATRIC SURGERY

Please check diets tried, include the year, durationg and the weight loss or gain (if applicable)
Example, Lindora, 2001, 6 months, -25 lbs.

Diet Type/Drug	Year	Duration	Weight loss/gain	Comments
Medically Supervised Protocols				
Radar Institute				
Lindora				
Psychologist				
Opti-Fast				
Medi-Fast				
Reg. Dietian				
Nutritionist				
Kaiser's Freedom from Fat				
Prescription Diet/Pills				
Meridia				
Amphetamines				

Name: ______________________________ Date: ____________________

Phen-Fen				
Fastin				
Xenecal				
Ionomin				
Didrex				
B-6/12 Shots				
Adipex				
Prozac				
Paxil				
Welbutrin				
Celexa				
Sarafen				
Lasix				
Redux				
Metabolite				
Herbalife				

Name: ______________________________ Date: ____________________

T-Burn Capsules				
Reduced Calorie or Limited Intake Diets				
500 Cal/day Diet				
1,000 Cal/day Diet				
1,200 Cal/day Diet				
1,500 Cal/day Diet				
2,200 Cal/day Diet				
Low Cholesterol Diet				
Low Carbohydrates Diet				
Medically and Non-Medically Supervised Diets				
Phys. Weight Loss Center				
HMR Program				
Diet Center				
Jenny Craig				
NutriSystems				
Weight Watcher's				

Name: ______________________________ Date: ____________________

TOPS				
Over Eater's Anonymous				
Loma Linda Medical Center (Rotation or Cabbage Soup Diet)				
Mayo Clinic Diet				
Cambridge Diet				
Over-the-Counter Diet Aids				
Acutrim				
Dexatrim				
Diuerex				
Xenadrine				
Herbal Phen/Fen				
Metabolife				
Metabolite				
Extreme Weight Loss Methods				
Gastric Bubble				
Hypnosis				

Name: ______________________________ Date: ____________________

Jay Wiring				
Acupuncture				
Gastric Surgery				
Diet Book Diets				
Scarsdale Diet				
Dr. Atkin's Diet				
The Zone Diet				
Dr. Hiller's Diet				
Fad Diets & Programs				
Susan Powers				
Juice diet				
Slim Fast				
Weght Down Diet				
Sweet Success				
Sugar Busters Diet				
The Anti-Diet				

Name: ______________________________ Date: ____________________

CA Slim				
Super Dieter's Tea				
Beverly Hills Diet				
BioSlim				
Herbalife				
Fasting				
The Hollywood 24 Hour Miracle Diet				
Richard Simmons Deal-A-Meal				
Self-Administered Exercise Tapes/Programs				
Please check all that apply				
Aerobic Tapes		Tae Bo Classes		
Dance Tapes		Aerobic Classes		
Tae Bo Tapes		Dance Classes		
Jazzercise Tapes		Exercise Classes/Centers		

Name: ______________________________ Date: ____________________

Richard Simmons Exercise Tapes		Personal Trainer		
Denise Austin Workout		Home Gym		
Jazzercise Classes		Step Aerobics		
Gyms				
Please check all that apply				
Family Fitness		Slim Down Express		
Imperial Fitness		Ladies Spa		
New Dimensions Gym		John's Aerobic Workout Shop		
Gold's Gym		LA Fitness		
Venus Di Milo Gym		California Fitness		
World Gym		Curves for Women Gym		
Vick Tanney Fitness		Sports Center		
YMCA		24 Hour Fitness		
Slender Lady Health Spa		Bally's Fitness Center		
Sports Plus		Lydia's Health Spa		
Fitness USA				

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PATIENT NAME: _______________________ DATE: __________________

AT WHAT AGE DID YOU BEGIN YOUR FIRST DIET? _______ **Years old.**

WHAT WAS YOUR SINGLE GREATEST WEIGHT LOSS? _______ **Lbs.**

HOW LONG DID YOU SUSTAIN THAT WEIGHT LOSS? ___________

HOW MANY TIMES HAVE YOU LOST OVER 25 POUNDS? ______________

SIGNS AND SYMPTOMS FORM

HISTORY

YES__ NO __ Have you ever experienced any serious illness?
How many days was your longest hospitalization? ______________ **Days**
Reason: ____
____

YES__ NO __ Recent weight changes?
YES__ NO __ Have you been in good health?
YES__ NO __ Skin disease
YES__ NO __ Jaundice
YES__ NO __ Hives, eczema, or rash
YES__ NO __ Frequent infection or boils
YES__ NO __ URI (cold) now
YES__ NO __ Spitting of blood
YES__ NO __ Chronic or frequent cough
YES__ NO __ Asthma, wheezing, or bronchitis
YES__ NO __ Difficulty breathing
YES__ NO __ Lung problems/pneumonia
YES__ NO __ Chest pain/angina pectoris
YES__ NO __ Shortness of breath/difficulty breathing (dyspnea)
YES__ NO __ Heart trouble/attack
YES__ NO __ High blood pressure
YES__ NO __ Swelling in hands/feet
YES__ NO __ Feeling of smothering (at night)
YES__ NO __ Heart murmur
YES__ NO __ Heart “flutters”
YES__ NO __ Peptic Ulcer
YES__ NO __ Vomiting blood/food
YES__ NO __ Gallbladder disease
YES__ NO __ Liver trouble (hepatitis)
YES__ NO __ Painful bowel movements
YES__ NO __ Black (tarry) stools
YES__ NO __ Hemorrhoids or piles
YES__ NO __ Bleeding with bowel movements
YES__ NO __ Recent change in stools
YES__ NO __ Frequent diarrhea
YES__ NO __ Upper indigestion/heartburn
YES__ NO __ Cramping or abdominal pain
YES__ NO __ Does foods stick in throat?
YES__ NO __ Loss of urine
YES__ NO __ Frequent urination

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Name________________________________ **Date**________________________

YES__ NO __ Night time urination
YES__ NO __ Burning or pain with urination
YES__ NO __ Blood in urine
YES__ NO __ Kidney trouble stones
YES__ NO __ Neck stiffness
YES__ NO __ Thyroid trouble
YES__ NO __ Enlarged glands
YES__ NO __ Headaches
YES__ NO __ Ear disease
YES__ NO __ Dizziness
YES__ NO __ Impaired hearing
YES__ NO __ Sinus trouble/Rhinitis
YES__ NO __ Anemia or blood disease
YES__ NO __ Are you slow to heal from cuts?
YES__ NO __ Pain or irregular menses
____________ Date of last period
YES__ NO __ Breast "Lumps"
YES__ NO __ Breast surgery(s)
____________ If yes, when?
YES__ NO __ Do you have any know allergies or sensitivities to drugs or foods?
Please list allergies and reactions: ____________________________________
____
YES__ NO __ Have you ever received a blood transfusion?
YES__ NO __ Are you HIV positive?
YES__ NO __ Hepatitis/liver disorder
YES__ NO __ Numbness
YES__ NO __ Diabetes
YES__ NO __ Varicose Veins
YES__ NO __ Cancer
YES__ NO __ Leg cramps
YES__ NO __ Gout
YES__ NO __ Seizures
YES__ NO __ TB
YES__ NO __ Stroke
YES__ NO __ Convulsions
YES__ NO __ Mental Disorder
YES__ NO __ Addiction to alcohol or drugs
YES__ NO __ Hernia
YES__ NO __ High Cholesterol or Triglyceride tests
YES__ NO __ Arthritis (joint pain)
YES__ NO __ Arthritic knees
YES__ NO __ Arthritic hips
YES__ NO __ Arthritic ankles
YES__ NO __ Arthritic neck
YES__ NO __ Arthritic shoulder
YES__ NO __ Other____

___________________________________ ___________________________________
Doctor Signature **Patient Signature**

____
If patient is a minor – Signature of Parent or Guardian.

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Name____________________________ **Date**______________________

Significant Family Information

Name:	**Maiden/AKA:**
Referred by:	
Height:	**Weight:**

Health

List any family member who has suffered or experienced any of the following conditions:

Hypertension
Diabetes
Cardiac Disease
Stroke
Lung Disease
Cancer
Obesity
Liver Disease
Early Death

PATIENT MEDICATION LIST

Name of Prescription Drugs
1.____________________
2.____________________
3.____________________
4.____________________
5.____________________

Dosage Prescribed Date of RX
1.__________________________
2.__________________________
3.__________________________
4.__________________________
5.__________________________

NAME OF OTHER MEDICATIONS (NON-PRESCRIPTION)
DOSAGE TAKEN & DATE
1.____________________
2.____________________
3.____________________
4.____________________
5.____________________

1.__________________________
2.__________________________
3.__________________________
4.__________________________
5.__________________________

LIST ALLERGIES OF ANY KIND INCLUDING FOOD, MEDICATIONS, AND AIRBORNE SUBSTANCES:
1.______________________
2.______________________
3.______________________
4.__________________________
5.__________________________
6._________________________

LIST ALL SURGICAL PROCEDURES YOU HAVE HAD AND DATES OF SURGERY:

1.______________________
2.______________________
3.______________________
4.__________________________
5.__________________________
6._________________________

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Name_______________________________ **Date**_______________________

PRE-OP QUESTIONNAIRE

GENERAL INFORMATION

1. Height __________ Weight ___________

2. Your height and weight five years ago? Height_________ Weight__________

3. Your height and weight ten years ago? Height_________ Weight__________

4. Height and weight of your spouse? Height_________ Weight__________

5. Average height and weight of your mother? Height_________ Weight__________

6. Average height and weight of your father? Height_________ Weight__________

7. What do you feel is a healthy weight for you? ___________Lbs.

8. Have you tried to lose weight before? ______Yes ______No If yes, when and How? (Please list your most recent attempts.) Last 5 years? (Complete if not previously done.)

A. ____
B. ____
C. ____
D. ____

9. Are you presently taking pills to help reduce your weight? (Circle) Yes No

10. When was the last time you had a complete physical examination by a physician?
Month ________ Year __________
Physician's recommendation: ____

11. Physician name: _____________________________
Address: _____________________________
City/St/Zip _____________________________
Phone: _____________________________

12. Do you smoke? ______Yes ______No If yes, how much per day? ___________

13. Do you drink alcoholic beverages? ____Yes ____No
If yes, indicate which kind and the amount per week.

A. Hard Liquor ____Yes ____No Amount? ___________

B. Beer ____Yes ____No Amount? ___________

C. Wine ____Yes ____No Amount? ___________

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Name________________________________ Date________________________

14. Is any member of your family obese? If your answer is yes, for how long?

Mother	____________________	**Father**	____________________
Sister	____________________	**Brother**	____________________
Aunt	____________________	**Uncle**	____________________
Grandparents	____________________	**Other**	____________________

PERSONAL INFORMATION

1. During what period of your life did you become obese? ____________________

2. Why do you want to lose weight? List in order of importance.

A.____
B. ____
C. ____
D. ____

3. Describe your feelings about being overweight.

____
____
____
____
____

4. How has being obese affected you in your employment?

____
____
____
____
____

5. How long has being obese affected your relationship with others?

____
____
____
____
____

6. How has obesity affected your sex life?

____
____
____
____
____

7. How do you think surgery will affect your personal problems?

____
____

Name_______________________________ Date_______________________

____
____
____

8. Do you think surgery will resolve your eating problems? ____Yes ____No
Explain: ____
____
____

EATING HABITS AND PREFERENCES

1. List your favorite foods (in order or preferences).

Meats
____
____
____

Vegetables
____
____
____

Fruits
____
____
____

Desserts
____
____
____

Beverages
____
____
____

Other Favorite Foods
____
____
____

2. Is your food usually fried, baked, or broiled? Number in order they are usually cooked.
_____Fried _____ Baked _____ Broiled

3. Do you eat candy? ____Yes _____No If yes, what kind and how much per week?

A. __________________________________
B. __________________________________
C. __________________________________

4. Describe your typical breakfast.
____
____

5. Describe your typical lunch.
____
____

6. Describe your typical dinner.
____
____

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Name_______________________________ **Date**_______________________

7. On which foods do you use salt and how much salt do you use?

Type of food	Little	Moderate	Great Deal
______________	( )	( )	( )
______________	( )	( )	( )
______________	( )	( )	( )
______________	( )	( )	( )

8. Do you drink coffee? _____Yes _____No If yes, how many cups per day?

Number of cups per day_______ Amount of sugar added_______

9. Do you eat snacks? ____Yes ____No If yes, when and what do you eat?

Time of day	What you eat
_____________________	________________________
_____________________	________________________
_____________________	________________________

10. What do you consider to be your poorest eating habits? List the most serious first.

A.____
B.____
C.____
D.____

EXERCISE INFORMATION

11. Do you exercise? _____Yes _____No

If yes, what kind of exercise and how often?
____
____
____

HOW DID YOU FIND US?

To help us effectively direct our advertising so that we can reach the people who need our help, please answer the following questions to the best of your recollection.

A. When did you first call regarding this program?

Date__________
Time__________

B. How did you hear about this Program?
TV _______ Radio _______ Print _______

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Name________________________________ Date________________________

C. What influenced you to pick up the phone and contact our office?

____
____
____
____

D. How did you feel after you spoke with the counselor?

____
____
____
____
____
____
____

Health Survey Questionnaire 2.0 International Bariatric Surgery Registry

Name____________________ Date___________
SSN____________________ Weight (kg or lb) ________
Chart No.______________

Note: circle unit of measurement used for weight. Use with initial visit and follow-up.

Instructions: Please answer ALL questions by circling one number for each question. Do not leave questions blank or circle more than one response to each question.

1. In general, would you say your health is:

(Please circle ONE number)

1 Excellent?
2 Very Good
3 Good
4 Fair
5 Poor

2. Compared to 1 year ago, how would you rate your health now?

1 Much Better
2 Somewhat Better
3 The Same
4 Somewhat Worse
5 Much Worse

The follow questions are about activities you might do during a typical day. Does your health now limit you in these activities? (Circle ONE number on each line.)

My health limits this activity….	not at all	a little	a lot
3. Vigorous activities, such as running, Lifting heavy objects, participating in Strenuous sports………………	1	2	3
4. Moderate activities, such as moving a			

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Name________________________________ Date________________________

Table, pushing a vacuum cleaner, bowling, Or playing golf…………………………..	1	2	3
5. Lifting or carrying groceries………..	1	2	3
6. Climbing several flights of stairs…….	1	2	3
7. Climbing one flight of stairs…….. ..	1	2	3
8. Bending, kneeling, or stooping……	1	2	3
9. Walking more than a mile………..	1	2	3
10. Walking several blocks………….	1	2	3
11. Walking one block……………….	1	2	3
12. Bathing or dressing yourself…….	1	2	3

The following questions are about how you feel and how things have been with you during the past four weeks. For each question, please give the ONE answer that comes closest to the way you have been feeling. How much of the time during the past four weeks?

(Please circle ONE number on each line.)

	All of the time	Most of the time	Good bit of time	some of the time	little of the time	none of the time
13. Did you feel full of pep?	1	2	3	4	5	6
14. Have you been a very nervous person?	1	2	3	4	5	6
15. Have you felt so down in? The dumps that nothing could cheer you up?	1	2	3	4	5	6
16. Have you felt calm and peaceful?	1	2	3	4	5	6
17. Did you have a lot of? Energy	1	2	3	4	5	6
18. Have you felt down-? hearted and blue?	1	2	3	4	5	6
19. Did you feel worn out?	1	2	3	4	5	6
20. Have you been a happy? person?	1	2	3	4	5	6
21. Did you feel tired?	1	2	3	4	5	6

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Name______________________________ Date______________________

22. During the past four weeks, how much of the time have your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)? Circle one.

1 all the time
2 most of the time
3 some of the time
4 a little of the time
5 none of the time

How true or false is each of the following for you?

	Definitely True	Mostly True	Don't Known	Mostly False	Definitely False
23. I seem to get sick a Little easier than Other people….	1	2	3	4	5
24. I am as healthy as Anybody I know….	1	2	3	4	5
25. I expect my health to Get worse…	1	2	3	4	5
26. My health is excellent…	1	2	3	4	5

27. In the past year, have you had two (2) weeks or more during which you felt sad, blue, or depressed, or when you lost all interest or pleasure in things that you usually cared about or enjoyed? (Circle one)

Yes No

28. Have you had two (2) years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes? (Circle one)

Yes No

29. Have you felt depressed or sad much of the time in the past year? (Circle one)

Yes No

What is your current combined family income, before taxes?

1 less than $20,000
2 $20,000 to $39,000
3 $40,000 to $59,000
4 $60,000 to $79,000
5 $80,000 or more

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Name______________________________ **Date**______________________

What is your current marital status?

1 Married
2 Widowed
3 Separated
4 Divorced
5 Never Married

What is your current educational level?

1 8th grade or less
2 Some high school
3 High School Graduate
4 Some College
5 College Graduate
6 Any post-grad work

THANK YOU!

The HSQ is used to collect information about how you feel about your health. The Health Outcomes Institute (HOI) of Minnesota distributes the Health Survey Questionnaire 2.0. The Rand Corporation of California bases it on the Rand 36-Item Health Survey produced. As an Outcomes Management Systems user the IBSR was given permission by HOI to include these items for your use.

Patient: ____________________________ **Date:**________________