WEIGHT LOSS HISTORY

(Incomplete information may delay or cause denial of insurance coverage)

How long have you been at your current weight? _____

At what age did you become obese? _____ What is your goal weight? _____

What is your lowest adult weight? _____ What year? _____

What is your highest adult weight? _____ What year? _____

What type of eating style do you have: big eater_____ sweets_____ snacker_____ grazer _____ combination of all _____

How many times do you eat out per week? _____ _____

Do you exercise? How often? _____ _____

_____

_____

Type of *previous* weight loss surgery

☐ Vertical banding ☐ Gastric Band ☐ Roux-en-Y Gastric Bypass ☐ Stapling ☐ Other

Present complications due to previous weight loss surgery: _____

Weight prior to *previous* weight loss surgery: _____

Reason you are in need of a revision weight loss surgery:

If you have prior weight loss surgery you must obtain your operative records from the surgeon or the hospital where the procedure was performed and submit them with your screening paperwork.

MEDICALLY SUPERVISED TREATMENT REGIMENTS:

Please list all diets and medications for weight loss you have used and the treating physician(s):

Did you take Fen-Phen? ☐ Yes ☐ No Year: _____ Physician: _____

Type/Name: _____ Year: _____ Physician: _____

Type/Name: _____ Year: _____ Physician: _____

OTHER WEIGHT LOSS ATTEMPTS:

Program:	Month(s) / Year(s):	Length of participation:	Amount of weight loss:
☐ Weight Watcher			
☐ Exercise			
☐ Calorie Control/Counting Calories			
☐ Slim Fast			
☐ Medifast			
☐ Nutrisystems			
☐ Sugar Busters			
☐ Jenny Craig			
☐ Metabolife			
☐ Optifast			
☐ Xenical			
☐ Adkins/South Beach			
☐ Dexatrim			
☐ Meridia			
☐ Overeaters Anonymous			
☐ LA Weight Loss			
☐ Hydroxycut			
☐ Alli			
☐ Other			

Have you ever been treated for an eating disorder? ☐ Yes ☐ No

Physicians and Specialists

Please list your physicians and specialists below:

If you have no physicians or specialists, please check this box: ☐

***Please complete an **Authorization For Release Of Information (Non-Baylor)** form for **EVERY** physician/specialist listed below.

Specialty	Name	Phone	Fax	Address
Primary Care Provider				
Psychologist				
Psychiatrist				
Weight Loss Physicians/ Programs				
Cardiologist				
Endocrinologist				
Gastroenterologist				
Oncologist/ Hematologist				
Nephrologist				
Obstetrics/ Gynecology				
Dietitian				
If you have completed any labs (blood work) recently, who was the provider? PLEASE REMEMBER TO BRING COPIES OF YOUR RECORDS.				
Labs				
Please list all other specialists or physicians below.				
1.				
2.				
3.				
4.				
5.				

Medications

☐ Not currently taking any medications

Medication (including strength)	How many times per day?	How long taken?
Example: Lipitor 40mg	1x per day	4 years
Non-Prescription/Over-The-Counter	**How many times a day?**	**How long taken?**
(Example: Vitamins, Herbs, Home Remedies, etc.)		

Patient History

Name:_____ Birth date:_____ Sex:_____ Date:_____

Medical Problems:

☐ Diabetes type I ___ type II___
☐ High Blood Pressure
☐ High Cholesterol/Triglycerides
☐ Liver problems/Fatty liver
☐ DVT/history blood clots
☐ Anxiety
☐ Asthma
☐ Emphysema
☐ Renal Failure
☐ Heart Disease
☐ Sleep Apnea
☐ Depression
☐ History of Cancer, Type:_____
☐ Stroke/TIA
☐ Heartburn/GERD/Ulcers
☐ Thyroid problems
☐ CPAP/BIPAP
☐ Bipolar

Other:_____

_____

Prior Surgical History:

☐ Appendectomy Year:_____
☐ Breast Biopsy/Mastectomy Year_____
☐ Open Heart Surgery Year_____
☐ C-section: How many? _____
☐ Gallbladder (Open/Closed) Year_____
☐ Hernia: Type:_____ Year_____
☐ Hysterectomy (Vaginal/Stomach) Year_____
☐ Knee/Hip replacement (circle which one) Year _____
☐ Previous Bariatric surgery type _____ Year _____

Other:_____

_____

Food or Medication Allergies: please list and type of reaction

_____

_____

_____

Social History (mark if answer is yes):

☐ Have you ever smoked? Age started:_____ Age quit:_____ Packs/day:_____
☐ Alcohol Use: Drinks per week:_____
☐ Other drug use: Type:_____ Last used:_____
☐ Caffeine: Type:_____ How much per day:_____
☐ Married ☐ Single ☐ Widowed ☐ Divorced
☐ Exercise: How many times a week_____ ☐ Use a walker/wheel chair

Family History:

☐ Diabetes: Who_____
☐ High blood pressure: Who_____
☐ High Cholesterol/triglycerides: Who_____
☐ Cancer: Type_____ Who_____
☐ Heart disease: Who_____
☐ Stroke: Who _____

☐ I am ready to pursue surgery as an option for treatment for my obesity.

☐ I agree to follow the program as prescribed and actively participate in my follow up care.

☐ I understand that I am primarily responsible for obtaining insurance approval for this procedure. I will furnish all records requested by the program in a timely manner. I will make and complete all necessary appointments to fulfill necessary requirements.

☐ I understand I am responsible for any charges not covered by my insurance.

_____ _____

Patient Signature Date

Patient Review of Symptoms (Current)

Name:_____ Birth date:_____ Sex:_____ Date:_____

Constitutional:

- ☐ Fatigue
- ☐ Persistent Fevers
- ☐ Thyroid problems
- ☐ Weakness
- ☐ Sensitive to heat/cold
- ☐ Received blood transfusion
- ☐ Night sweats
- ☐ Marked weight loss/gain
- ☐ Daytime sleepiness

Eyes:

- ☐ Temporary vision loss
- ☐ Cataracts
- ☐ Glasses/Contacts

Ears/Nose/Mouth/Throat:

- ☐ Loss of hearing/wear hearing aides
- ☐ Bleeding gums
- ☐ Sinus/Allergy problems
- ☐ Hoarseness/sore throat
- ☐ Dentures
- ☐ Frequent ear infections
- ☐ Ringing in ears
- ☐ Snoring
- ☐ Loss of smell

Breasts:

- ☐ Breast lumps/fibrocystic disease
- ☐ Mammogram: Year:_____
- ☐ Breast tenderness
- ☐ Nipple discharge

Heart:

- ☐ Chest Pain
- ☐ Stress test/echo Year: _____
- ☐ Palpitations/rapid heartbeat
- ☐ Leg swelling
- ☐ Rheumatic fever
- ☐ Leg pain with walking

Lungs:

- ☐ Persistent cough/productive cough
- ☐ Pneumonia: Year: _____
- ☐ Chest X-ray: Year: _____
- ☐ Shortness of breath
- ☐ Tuberculosis
- ☐ Blood in sputum
- ☐ Wheezing

Musculoskeletal:

- ☐ Back/neck pain
- ☐ Muscle cramps
- ☐ Knee pain
- ☐ Joint swelling
- ☐ Shoulder
- ☐ Disc/Joint Disease

Gastrointestinal:

- ☐ Nausea/vomiting
- ☐ Constipation
- ☐ Blood in stools
- ☐ UGI/Barium Swallow: Year:_____
- ☐ Heartburn
- ☐ Diarrhea
- ☐ Vomiting blood/ulcers
- ☐ Endoscopy: Year:_____
- ☐ GERD
- ☐ IBS
- ☐ Difficulty swallowing
- ☐ Colonoscopy: Year:___

Genitourinary:

- ☐ Leakage of urine
- ☐ Frequent urination at night
- ☐ Frequent urination
- ☐ Erectile dysfunction
- ☐ Kidney failure
- ☐ Blood in urine

Gynecologic:

- ☐ Irregular periods
- ☐ PCOS
- ☐ Heavy periods
- ☐ Post menopausal/no periods
- ☐ Fibroids
- ☐ Infertility

Dermatology:

- ☐ Chronic skin condition: Type_____
- ☐ Hair loss
- ☐ Cancer: Type:_____

Neurologic:

- ☐ Headaches/Migraines
- ☐ Numbness: Where_____
- ☐ Seizures
- ☐ Balance issues/Falls
- ☐ Memory loss

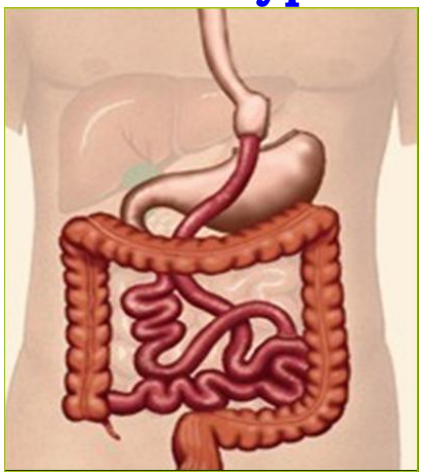
Mental Health:

- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar

CHOICES

Which weight loss surgery procedure do I choose? This is the second most important decision t
you have to make. The first decision was to have surgery at Baylor University Medical Center at Dallas. T
surgeons are available to assist you in this process.

Gastric Bypass



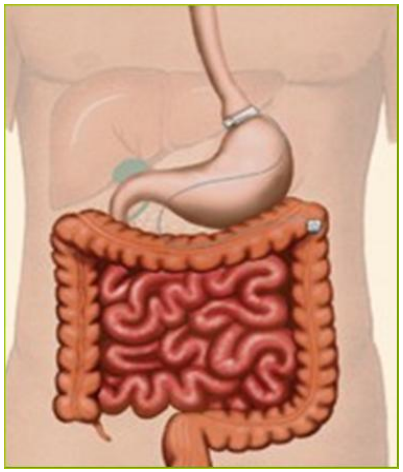
Advantages

Rapid weight loss
No need for adjustment
Restrictive and malabsorptive

Disadvantages

Higher risk
Non-adjustable
Lifetime need for supplements

Adjustable Gastric Band



Advantages

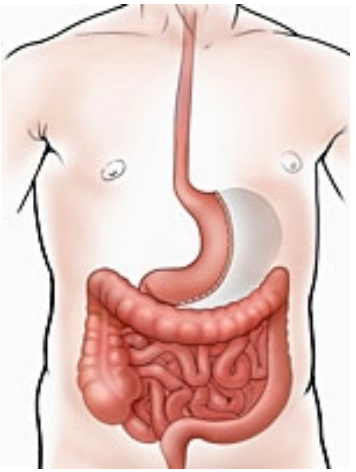
Gradual weight loss
Adjustable
No malabsorption
Lower risk

Disadvantages

Slow weight loss
Frequent clinic visits for fills
Foreign body

BAYLOR
University Medical Center
at Dallas

Gastric Sleeve



Advantages

Moderate weight loss
No malabsorption
Moderate risk
No foreign body

Disadvantages

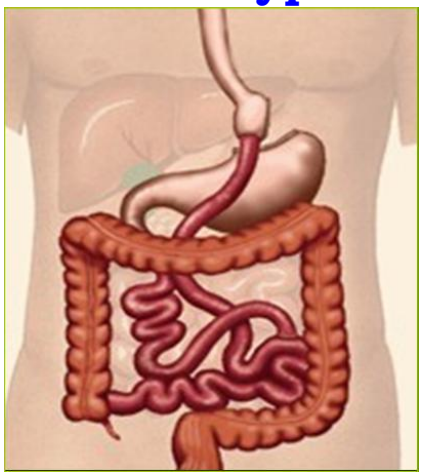
Slower weight loss than the
Gastric Bypass
Non-adjustable
No long term results available

What are the risks for weight loss surgery? All surgeries, especially in the obese, carry risks. Common to all types of surgery are:

- Pulmonary complications such as blood clots, pneumonia, and shortness of breath
- Infections such as wound breakdown or abscess
- Heart, kidney, spleen, or other organ injury

WE TAKE PRECAUTIONS AGAINST ALL OF THESE AND MONITOR PATIENTS CLOSELY.

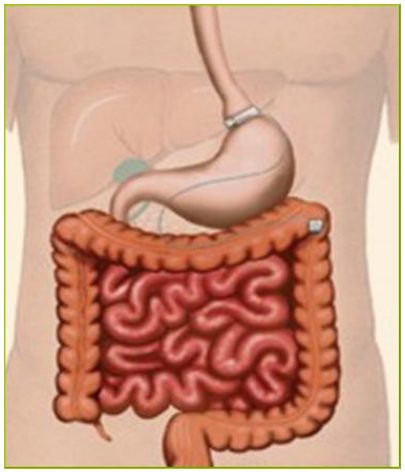
Gastric Bypass



Risks

Leakage from staple lines
Bleeding
Strictures
Too much weight loss
Too much malabsorption
Longer surgery

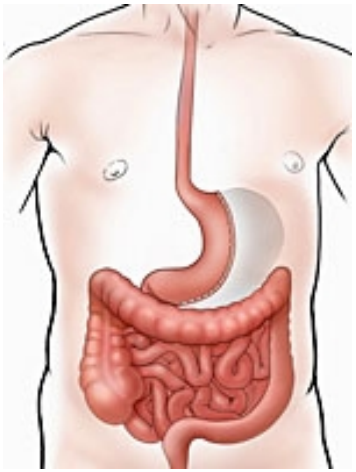
Adjustable Gastric Band



Risks

Band slippage
Band erosion
Inadequate weight loss

Gastric Sleeve



Risks

Leakage from staple lines
Inadequate weight loss

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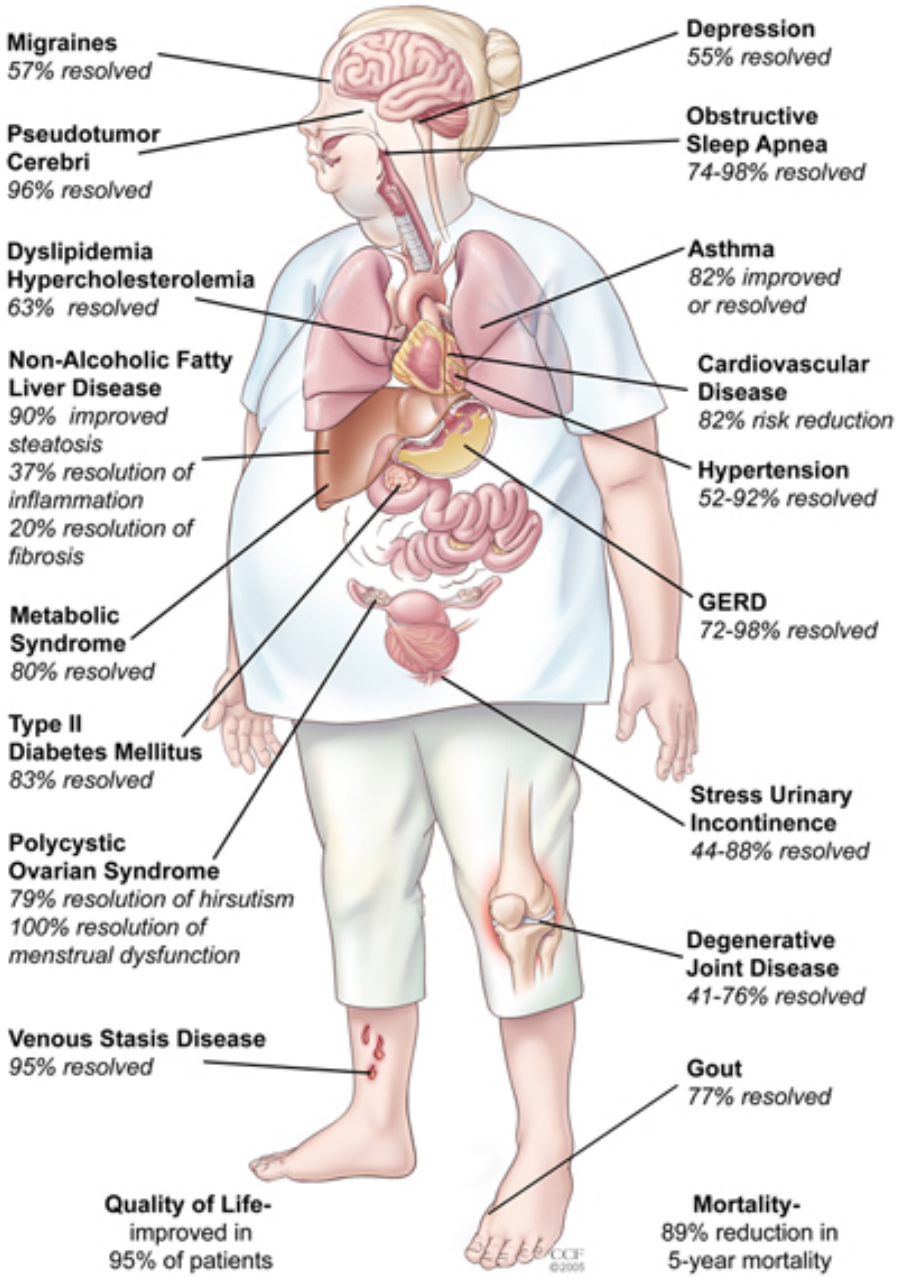
Bariatric Surgery is known to be the most effective and long lasting treatment for morbid obesity



Mounting evidence suggests it is among the most effective treatments for metabolic diseases and conditions including:
Type 2 Diabetes,
High blood pressure,
High cholesterol,
Non-alcoholic fatty liver disease and
Obstructive sleep apnea.