



2010 South Ben Merritt Drive, Suite B Decatur, TX 76234 (main office)
 8100 Lomo Alto, Suite 100 Dallas, TX 75225
 4312 Heritage Trace Pkwy., Ste. 704 Keller, TX 76248
 Phone: 940-249-9009 / 1-888-576-9892
 Fax: 940-626-1920
www.MyBariatricSolutions.com

Dear New Patient,

Thank you for considering Bariatric Solutions to help you take control of obesity and your life. Our highly trained team is committed to providing the highest level of patient care every step of the way. Our program was designated to be a Center of Excellence hospital through American Society of Metabolic and Bariatric Surgery. If you have tried non-surgical weight loss therapies without success, weight loss surgery may be your solution. Studies demonstrate that weight loss surgery yields the longest period of sustained weight loss in patients who have failed other non-surgical therapies. For best results, we have found patients need to actively participate in a multi-disciplinary weight loss program, which includes nutritional, emotional and exercise counseling.

We highly recommend that you call your insurance company as well to verify your benefits so that together we are getting the most accurate information from your insurance company. Bariatric Solutions cannot guarantee benefits that have been quoted to us by your insurance carrier.

Please note that this is not an overnight process, as it requires steps that involve multiple parties. We will make every effort to expedite this process for you. To help us expedite your process, we **REQUIRE** that we receive the health history patient information prior to your consultation date. Unfortunately, if we do not receive at least the health history information prior to your consultation, you will be asked to reschedule your consultation.

Please bring insurance card(s), photo ID and a list of ALL of your medications as well.

Your physician consult is with: _____ **Dr. Scott Stowers**

Day: _____ **Date:** _____ **Time:** _____

Appt is located at:

_____ **Decatur Office**
2010 South Ben Merritt Drive Suite B
Decatur, Texas 76234

_____ **Dallas Office**
8100 Lomo Alto Suite 100
Dallas, Texas 75225

In the meantime, you can begin taking positive steps toward your post-surgical success. Please read the information provided at www.MyBariatricSolutions.com and let us know if you have any questions prior to your consultation date. We look forward to you becoming part of our family at Bariatric Solutions and to helping you achieve your health goals.

****Please notify the office within 24 to 48 hours if you are unable to make your appointment. Our office policy is that "If you have 2 consecutive cancellations without providing 24 to 48 hours advanced notice you will be charged \$50 on your 2nd cancellation.**

Best Regards,



Patients Name: _____ Date of Birth: _____

Patient History Questionnaire

The information requested in this questionnaire is very important. To give you the best care and to obtain your insurance approval we must have complete answers. Please be thorough. Blue or black ink only please.

I. WEIGHT HISTORY

A. Desired Procedure

First Choice

- Laparoscopic Adjustable Band
- Gastric Bypass
- Gastric Sleeve
- Other _____

Second Choice

- Laparoscopic Adjustable Band
- Gastric Bypass
- Gastric Sleeve
- Other _____

B. Obesity History

1. Years you have been obese _____
2. Years 35 pounds overweight _____
3. Years 100 pounds overweight _____
4. Age you started to diet _____

C. Most significant weight loss

1. Amount lost _____
2. Number of years weight loss sustained _____
3. Method of weight loss _____

D. Eating Habits

1. Volume Eater
2. Sweet Eater
3. Snacker/Grazer

E. Unsupervised Diet

Which of the following unsupervised diets have you tried? (check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Atkins | <input type="checkbox"/> Low Fat | <input type="checkbox"/> Cabbage Soup |
| <input type="checkbox"/> Body for Life/Bill Philips | <input type="checkbox"/> Mayo Clinic | <input type="checkbox"/> Zone |
| <input type="checkbox"/> Calorie Counting | <input type="checkbox"/> Pritikin | <input type="checkbox"/> Binging/Purging |
| <input type="checkbox"/> Gloria Marshall | <input type="checkbox"/> Richard Simmons | <input type="checkbox"/> Fasting |
| <input type="checkbox"/> Health Spa | <input type="checkbox"/> Scarsdale | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Herbal Life | <input type="checkbox"/> Slim Fast | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> High Protein | <input type="checkbox"/> South Beach | |
| <input type="checkbox"/> Low Carb | <input type="checkbox"/> Sugar Busters | |

Patients Name: _____ Date of Birth: _____

F. Supervised Diet

Which of the following supervised diets have you tried? (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Diet Center | <input type="checkbox"/> Nutri-Systems | <input type="checkbox"/> TOPS |
| <input type="checkbox"/> HMR | <input type="checkbox"/> Opti-Fast/Medi-Fast | <input type="checkbox"/> Weigh Watchers |
| <input type="checkbox"/> Jenny Craig | <input type="checkbox"/> Overeaters Anonymous | |
| <input type="checkbox"/> LA Weight Loss | <input type="checkbox"/> Physicians Weight Loss | |

List any other diets and/or weight loss methods you have tried (especially physician-supervised and other documented attempts):

G. Weight Loss Medications

- | | | |
|---|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Acutrim | <input type="checkbox"/> Mazanor | <input type="checkbox"/> Redux |
| <input type="checkbox"/> Amphetamines | <input type="checkbox"/> Meridia | <input type="checkbox"/> Sanorex |
| <input type="checkbox"/> Anorex | <input type="checkbox"/> Obalan | <input type="checkbox"/> Tenuate |
| <input type="checkbox"/> Byetta | <input type="checkbox"/> Phendiet | <input type="checkbox"/> Tepanole |
| <input type="checkbox"/> Dexatrim | <input type="checkbox"/> Phentrol | <input type="checkbox"/> Wechless |
| <input type="checkbox"/> Didrex | <input type="checkbox"/> Phenteramine | <input type="checkbox"/> Wellbutrin |
| <input type="checkbox"/> Adipex | <input type="checkbox"/> Plegine | <input type="checkbox"/> Xenical |
| <input type="checkbox"/> Fastin | <input type="checkbox"/> Pondimin | |
| <input type="checkbox"/> Fen-Phen # of months _____ | <input type="checkbox"/> Prozac | |

What other prescriptions and/or dietary supplements/vitamins are you taking if any? (Be as specific as you can)

H. Behavioral Changes

What exercises have you tried in the past to lose weight?

- | | |
|--|--|
| <input type="checkbox"/> Walking or Running | <input type="checkbox"/> Weight Training |
| <input type="checkbox"/> Stationary cycle or treadmill | <input type="checkbox"/> Team Sports |
| <input type="checkbox"/> Swimming | |

What kinds of therapy have you tried for weight loss?

- | | |
|---|--|
| <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Psychological Therapy |
| <input type="checkbox"/> Hypnosis | <input type="checkbox"/> Residential Programs |
| <input type="checkbox"/> Physical Therapy | |

Patients Name: _____ Date of Birth: _____

II. MEDICATIONS AND ALLERGIES

A.

Medication	Dose	Frequency
PLEASE REFER TO PAGE 1 "Medication List"		

B.

Allergies	Type	Severity	Reaction

- No known drug allergies
- No known allergies to latex
- No known allergies to iodine
- No known allergies to IV contrast
- No known allergies to adhesives

Vitamins

- Multiple Vitamins
- Calcium
- Vitamin B12
- Iron
- Vitamin D
- Vitamin A, D, E combo
- Calcium with Vitamin D

III. **MEDICAL HISTORY**

- | | |
|--|--|
| <input type="checkbox"/> Angina | <input type="checkbox"/> Dysmenorrhea |
| <input type="checkbox"/> Allergic rhinitis | <input type="checkbox"/> Dyspnea with Exertion |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Elevated liver enzymes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Fatty liver (alcoholic) |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Fatty liver (nonalcoholic) |
| <input type="checkbox"/> CAD (no CABG) | <input type="checkbox"/> Fibrocystic disease |
| <input type="checkbox"/> CAD (with CABG) | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> GERD |
| <input type="checkbox"/> Carpal tunnel syndrome | <input type="checkbox"/> Gestational disease |
| <input type="checkbox"/> Chest pain with exertion | <input type="checkbox"/> Glucose intolerance |
| <input type="checkbox"/> Cholelithiasis | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Chronic back pain | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> CVA | <input type="checkbox"/> Hypercholestermia |
| <input type="checkbox"/> Deep Venous Thrombosis | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Degenerative Disk Disease | <input type="checkbox"/> Hypertriglyceridemia |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Diabetes Type I (controlled) | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Diabetes Type I (uncontrolled) | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Diabetes Type II (controlled) | <input type="checkbox"/> Intermittent Claudication |
| <input type="checkbox"/> Diabetes Type II (uncontrolled) | <input type="checkbox"/> Interiginous dermatitis |
| <input type="checkbox"/> Dysfunctional Uterine bleeding | <input type="checkbox"/> Irritable bowel syndrome |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Pulmonary embolism |
| <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Metabolic syndrome | <input type="checkbox"/> Seasonal allergies |
| <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Myocardial infarction | <input type="checkbox"/> Sleeping disorder |
| <input type="checkbox"/> Peripheral edema | <input type="checkbox"/> Stress urinary incontinence |
| <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Thrombophlebitis |
| <input type="checkbox"/> Peptic ulcer | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Polycystic ovarian syndrome | <input type="checkbox"/> Venous insufficiency |
| <input type="checkbox"/> Pseudotumor cerebri | |

Osteoarthritis

- | | |
|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Ankles/Foot | <input type="checkbox"/> Knees |
| <input type="checkbox"/> Elbows | <input type="checkbox"/> Neck/back |
| <input type="checkbox"/> Hands | <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> Hip | <input type="checkbox"/> Wrist |

Pain

- | | |
|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Ankles/Foot | <input type="checkbox"/> Knees |
| <input type="checkbox"/> Elbows | <input type="checkbox"/> Neck/back |
| <input type="checkbox"/> Hands | <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> Hip | <input type="checkbox"/> Wrist |

Patients Name: _____ Date of Birth: _____

IV. SURGICAL HISTORY

A. Which of the following surgical procedures have you had, if any? (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Anti-reflux | <input type="checkbox"/> Breast cancer, radiation | <input type="checkbox"/> Heart bypass surgery |
| <input type="checkbox"/> Breast Cancer, mastectomy | <input type="checkbox"/> Bowel resection | <input type="checkbox"/> Hysterectomy (+/- oophorectomy) |
| <input type="checkbox"/> Gall bladder, removal | <input type="checkbox"/> Hip replacement | <input type="checkbox"/> Nissen fundoplication |
| <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Laminectomy | <input type="checkbox"/> Vagotomy |
| <input type="checkbox"/> Peripheral vascular procedure | <input type="checkbox"/> Tubal ligation | |
| <input type="checkbox"/> Vasectomy | <input type="checkbox"/> Breast cancer, biopsy | |

B. Which other surgical procedure have you had, if any? (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Appendectomy (open) | <input type="checkbox"/> Inguinal hernia repair (lap) | <input type="checkbox"/> Wisdom teeth extraction |
| <input type="checkbox"/> Appendectomy (lap) | <input type="checkbox"/> Umbilical hernia repair (open) | <input type="checkbox"/> Arthroscopy |
| <input type="checkbox"/> Incisional hernia (open) | <input type="checkbox"/> Umbilical hernia repair (lap) | <input type="checkbox"/> Breast lumpectomy |
| <input type="checkbox"/> Incisional hernia (lap) | <input type="checkbox"/> Cesarean section | |
| <input type="checkbox"/> Inguinal hernia repair (open) | <input type="checkbox"/> Tonsillectomy | |

C. What other non-weight loss surgeries have you had, that are not listed above if any?

- _____
- _____
- _____

D. Have you had any problems with anesthesia? Yes No

If yes, what problems did you have? _____

E. What weight loss surgery have you had, if any?

Procedure Type	Year	Original Weight	Lowest Weight	Year of Lowest Weight	Surgeon

Patients Name: _____ Date of Birth: _____

Disability

Patient is disabled

Number of years disabled _____

Cause of disability

Motor vehicle crash

Medical condition

Illness

Other _____

Work related injury

Patient requires assistant device

Type of device

Cane

Walker

Crutches

Braces

Patient requires wheelchair or powered scooter

Length of time in wheelchair _____

Exercise Tolerance

No impairment

Requires wheelchair

Can walk 200ft with assistance (cane/crutch)

Bedridden

CANNOT walk 200ft with assistance

V. FAMILY HISTORY

For each problem, place a checkmark in the column of a relative who was diagnosed, if any. If there is no history of a problem in your family, leave the boxes in that row blank.

Problem	Mother	Father	Sister	Brother	Grandmother	Grandfather
Diabetes						
Hypertension						
Heart Attack						
Stroke						
Cancer						
Obesity						
Renal Failure						
Arthritis/Joint Replacement						

Patients Name: _____ Date of Birth: _____

VI. SOCIAL HISTORY

Do you currently smoke? No Rarely Occasionally Frequently

How many packs per day? Less than 1 1 to 2 2 to 3 3 to 4 More than 4

Did you smoke in the past? Yes No Quit Date: _____

Do you drink alcohol? No Rarely Occasionally Frequently

How many times per week _____

How many drinks each time _____

Do you use illicit drugs? No Rarely Occasionally Frequently

How often?

Less than once a day

Once per day

Several times a day

Once a week

Several times per week

What type of drugs (check all that apply)

Cocaine

Ecstasy

Heroin

Marijuana

Pain Medications

Other prescription medications

Physician List

Please list the names, addresses and phone numbers of ALL the doctors you are currently seeing (including PCP, heart doctor, psychiatrist, therapist, dietitian, etc); if you do not know the address (including ZIP code), please call the office and obtain a complete mailing address. If not enough space is provided, feel free to complete the list on the back of this form.

Name	Specialty	Phone	Fax	Mailing Address