



Bariatric Solutions

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(check one) Scott C. Stowers, DO Dirk I. Rodriguez, MD

Patient Profile

Please print all information and provide as much detail as possible. We do not accept any incomplete forms.

Personal Information

Last Name _____ Date _____

First Name _____ Middle Initial _____

Date of Birth _____ Social Security # _____

Race (check one) White African American American Indian Pacific Islander Hispanic Other

Marital Status (check one) Married Single Divorced Widowed Partnered

Occupation (check one) Full Time Part Time Retired Self-Employed Homemaker Student Disabled Unemployed

Home Address _____

City _____ State _____ Zip Code _____

Telephone _____ Cell Phone _____ Email _____

Employer _____ Business Phone _____

Address _____

Contact Persons

Spouse _____ Date of Birth _____

Street Address _____

City _____ State _____ Zip Code _____

Telephone _____ Cell Phone _____ Email _____

Emergency Contact _____ Relationship _____

Street Address _____ City _____

State _____ Zip Code _____ Date of Birth _____

Telephone _____ Cell Phone _____

How did you hear about our program? Doctor TV Friend Word of Mouth Newspaper Internet Patient Referral

If Patient Referral, who can we thank? _____

Referral Information

Primary Care Physician _____

Street Address _____

City _____ State _____ Zip Code _____

Telephone _____

Fax _____

E-mail _____

Specialty Physician _____

Street Address _____

City _____ State _____ Zip Code _____

Telephone _____ Fax _____

E-mail _____

Insurance Information

Primary Insurance Company _____

Street Address _____

City _____ State _____ Zip Code _____

Telephone _____

Subscriber's Name _____

Subscriber's Social Security # _____ Date of Birth _____

Policy I.D. # _____ Group I.D. # _____

Secondary Insurance Company _____

Street Address _____

City _____ State _____ Zip Code _____

Telephone _____

Subscriber's Name _____ Date of Birth _____

Policy I.D. # _____ Group I.D. # _____

I hereby assign insurance benefits to (circle one) Scott Stowers, DO, /Dirk Rodriguez, MD. I understand that I am financially responsible for any charges that are NOT covered by insurance. Should the account become delinquent, I understand that I am responsible for all finance charges, legal fees, court costs and collection agency fees charged as a result of any collection activity. I hereby authorize Dr. Wellborn to release my medical records or other information needed for my medical information.

Signed _____ Date _____

Co-Pay must be paid at time of service.

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

- Laparoscopic Adjustable Band
- Gastric Sleeve
- Gastric Bypass
- 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)

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

F. Supervised Diet

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

- Diet Center
- Opti-Fast/Medi-Fast
- TOPS
- Jenny Craig
- Overeaters Anonymous
- LA Weight Loss
- HMR
- Physicians Weight Loss
- Nutri-Systems
- Weigh Watchers

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

G. Weight Loss Medications

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

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 | |

II. ALLERGIES/MEDICATIONS

Medication	Dose	Frequency

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

Please list any other allergies you have:

III. MEDICAL HISTORY

- | | |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Angina <input type="checkbox"/> Allergic <input type="checkbox"/> Anxiety <input type="checkbox"/> Asthma <input type="checkbox"/> Breast cancer <input type="checkbox"/> CAD (no CABG) <input type="checkbox"/> CAD (with CABG) <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Carpal tunnel syndrome <input type="checkbox"/> Chest pain with exertion <input type="checkbox"/> Cholelithiasis <input type="checkbox"/> Chronic back pain <input type="checkbox"/> Congestive heart failure | <ul style="list-style-type: none"> <input type="checkbox"/> CVA <input type="checkbox"/> Deep Venous Thrombosis <input type="checkbox"/> Degenerative Disk Disease <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes Type I (controlled) <input type="checkbox"/> Diabetes Type I (uncontrolled) <input type="checkbox"/> Diabetes Type II (controlled) <input type="checkbox"/> Diabetes Type II (uncontrolled) <input type="checkbox"/> Dysfunctional Uterine bleeding <input type="checkbox"/> Dysmenorrhea <input type="checkbox"/> Dyspena with Exertion <input type="checkbox"/> Elevated liver enzymes |
|--|---|

- Fatigue
- Fatty liver (alcoholic)
- Fatty liver (nonalcoholic)
- Fibrocystic disease
- Fibromyalgia
- GERD
- Gestational disease
- Glucose intolerance
- Gout
- Heartburn
- Joint pain
- Menstrual irregularity
- Metabolic syndrome
- Migraine headaches
- Myocardial infarction
- Peripheral edema
- Peripheral vascular disease
- Peptic ulcer
- Polycystic ovarian syndrome

- Hemorrhoids
- Hypercholestermia
- Hypertension
- Hypertriglyceridemia
- Hypothyroidism
- Infertility
- Insomnia
- Intermittent Claudication
- Interiginous dermatitis
- Irritable bowel syndrome
- Pseudotumor cerebri
- Pulmonary embolism
- Seasonal allergies
- Sleep apnea
- Sleeping disorder
- Stress urinary incontinence
- Thrombophlebitis
- Varicose veins
- Venous insufficiency

Osteoarthritis

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

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 |

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, masectomy | <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"/> 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

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						
Heart Attack						
Cancer						
Renal Failure						
Hypertension						
Stroke						
Obesity						
Arthritis/Joint Replacement						

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

Do you drink alcohol? No Rarely Occasionally Frequently

Do you use illicit drugs? No Rarely Occasionally Frequently

What type of drugs (check all that apply)

- Cocaine Marijuana
- Ecstasy Pain Meds
- Heroin Other

Exercise Tolerance

- No impairment
- Can walk 200ft with assistance (cane/crutch)
- CANNOT walk 200ft with assistance
- Requires wheelchair
- Bedridden

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