

PATIENT INFORMATION

Please fill in **all** the information on the following pages. Print clearly using a pen, not pencil.

Please have **nothing to eat and only water** to drink for **one hour prior** to your first appointment.

Please be as complete as possible. We know this is a lot of paperwork, but it is necessary for us to help you. This form will be used to help us evaluate your health and medical history. It will also be used to provide the necessary information to get approval from your insurance company for your surgery. **Have this form filled out before you come for your bariatric consultation. Bring this book with you. Thank you!**

Name: _____ Age: _____
First Middle Last

Date of birth: _____ / _____ / _____ SS#: _____ - _____ - _____
Month/ Day/ Year

If you live outside the Fresno-Clovis area, how many miles from our office do you live: _____ How long of a trip: _____

Date of filling out this form: _____

NOTICE - PLEASE READ BEFORE YOU SEE THE DOCTOR

Surgery sometimes requires the use of blood or blood products. If you will not agree to the use of such products, please inform us **BEFORE** we do your workup. This will not prevent you from having surgery. We just need to know before scheduling.

1. **MEDICATIONS YOU TAKE** (daily, occasionally, or "as needed").
Include both prescription and non-prescription drugs, and vitamins, supplements, herbal products, etc.

Name of Medication	Strength	Dose	Reason for taking
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Ex:

2. **SURGICAL HISTORY** Please list surgeries you have had.

TYPE OF SURGERY

YEAR

3. PSYCHIATRIC HISTORY

Have you been evaluated for psychological problems causing your obesity?

YES ___ NO ___ Results:

Have you ever seen a psychologist/psychiatrist/therapist in the past?

YES ___ NO ___ If so, for what reason and when?

Are you currently seeing a psychologist/psychiatrist/therapist?

YES ___ NO ___ Reason:

4. ALLERGIES TO MEDICATIONS

Name of Medication

Reaction it causes (Ex.: rash, swelling)

Name of Medication	Reaction it causes (Ex.: rash, swelling)
_____	_____
_____	_____
_____	_____

Problems with anesthesia? YES _____ NO

If YES, describe:

5. THYROID PROBLEMS

Have you been tested for thyroid problems? YES ___ NO

Have you ever had thyroid problems? YES ___ NO

Are you taking thyroid medication? YES ___ NO

If you are taking thyroid medication, has it affected your weight

(i.e., gained or lost weight)? YES ___ NO

If so, describe: _____

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6. DIET and DIET MEDICATION HISTORY

Your insurance requires this information to process your authorization. We also need it to complete your chart.

List **DIETS** you have tried (medications on next page) starting with the most recent. (Examples: Weight Watchers, Atkins, Slim Fast, Pritikin, Jenny Craig, diabetic diet, low carbohydrate, liquid, etc.) Give **DATES** in month/year and **amount of weight lost FOR THE PAST TWO YEARS**. For older diets just give the name or description of diets.

DIET	STARTED	STOPPED	WEIGHT LOST	WEIGHT GAINED BACK (Some/All/More)
Ex: <u>Pritikin</u>	<u>02/99</u>	<u>08/99</u>	<u>22 lbs</u>	<u>More</u>
1.				
2.				
3.				
4.				
5.				
6.				
7.				

DIET MEDICATION	STARTED	STOPPED	WEIGHT LOST	WEIGHT GAINED BACK (Some/All/More)
Ex: <u>Phentermine</u>	<u>08/99</u>	<u>02/00</u>	<u>40 lbs</u>	<u>More</u>
1.				
2.				
3.				

Have you ever taken Fen-Phen, Redux, or Pondimin? YES _____ NO

Circle which apply. When? _____ How long?

7. ATTEMPTED WEIGHT LOSS METHODS

Please check all of the following methods you have tried:

METHOD	YES	NO	METHOD	YES	NO
Diets	_	_	Exercise		
Counseling	_	_	Hypnosis		
Diet medicines (prescription)	_	_	Diet medicines (non-prescription)		
Ear staple/ acupuncture	_	_	Fasting/ starvation		
Support Group	_	_	Injections		

ATTEMPTED WEIGHT LOSS METHODS (continued)

Other methods of weight loss tried:

Worked on weight loss with a **doctor**:

YES ___ NO ___ Year(s) _____ Length of Time

Names of these doctors:

Worked on weight loss with a **nutritionist**:

YES ___ NO ___ Year(s) _____ Length of Time

Worked on weight loss with a **dietitian**:

YES ___ NO ___ Year(s) _____ Length of Time

Do you find it harder to lose weight as you get older? YES ___ NO

8. TIME COURSE

Your Age Now: _____ How long have you been overweight:

Since age: _____. (OR) For _____ years.

Within a 20-pound weight gain or loss, how many months/years have you been at your current

weight? _____ What has been your heaviest weight? _____ lbs. Year:

What has been your largest amount of weight lost throughout your diet history? _____ What

year? _____ What weight loss program (diet, medicine, etc.) was that with?

_____.

9. WEIGHT LOSS ATTEMPTS — This is the Diet History we may send to your insurance company. You may be denied by your insurance company without this page completed.

At what age did you start dieting?

Please check all that apply.

- Diet prescribed by your doctor Low-Calorie Diet
- Jenny Craig Cambridge Diet Low-Carbohydrate
- Diet Center Pritikin Low-Fat Diet
- Atkins Scarsdale Diet High-Protein Diet
- Weight Watchers Lean Cuisine Healthy Choice Meals
- Nutri-Systems Prism Diet Hollywood Diet
- TOPS Fruit Diet L.A. Weight Loss
- Susan Powter Adipex Weight Loss Camp
- Diabetic Diet No-Sugar Diet Grapefruit Diet
- Liquid Diet Vegetarian Diet Cabbage Soup Diet
- Stillman Diet Diet Teas South Beach Diet
- Mayo Clinic Diet Rotation Diet The Zone
- Overeaters Anonymous Richard Simmons Deal-A-Meal
- Weigh Down Colorad Choose-To-Lose e-Diets.com
- Beverly Hills Diet Dr. Phil's Diet Program Sylvan
- Inpatient Program for Weight Loss Body for Life
- Lindora Physicians Weight Loss Center Trim Spa
- Metabolife Stacker 2 Fat Trapper Slim Fast
- California Slim Acutrim Hydroxycut
- Herbalife Fastin Redux
- Phentermine Ephedrine Fen-Phen
- Pondimin Hoodia Tenuate
- Xenical Meridia Optifast
- Medifast Wellbutrin Nestles Sweet Success
- B-12 Injections B-6 Injections HCG Injections
- Body Solutions Fat Burners Dexatrim
- Chromaslim Xenadrine Celexa Leptopril
- Diuretics (water pills) Laxatives Amphetamines
- Purging (self-induced vomiting) Fasting
- Acupuncture/Ear Staple Body Wraps Jaw Wiring

- Hypnosis Group Counseling Individual Counseling
 Church Diet Group Other Diet Group Joined a Gym
 Aerobics Classes Purchased Exercise Equipment Tae Bo
 Hired Personal Trainer Exercise Videotapes
 Attended Exercise Classes Water Aerobics Class P.5

10. COMORBID FACTORS — Obesity Related Medical Problems

Please read carefully and make sure you write an "X" on each line.

I

MEDICAL PROBLEM	NOT		TAKE MEDICINE	
	YES	NO	FOR THIS	YES NO
High Blood Pressure				
Heart Problems				
Stroke				
Fatty Liver (<i>hepatic steatosis</i>)				
High Cholesterol				
Asthma (not to be confused with allergies)				
Sleep Apnea(documented) Use CPAP: Yes <input type="checkbox"/> No <input type="checkbox"/>				
Sleep Apnea (un-documented)				
Reflux (<i>GERD,</i> <i>frequent heartburn</i>)				
Urinary Incontinence (<i>can't hold urine</i>) Use pads for this?				
Degenerative Joint Disease (DJD)				
Arthritis				
Joint Pain (back, knees, ...)				
Heel Spurs				
Gout				
Varicose Veins Painful?				
Rashes Due to Skin Folds				
Diabetes				
Thyroid Problems				
FEMALES:				
Infertility (if not from tubal ligation, menopause, or hysterectomy)				
Irregular Periods				

Polycystic Ovarian Disease

Excessive Amount of Hair

Face _____ Body

Have you been diagnosed with hirsutism? YES _____ NO

PLEASE! If you checked "YES" for any medicines make sure that medicine is listed on Page 1 (include prescription, non-prescription, herbal).

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Use the following lines to give **details or descriptions** about medical conditions mentioned on the previous page, or other medical conditions, that you feel should be known to your doctor.

(ex.: Incontinence--Only when I cough, sneeze, or laugh.)

If you get frequent pain in any of the following areas, please write an "X" where it applies to you.

PAIN IS:	Mild	Moderate	Severe	I take medicine
	<i>(Not Bad)</i>	<i>(Pretty Bad)</i>	<i>(Very Bad)</i>	for this

NECK

BACK

HIPS

LEGS

KNEES

ANKLES

FEET

If you get **swelling** in any of the areas listed ABOVE, please **circle** the ones that apply.

MEDICAL PROBLEMS WE FORGOT TO MENTION

Are there any medical problems or symptoms not mentioned in this form you feel your doctor should know about? **YES** _____ **NO**

Describe/Explain:

LIST THE DOCTORS YOU SEE, their area of specialty, and the problems you see them for.

11. PROBLEMS IN DAILY LIVING BECAUSE OF OBESITY

A. List problems you have **AT YOUR JOB** due to your size, weight, or weight-related physical problems such as shortness of breath. (*Examples: Don't fit in regular office chairs. Cannot easily reach computer keyboard. Sitting for long periods causes back pain, feet swell.*) **Give as many specific examples as possible.**

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.

B. List problems you have **in your PERSONAL/FAMILY life** due to obesity and related problems. (*Examples: Personal hygiene is hard because I cannot reach where I need to. I do not fit into public restrooms. Other examples of difficulties could be: Playing or caring for children, getting out of bathtub, can't bike ride with family, avoid social activities because of embarrassment about your size, doing yard work, housework, bathing, dressing, sex, taking walks, bending.*) **Give as many specific examples as possible.**

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.

Please be specific. Your insurance wants information to base their decision on other than your weight.

12. POSSIBLE CAUSES FOR YOUR OBESITY/FAMILY HISTORY

A. FAMILY HISTORY OF OBESITY (Write in number of brothers and sisters in their correct weight categories.)

	Normal Weight	Overweight (Up to 50#	Obese (Up to 100# over ideal)	Morbidly Obese (More than 100# over ideal)
Father	_____			
Mother	_____			
Brother(s)	_____			
Sister(s)	_____			

Medical Problems

Father

Mother

Sisters

Brothers

HEREDITARY Health Risks – List health problems that **other family members** have had(diabetes, heart problems, asthma, etc.)

RELATIONSHIP TO YOU (uncle, grandfather, etc.)	MEDICAL PROBLEM/DISEASE
<u>ex: Maternal grandfather</u>	<u>Obesity, thyroid cancer.</u>

Family members who are deceased (including parents, grandparents, brothers, sisters, aunts, uncles, and your children):

RELATIONSHIP TO YOU	AGE DIED	CAUSE OF DEATH
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13. SOCIAL HISTORY

A. Marital Status:

Single ___ Married ___ Separated ___ Divorced ___ Widowed

Children: How many? ___ Ages

Stepchildren living with you: How many? ___ Ages

Do you take care of young children at home?

How many? _____ Ages:

B. Employment:

Do you have a job?

Self-employed: ___ Full-time: ___ Part-time

What type of work/business?

Your title or what you do:

Homemaker:

Currently on Disability: ___ Permanent ___ Temporary

Reason for disability:

C. Use of alcohol: Yes ___ No

Estimate how many drinks (**write in a number**):

Daily ___ Monthly ___ Yearly

D. Use of tobacco: Never ___ Current smoker ___ Age started ___ 1 pack/week ___ 1 pack/day
___ 2 packs/day ___ More

Ex-Smoker ___ Quit smoking in (year)

How long did you smoke?

D. Use of recreational drugs: Never

Currently ___ Type/frequency

Used in the past: YES __ NO __ If YES, how long ago?

Type/frequency

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14. MORE MEDICAL HISTORY

Some of this may be repeated elsewhere in this form. However, please be complete, as **this is required by insurance companies**. Thank you.

Do you have, or have you ever had, any of the following. Please check YES or NO.

	YES	NO	
Convulsions/Seizures			
Bleeding Tendency			
Acute Infection			
Hepatitis	___	___	Type:
Diabetes	___	___	On insulin?
Gestational Diabetes	___	___	Year:
Cancer	___	___	Year:

Specify type/location: _____

15. SYSTEMS REVIEW

YES NO Explanation/Details

General

Good General Health
Recent Weight Changes
Fever

Eyes

Wear Glasses or Contacts
Past/Present Eye Disease
Transient Blindness

YES NO Explanation/Details

Ears/Nose/Mouth/Throat

Hearing Loss or Ringing
Chronic Sinus Problems
or Rhinitis
Dentures
Nose Bleeds

Cardiovascular

Heart Attack
Chest Pain

If YES, did you see a doctor for it? YES ___ NO

Was it caused by:

Anxiety: YES __ NO __ Stomach/gallbladder: YES __ NO

Respiratory (asthma, emphysema): YES __ NO __ Don't know

Did you have tests or treatment for the chest pain? YES__ NO

Have you had a cardiac workup within the last year? If so, please give details:

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YES NO Explanation/Details

Cardiovascular (continued)

Shortness of Breath
with Exertion
Shortness of Breath
with Laying Flat
Swelling of Feet, Ankles,
Hands (please circle which)

YES NO Explanation/Details

Respiratory

Chronic or Frequent Cough
Spitting Up Blood
Asthma
Shortness of Breath
Past TB, Pneumonia, or
Valley Fever (circle which)

Gastrointestinal

Loss of Appetite
Change in Bowel Movements
Rectal Bleeding
Blood in Stool
Stomach Ulcer
Frequent Heartburn
Nausea or Vomiting
Liver Disease
Pancreas Disease
(not diabetes)

YES NO Explanation/Details

Genitourinary

Painful or Burning Urination
Difficulty Urinating
Blood in Urine
Kidney Stones
Testicular Pain
Irregular Periods
Infertility

History of Hysterectomy

Ovaries Removed

Urinary Incontinence

(can't hold urine)

YES NO Explanation/Details

Musculoskeletal

Joint Pain, Stiffness

Back Pain

Difficulty or Painful

Walking

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YES NO Explanation/Details

Integumentary (Skin)

Rash or Itching

Breast Pain

Breast Lump

Change in the Appearance
of a Breast

Nipple Discharge

YES NO Explanation/Details

Neurological

Frequent Headaches

Migraine Headaches

Dizzy/Lightheaded

How often?

Numbness/Tingling

Where? _____

Tremors

Stroke (Year ____)

Paralysis

Head Injury (Year ____)

Convulsions or Seizures

YES NO Explanation/Details

Endocrine

Hormone Problems

Thyroid Disease

Diabetes

Excessive Thirst or

Urination

Heat or Cold Intolerance

YES NO Explanation/Details

Hematologic/Lymphatic

Slow to Heal after Cuts

Bleeding Tendency

Bruising Tendency

Anemia

Blood Clots

Legs ___ Lungs ___

Past Blood Transfusion

16. The following is space for you to tell us anything we might have missed that you think we should know.

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17. How did you learn about us?

Another patient? (If so, give name):

From your doctor? (If so, give name):

Did you **first** learn about us through our website at “bariatricsurgeons.com”?

Did you **first** go to the internet website “obesityhelp.com”?

Other Internet/Web Site (write it in, if possible, or as much as you can remember):

Seminar (if so, write in month and year, if possible):

Newspaper: ___ Theater: ___ Radio:

Other Advertisement? (please describe):

From your insurance company?

Other source:

18. Have you attended **our** bariatric seminar? YES ___ NO

Give month and year you did (or plan to) attend:

(You are **required to attend our** seminar before having surgery.)

DISABILITY FORMS, FLMA FORMS, etc.

Due to the time involved in filling out the variety of forms for disability, we require a fee of \$10. We do not have the forms in our office. We cannot promise same-day service, as most of these forms are several pages and require us looking up dates and medical codes. We cannot give these forms to you or send them in prior to your surgery. If you need a note or short letter to return to work, we will be happy to do that for you.

ADVANCED BARIATRIC CENTER PROGRAM

(FEE DUE AT TIME OF PREOPERATIVE VISIT)

This program includes protein samples, vitamins, a session with a Registered Dietitian, and a private session with a Certified Fitness Practitioner. You have access to 24-hour 7-day-a-week medical help from our physicians, as needed. Our support group is available either at monthly meetings or online if you live out of the area. We also have a newsletter online that has many helpful hints. Let us know if you are not online and this will be mailed to you. Once you have attended your preoperative appointment, the fee for the Bariatric Program will not be refunded under any circumstance, including your cancelling surgery. Your deposit should be in the form of cash, cashier's check, money order, Master Card, or Visa credit card. Please, no personal checks. This program is mandatory for all of our bariatric patients.

Hospitals and other surgery facilities often require prepayment of your insurance deductible. Please be prepared to make this payment before having surgery. You may call the hospital business office to make arrangements for payment.

I have given complete information in all parts of this Medical History Form to the best of my knowledge and have not knowingly omitted any information relating to my present or past health. I realize withholding or misstating medical information may be detrimental to my health and health care.

My signature below acknowledges my agreement to the terms described above.

YOUR NAME (PRINT)

YOUR SIGNATURE

DATE YOU COMPLETED THIS FORM _____

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RISK FACTORS

Many of the risks and complications of this surgery are detailed in the booklet you received from our office. These are found under the headings "Serious and/or Life Threatening Complications," "Problems That are Usually Less Serious," and "Nuisance or Temporary Complications." They are summarized here, but review the booklet before signing below.

- Hair Loss** Some patients develop hair loss for a short period after the operation. This usually responds to increased vitamins and protein but can be permanent.
- Deficiencies** After gastric bypass there may be malabsorption of many vitamins and minerals. Patients must take vitamin and mineral supplements forever to protect themselves from deficiencies. Supplements include, but are not limited to, multivitamins, calcium, and protein. Yearly blood tests must be done lifelong to detect and treat nutritional deficiencies.
- Pregnancy** Vitamin and mineral deficiencies in mothers who have had gastric bypass can impair normal fetal development. No pregnancy should occur for the first year after gastric bypass. It is important to know that fertility may increase during and following weight loss. Patients must inform their OB/GYN of their gastric bypass if they later become pregnant. Use of a dependable contraceptive immediately following surgery and for the first year is crucial.
- Laparoscopic Surgery Risks** Laparoscopic surgery uses punctures to enter the abdomen and can lead to injury, bleeding, or death. Other risks of this surgery include injury to the spleen, stapler malfunction, and the necessity to convert from a laparoscopic to an open procedure.
- Death** The risk of dying from Roux-en-Y gastroplasty is slightly less than 1%. As with any surgery, there is this risk.
- Driving, Prolonged Sitting** It is imperative that you have someone drive you when you are released from the hospital. Sitting puts you at risk for developing dangerous, even deadly, blood clots. You must get up every 30-40 minutes and walk for at least 10 minutes. You must also continuously sip liquids to avoid dangerous dehydration. Avoid movie theaters and long car rides for the first two weeks.
- Other** Any major abdominal surgery, including gastric bypass, is associated with a large variety of risks and complications, both recognized and unrecognized, that may occur both soon after or long after the operation. These include pneumonia, infection, blood clots, and leakage. Postoperative stenosis is not uncommon after this surgery and may require treatment. The occurrence of developing gallstones is increased with rapid weight loss.

By my signature below I accept and understand the possible risks and complications as mentioned above and in the booklet issued by the Advanced Bariatric Center. I wish to proceed with my gastric bypass surgery.

Signature of Patient

Date

Blue Cross of California, Blue Shield of California,
TriCare, and all other insurances

MEMBER (PATIENT) RESPONSIBILITY AGREEMENT

This waiver form shall be used to document the mutual agreement between the Member and a participating healthcare professional/facility (Provider) for services, products, or upgrades that are deemed not medically necessary, or are considered not a covered expense under the Member's Benefit Agreement, but that the Member chooses to receive such services, products, or upgrades at his/her own expense.

To be effective and valid, this document must be executed prior to the delivery of any non-covered services, products, or upgrades.

MEMBER (PATIENT) NAME: _____ **DOB:** _____

PROVIDER: E.L. Felix, M.D., Inc. PROVIDER TAX I.D.: 77-0558944

PROVIDER PHONE: (559) 431-8446

MEMBER:

I AGREE TO PAY Provider for those services, products, or upgrades determined for the reason(s) specified below not to be covered under my Benefit Agreement:

- Not medically necessary
- Primarily for comfort and convenience
- Otherwise not a covered benefit or excluded under my coverage.

I understand that a participating Provider may not charge me for anything determined to be not medically necessary unless I specifically agree to pay for it. I also understand that the Provider and/or I may appeal any determination of non-coverage by following the grievance and appeals procedures described in my Benefit Agreement or Evidence of Coverage.

For the non-covered services, products, or upgrades listed below, I also understand that I am responsible for the difference between the covered expense for covered services and the Total Cost listed below, even though they may not be shown on my Explanation of Benefits (EOB) as my responsibility. If the Total Cost of the service, product, or upgrade is not a covered expense, I understand that I am responsible for the Total Cost.

DATE OF SERVICE	SERVICE, PRODUCT, OR UPGRADE	TOTAL COST	MEMBER'S (PATIENT'S) RESPONSIBILITY
TBD	Bariatric Pkg.	\$950.00	\$950.00

*Member Responsibility is defined as cost of non-covered services, products, or upgrades. In addition to being responsible for the non-covered expense, I will be billed and held responsible for any co-pay, deductible, and/or coinsurance as stated in my Member's Benefit Agreement.

PATIENT SIGNATURE: _____ **DATE:** _____