

Texas Center for Medical & Surgical Weight-Loss
8811 Village Drive, Suite 300,
San Antonio, TX 78217
(210) 651-0303 Fax (210) 651-0302
www.texasbariatric.com

Patient Questionnaire

Date: _____

Personal Information:

Patient Name _____

Gender: Male Female HT: _____ WT: _____ BMI: _____

Social Security #: _____ Age: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: Home _____ Wk _____ Cell _____

Where can we BEST reach you during our working hours (9-5) _____

Referral:

How did you hear about us?

Who referred you to Dr Cavazos or Northeast Baptist Hospital Bariatric Center

Your Primary Care Doctor _____ Phone # _____

Address _____

City _____ State: _____ Zip: _____

Please state why you want to lose weight and how you believe it will change your life:

Name _____ Date _____

Next of Kin Information

Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____

Patient Employment Information

Employment status: Full Time ____ Part Time ____ Not Employed ____ Student ____
Employer/ School Name: _____
Occupation: _____
Employer Address: _____ WK Phone _____
City: _____ State: _____ Zip: _____

Guarantor Employment Information

Employment Status: Full Time ____ Part Time ____ Not Employed ____ Student ____
Employer/School Name: _____ Occupation: _____
Employer Address: _____ Wk Phone: _____
City: _____ State: _____ Zip: _____
Name: _____ Relationship to pt. _____
Date of Birth: _____ Social Security Number: _____
Home Phone: _____
Marital Status: Single ____ Married ____ Divorced ____ Widowed ____
Mailing Address: _____ Apt #: _____
City: _____ State: _____ Zip: _____

Insurance Information:

Name of Primary Insurance _____
Name insurance is under _____
ID number _____ Group number _____
Ins. Phone number _____
Address where insurance form gets sent _____

Secondary Insurance _____
Name Insurance is under _____
ID number _____ Group number _____
Ins. Phone number _____
Address where insurance form gets sent _____

Name _____ Date _____

Dietary History

Diet Programs tried in the past (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Doctor Supervised diet | <input type="checkbox"/> Previous Gastric Surgery |
| <input type="checkbox"/> Jenny Craig | <input type="checkbox"/> Weight Watchers |
| <input type="checkbox"/> Atkins Diet | <input type="checkbox"/> Herbalife |
| <input type="checkbox"/> OTC Liquid Diet | <input type="checkbox"/> Low fat |
| <input type="checkbox"/> OTC Pills | <input type="checkbox"/> Hypnosis |
| <input type="checkbox"/> Exercise program | <input type="checkbox"/> Diet Center Program |
| <input type="checkbox"/> Doctor directed diet program
using diet pills | <input type="checkbox"/> Nutri-System |
| | <input type="checkbox"/> Richard Simmons |

Most weight lost on a diet _____ Obese since _____ # of years at current weight _____

Maximum weight _____ Minimum weight in last 5 years _____

Medications taken for weight loss _____

Other _____

Were any of these diets physician-supervised with documented weight loss attempt? _____

How long have you been overweight? _____

PAST MEDICAL HISTORY (Check if you have or had any of the following?)

Cancer _____

High Blood Pressure _____

High cholesterol _____

High Triglycerides _____

Lower back pain _____

Arthritis _____

Diabetes: Type 1 or Type II _____

Sleep Apnea requiring CPAP _____

Gastroesophageal reflux (GERD)/ heartburn _____

Heart Disease (heart attacks, angina) heart operation or procedure? _____

Name _____ Date _____

Review of Systems

General

- ___ Weight Gain
- ___ Weight Loss
- ___ Fatigue
- ___ Night Sweats

Skin

- ___ Skin Disease
- ___ Itching
- ___ Rashes
- ___ Sores

Head

- ___ Trauma
- ___ Headache
- ___ Visual Changes
- ___ Nausea/Vomiting

Eyes

- ___ Visual Changes
- ___ Blurry Vision
- ___ Tearing
- ___ Itching

Ears

- ___ Hearing Loss
- ___ Ringing in Ears
- ___ Vertigo
- ___ Earache

Nose/Sinuses

- ___ Runny Nose
- ___ Nose Bleeds
- ___ Allergy

Mouth/Throat/Neck

- ___ Difficulty Swallowing
- ___ Hoarseness
- ___ Bleeding Gums
- ___ Sore Throat

Respiratory

- ___ Shortness of Breath
- ___ Coughing up Blood
- ___ Wheezing
- ___ Coughing
- ___ Asthma

Cardiac

- ___ High Blood Pressure
- ___ Murmurs
- ___ Palpitations
- ___ Shortness of Breath
- ___ Chest Pain

Gastrointestinal

- ___ Change in appetite
- ___ Heartburn
- ___ Nausea
- ___ Vomiting
- ___ Change in Bowels
- ___ Jaundice
- ___ Blood in Stools
- ___ Abdominal Pain

Urinary

- ___ Change in Frequency
- ___ Painful Urination
- ___ Blood in Urine
- ___ Frequent Urination at Night
- ___ Incontinence

Vascular

- ___ Leg Swelling
- ___ Pain with exercise
- ___ Varicose Veins
- ___ Thromboses

Musculoskeletal

- ___ Weakness
- ___ Pain
- ___ Joint Stiffness
- ___ Swelling
- ___ Arthritis

Neurologic

- ___ Numbness
- ___ Tingling
- ___ Tremors
- ___ Weakness/Paralysis
- ___ Fainting
- ___ Seizures

Hematologic

- ___ Anemia
- ___ Abnormal bleeding or bruising
- ___ History of Transfusions
- ___ Blood Disease

Endocrine

- ___ Heat/cold Intolerance
- ___ Excessive Sweating
- ___ Thyroid Problems
- ___ Diabetes

Psychiatric

- ___ Have a Mental Health Provider?
- ___ Depression
- ___ Anxiety
- ___ Memory Problems

Please take time and explain any above checked boxes. Describe any treatment and dates

Name _____ Date _____

Your physician information:

	<u>Name</u>	<u>Address</u>	<u>Phone Number</u>
Primary Doctor			
Internist			
GYN			
Therapist			
Psychologist or Psychiatrist			
Cardiologist			
Other			
Other			

**TEXAS CENTER FOR MEDICAL &
SURGICAL WEIGHT LOSS
PATIENT CONSENT FORM**

The Department of Health and Human Services has established the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This privacy rule is to help insure that personal health care information is protected for privacy. The privacy rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of their Private Health Information which may also include any information regarding any accident/work injury. Please understand that this information can be used to:

- Conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers/insurance carriers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all that we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose Personal Health Information for purposes of treatment, payment, or health care operations.

You may refuse to consent to the use or disclosure of your Personal Health Information, but this must be done in writing. Under this law, you may restrict how your private information is used or disclosed to carry out treatment, payment, or other healthcare operations. Under this law, we also have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI).

I HAVE READ AND UNDERSTAND THIS CONSENT AND REALIZE THAT I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME.

Patient Name: _____

Signature: _____ Date: _____

Relationship to Patient: _____

**TEXAS CENTER FOR MEDICAL &
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PERMISSION TO CONTACT FORM

Dear Patient,

Due to recent changes in disclosure laws we need to obtain your permission to contact you or leave messages at home or at work regarding your appointments and or treatment. Please provide the requested phone number below and indicate if we have your permission to contact you and/or leave a detailed message at that number.

Work Phone #: _____ Permission to contact: yes no detailed msg.

Home Phone #: _____ Permission to contact: yes no detailed msg.

Mobil Phone#: _____ Permission to contact: yes no detailed msg.

Please list the BEST number where we can reach you between the hours of 9:00am and 5:00pm:

Signature

Date