



My New Beginning

DISCOVER LIFE AFTER WEIGHT LOSS.

A department of Baylor Scott & White Medical Center – White Rock

**To find out if you're a candidate for weight loss surgery, please complete the enclosed information and return to our clinic.
If you have questions, call us at 214.324.6127.**

Our team at My New Beginning is here to support you through every step of the journey.



Baylor Scott & White

MEDICAL CENTER

WHITE ROCK

My New Beginning Surgery Weight Loss Clinic
1151 N. Buckner Suite #308
Dallas, Texas 75218
Office: 214.324.6127 | FAX 214.324.6627

PATIENT INFORMATION

LAST NAME, FIRST, MIDDLE	RACE	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	AGE	DATE OF BIRTH
STREET ADDRESS		CITY, STATE, ZIP		
SOCIAL SECURITY	HOME /CELL PHONE	WORK PHONE		
OCCUPATION		EMPLOYER		
EMAIL ADDRESS	HOW DID YOU HEAR ABOUT US?	HIGHEST LEVEL OF EDUCATION:		
PRIMARY CARE PHYSICIAN	ADDRESS	PHONE/FAX:		

RESPONSIBLE PARTY INFORMATION

LAST NAME, FIRST, MIDDLE	SOCIAL SECURITY	DATE OF BIRTH
RELATIONSHIP TO PATIENT	STREET ADDRESS	CITY, STATE, ZIP
HOME /CELL PHONE	WORK PHONE	EMPLOYER

INSURANCE INFORMATION

INSURANCE NAME	POLICY t	GROUP t	PHONE	POLICY HOLDER & DOB
INSURANCE NAME	POLICY t	GROUP t	PHONE	POLICY HOLDER & DOB
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IN CASE OF EMERGENCY NOTIFY *(Other Than Responsible Party)*

NAME	ADDRESS, IF POSSIBLE	PHONE
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_____ Initials

**PREVIOUS HOSPITALIZATIONS/
SURGERIES/SERIOUS ILLNESSES**

Have you had a previous weight loss surgery?
 Yes No

Have you or any of your family members
had any type of problem with anesthesia?
 Yes No

PATIENT SOCIAL HISTORY

Marital Status
 Single Married Separated
 Divorced Widowed

Patient Lives
 Alone With Family Other: _____

Use of Alcohol
 Never Rarely Moderate
 Daily

Use of Tobacco
 Never Previously, but quit _____
 Current packs per day: _____

Use of Drugs
 Never
 Type/Frequency: _____

Adaptive Self-Care aids
 None Cane Walker
 Wheelchair Oxygen
 Other: _____

FAMILY SUPPORT

How does your support person (family) feel
about you having this type of surgery?

BIOPSYCHOSOCIAL

Religion: _____

Are there religious needs we may help you
with during your hospital stay? Yes No

_____ Initials

Explain prior weight loss surgery (where/when/type):

Other Previous Surgeries:

FAMILY MEDICAL HISTORY (*parents, grandparents,
brothers, sisters*)

Please indicate who has or has had these health problems:

Obesity: _____

Lung Disease, Asthma or Emphysema: _____

Diabetes: _____

Kidney Disease: _____

High Blood Pressure: _____

Bleeding Tendency or Blood Disorder: _____

Heart Disease (*indicate what type*):

Breast Cancer: _____

High Blood Cholesterol: _____

Colon Cancer: _____

Liver Problems: _____

WEIGHT HISTORY

Current Height: _____ ft. _____ in.

Current Weight: _____ pounds

What was your approximate weight for each of the
past five years?

Year	Weight	Year	Weight
20____	_____	20____	_____
20____	_____	20____	_____
20____	_____		

Please list all diets, diet pills, diet programs and exercise programs that you have attempted:

REVIEW OF SYMPTOMS

Please indicate any personal history below:

Genitourinary

- None
- Frequent Urination
- Kidney Stones
- Kidney Failure
- Nephritis
- Urinary Tract Infections
Last UTI: _____
- Incontinence or Dribbling
- Pain with Urination
- Leakage of urine with coughing, laughing or sneezing
- On Dialysis

Respiratory

- None
- Cough/Wheezing
- Shortness of breath
 frequent on exertion

If you walk at a fairly good pace, how far can you walk before being out of breath? _____

Ever hospitalized for asthma? Yes No

On Oxygen? Yes No ____ l/min

Pulmonary embolus (blood clot in lung)

- COPD
- Emphysema
- Bronchitis: When: _____
- Sleep Apnea
 CPAP BIPAP
 Snore Stop Breathing

When and where was the sleep study done?

Comments: _____

Endocrine

- None
- Thyroid Disease
When diagnosed: _____
Medication: _____
- Diabetes Insulin Oral Agent
Date of onset: _____
- Diabetic Diet Instruction
Calorie Level: _____

Comments: _____

Psychological

- None
- Nervousness
- Anxiety
- Depression
Medication: _____
- Hospitalization for emotional problem
When/Where? _____

Name of doctor treating/has treated you:

_____ Initials

Is your physician aware that you are interested in having bariatric surgery? Yes No

Comments: _____

Cardiovascular

- None
- Angina
- Palpitations

Can you lie flat on your back? Yes No
If no, what happens when you lie down?

- Pain in neck, chest, arms
- Heart Attack
- Abnormal Electrocardiogram
- Irregular Heartbeat
- High Blood Pressure

How long? _____

Medication: _____

- Congestive Heart Failure
- High Cholesterol/ Triglycerides

How long? _____

- Blood clots in legs
- IVC filter?
- Recent ECG Date: _____
- Pacemaker
- Heart Cath

Comments: _____

Musculoskeletal

- None
- Pain/Swelling in Joints
- Degenerative Joint Disease
- Arthritis
- Low back pain/back injury
- Ankle and foot pain

- Joint Replacements

Which ones? _____

- Ankle and foot pain
- Fibromyalgia
- Multiple Sclerosis
- Rheumatoid Arthritis

Comments: _____

Neurological

- None
- Stroke
- Sleeping difficulty

What kind? _____

- Dizziness, Vertigo
- Numbness, tingling feelings, weakness.

Where? _____

- Tremors
- Convulsions/Seizures

When and what caused it? _____

- Loss of consciousness

When & why? _____

- Pseudotumor Cerebri

Comments: _____

Gastrointestinal

- None
- Indigestion
- Nausea/Vomiting
- Diarrhea
- Constipation
- GERD Medication: _____
- Pain with bowel movement
- Blood in stools
- Hemorrhoids

_____ Initials

- Irritable Colon
- Colitis
- Gallbladder Disease
- Gallbladder Removal
- Recent Colonoscopy
- Recent EGD or "Scope"
- Ulcers
- History of H.pylori
- Liver problems
- Hepatitis
- Crohn's disease

Comments: _____

Other Conditions

- None
 - HIV/AIDS
 - Bleeding Disorder
 - Blood Clotting Disorder
 - Other conditions we should be aware of?
- _____
- _____
- _____

MEDICATION LOG

- Medication List Added Separately
- Are you on any blood thinners or steroids, e.g. Prednisone? Yes No

DATE RX	MEDICATION	DOSAGE	FREQUENCY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Your pharmacy's name and phone number: _____

_____ Initials

Allergies to Medications and reaction to each:

- No known allergies**

Allergies to Food:

Latex or other Allergies: **No latex allergy**

WHAT ARE YOUR EXPECTATIONS OF BARIATRIC SURGERY?

HOW MUCH WEIGHT DO YOU EXPECT TO LOSE?

WHICH PROCEDURE DO YOU PREFER:

- Roux-en-Y Gastric Bypass
- Sleeve Gastrectomy
- Lap-Band