My New Beginning

DISCOVER LIFE AFTER WEIGHT LOSS.

**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.**

CITY HOSPITAL at White Rock

**My New Beginning Surgery Weight Loss**
1151 N. Buckner #308
Dallas, Texas 75218
Office: 214-324-6127
FAX 214-324-6627

## PATIENT INFORMATION

| LAST NAME, FIRST, MIDDLE | RACE | ❑ MALE<br>❑ 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 |
| INSURANCE NAME | POLICY t | GROUP t | PHONE | POLICY HOLDER & DOB |

## IN CASE OF EMERGENCY NOTIFY *(Other Than Responsible Party)*

| NAME/ Relatio nship to patient | ADDRESS, IF POSSIBLE | PHONE |
|---|---|---|

_____ 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?

_____

_____

_____

Allergies to Medications and reaction to each:

❑ **No known allergies**

_____

_____

_____

_____

Allergies to Food:

_____

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

_____

**Are you willing to receive blood products: Y N**

**Are you willing to receive text messages with appointment reminders from our clinic: Y N**

_____

## 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

## MEDICATION LOG

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

| MEDICATION | DOSAGE | FREQUENCY TAKEN |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Your pharmacy's name and phone number: