CHRISTUS®
Southeast Texas Bariatric Center
3030 North Street, Suite 340, Beaumont, TX 77702
409.839.LOSE (5673) | 409.839.5699 fax

CONFIDENTIAL PATIENT INFORMATION

Please complete the following questionnaire and bring it to your first appointment at the Southeast Texas Bariatric Center.
So that we will be able to understand your health status and discuss your surgical options, it is very important that we have this information.
If you are unsure about how to answer a question, make a guess or leave it blank.

NAME:		DATE:	BMI:
DATE OF BIRTH:	AGE:	HEIGHT:	WEIGHT:

PAST MEDICAL / SURGICAL HISTORY

PREVIOUS SURGERIES / PROCEDURES:

1		DATE	4		DATE
2		DATE	5		DATE
3		DATE	6		DATE

HOSPITALIZATIONS:

1		DATE	4		DATE
2		DATE	5		DATE
3		DATE	6		DATE

ILLNESSES: Describe illnesses not requiring hospitalization; list any health conditions you are currently being treated for (ie. diabetes, sleep apnea, high blood pressure, etc).

1		DATE	4		DATE
2		DATE	5		DATE
3		DATE	6		DATE

INJURIES: List and give approximate date.

1		DATE	4		DATE
2		DATE	5		DATE
3		DATE	6		DATE

ALLERGIES: List all.

SUBSTANCE:	REACTION:
SUBSTANCE:	REACTION:
SUBSTANCE:	REACTION:
SUBSTANCE:	REACTION:
SUBSTANCE:	REACTION:
SUBSTANCE:	REACTION:
SUBSTANCE:	REACTION:

CURRENT MEDICATIONS: Include daily medications as well as those used as needed.

MEDICATION:	DOSE:	HOW OFTEN:
MEDICATION:	DOSE:	HOW OFTEN:
MEDICATION:	DOSE:	HOW OFTEN:
MEDICATION:	DOSE:	HOW OFTEN:
MEDICATION:	DOSE:	HOW OFTEN:
MEDICATION:	DOSE:	HOW OFTEN:
MEDICATION:	DOSE:	HOW OFTEN:

VITAMINS AND SUPPLEMENTS:		
NAME:	AMOUNT:	HOW OFTEN:
NAME:	AMOUNT:	HOW OFTEN:
NAME:	AMOUNT:	HOW OFTEN:
NAME:	AMOUNT:	HOW OFTEN:
NAME:	AMOUNT:	HOW OFTEN:
NAME:	AMOUNT:	HOW OFTEN:

PHYSICIANS: NAME	PHONE	FAX
Primary Care:		
Pulmonologist:		
Gastroenterologist:		
Orthopedist:		
Neurologist:		
Cardiologist:		
Psychiatrist:		
Endocrinologist:		
Gynecologist:		
Other:		

SOCIAL HISTORY

Your occupation: Spouse's occupation:

List any hobbies or volunteer work in which you participate:

Number of children: General health of children:

PERSONAL HABITS

Do you smoke? Y / N	How much?	How long have you smoked?	When did you quit smoking?
Do you drink alcohol? Y / N	How much?	How long have you drank?	When did you quit drinking?
Do you use illegal substances? Y / N	Ever used illegal substances? Y / N	What kind?	How often?
Do you exercise? Y / N	What kind of exercise?	How often do you exercise?	

Do you have any limitations to exercise?

FAMILY HISTORY

RELATIONSHIP	AGE	HEALTH	IF DECEASED, CAUSE:	WEIGHT STATUS:	RELATIONSHIP	AGE	HEALTH	IF DECEASED, CAUSE:	WEIGHT STATUS:
Father		Good / Fair / Poor		Thin / Avg / Overweight	Brother / Sister		Good / Fair / Poor		Thin / Avg / Overweight
Mother		Good / Fair / Poor		Thin / Avg / Overweight	Son / Daughter		Good / Fair / Poor		Thin / Avg / Overweight
Brother / Sister		Good / Fair / Poor		Thin / Avg / Overweight	Son / Daughter		Good / Fair / Poor		Thin / Avg / Overweight
Brother / Sister		Good / Fair / Poor		Thin / Avg / Overweight	Son / Daughter		Good / Fair / Poor		Thin / Avg / Overweight
Brother / Sister		Good / Fair / Poor		Thin / Avg / Overweight	Son / Daughter		Good / Fair / Poor		Thin / Avg / Overweight
Brother / Sister		Good / Fair / Poor		Thin / Avg / Overweight	Son / Daughter		Good / Fair / Poor		Thin / Avg / Overweight
Brother / Sister		Good / Fair / Poor		Thin / Avg / Overweight	Son / Daughter		Good / Fair / Poor		Thin / Avg / Overweight

Do you know of any blood relative who has had any of these conditions (If yes, give relationship of relative):

Stroke: Y / N ________	Heart disease Y / N ________	Tuberculosis Y / N ________	Problems with anesthesia Y / N ________
High blood pressure Y / N ________	Cancer Y / N ________	Bleeding tendencies Y / N ________	Other: ____________________
Diabetes Y / N ________	Overweight (20-99 lbs.) Y / N ________	Severely obese (>100 lbs.) Y / N ________	Other: ____________________

REVIEW OF SYSTEMS

NEUROLOGICAL:

Have you ever fainted?	Y / N	Weakness in arms/legs?	Y / N
Have you ever had a convulsion?	Y / N	Visual disturbances?	Y / N
Double vision?	Y / N	Headaches that wake you at night?	Y / N
Ringing in your ears?	Y / N	Can you get relief for your headaches?	Y / N
Severe headaches?	Y / N	Pain on one side of your head?	Y / N

CARDIORESPIRATORY:

Have you ever had shortness of breath doing normal work?	Y / N	Do you have bleeding problems?	Y / N
Have you ever had shortness of breath awaken you at night?	Y / N	Do you have palpitations?	Y / N
Have you ever had shortness of breath climbing a flight of stairs?	Y / N	Have you ever had chest pain or tightness?	Y / N
Have you ever had shortness of breath accompanied by wheezing?	Y / N	Does the chest pain occur only at rest?	Y / N
Do you have a chronic cough?	Y / N	Does the chest pain disappear if you rest?	Y / N
Do you cough up sputum?	Y / N	Does the chest pain radiate to the arms, neck or back?	Y / N
Do you need more that one pillow to sleep?	Y / N	Have you ever had chest pain or tightness when exerting yourself?	Y / N
Do you have varicose veins?	Y / N	Have you ever had chest pain or tightness after a heavy meal?	Y / N
Do you have phlebitis or inflamed leg veins?	Y / N	Have you ever had chest pain or tightness when excited or upset?	Y / N
Do you have swelling of the ankles?	Y / N	Have you ever had a heart attack?	Y / N

PSYCHIATRIC

Do you have a history of psychiatric illness?	Y / N	Obsessive compulsive disorder?	Y / N
Anxiety?	Y / N	Hospitalizations?	Y / N
Suicide attempts?	Y / N	Bi-polar or manic depression?	Y / N
Depression?	Y / N	Have you ever self-mutilated?	Y / N
Do you have an eating disorder?	Y / N	Do you have bulimia?	Y / N

GASTROINTESTINAL:

Do you have GERD or reflux?	Y / N	Pain in your stomach while eating or immediately after eating?	Y / N
Pain in your stomach which occurs 1 or 2 hours after meal?	Y / N	Do you have abdominal cramps?	Y / N
Pain in your stomach which awakens you at night?	Y / N	Do you have pain during or after bowel movements?	Y / N
Pain in your stomach which is relieved with antacid?	Y / N	Do you have black stools?	Y / N
Pain in your stomach relieved by a bowel movement?	Y / N	Do you have alternating diarrhea and constipation?	Y / N
Pain in your stomach brought on by eating fried or greasy food?	Y / N	Do you have mucous in the stool?	Y / N
Pain in your stomach which is relieved by eating?	Y / N	Do you have coffee ground looking stool?	Y / N

URINARY:

Have you had burning when urinating?	Y / N	Have you had trouble holding urine?	Y / N	Have you had blood in your urine?	Y / N
Have you had stress incontinence?	Y / N	Have you passed a kidney stone?	Y / N	Have you had trouble starting to urinate?	Y / N
Have you had dark colored urine?	Y / N	Have you had loss of bladder control?	Y / N	Have you had frequency/awakening at night?	Y / N

MUSCULOSKELETAL:

Do you have pain in your calves while walking?	Y / N	Do you have cramps in your legs at night?	Y / N
Do you have pain in a big toe?	Y / N	Do you have joint pain or arthritis?	Y / N
Do you have back problems?	Y / N	Do you have difficulty ambulating/walking?	Y / N

If you answered yes to any of these questions, use the space provided on the following page for your explaination.

MALE SPECIFIC QUESTIONS:

Have you ever had a hernia? Y / N	Have you had loss of sexual function? Y / N
Have you ever had prostate problems? Y / N	Other:

FEMALE SPECIFIC QUESTIONS:

Are you still having monthly periods? Y / N	Are they: Heavy / Irregular / Painful	Date of last period?
Bleeding between periods? Y / N	Method of birth control?	
Do you plan a pregnancy in the next two years? Y / N	Date of last pap test?	Date of last mammogram?

Number of pregnancies? _____ Number of live births? _____ Number of miscarriages? _____ Caesarean sections? _____

Number of premature births? _____ Other complications?

If you answered yes to any of the questions, please explain below (use additional paper if needed)**:**

Describe the limitations (emotional, physical, employment) which morbid obesity imposes on you.

This section must be completed – we will not process your chart without this information. You may use additional paper if needed.

WEIGHT MANAGEMENT HISTORY

This form will be submitted to your insurance company with your letters of medical necessity from the physicians. Approval or denial of your request for surgery depends on meeting the criteria put forth by your insurance company. Most insurance carriers require documentation of medically supervised weight loss attempts within the last two years.

How many years have you been obese?			
Please indicate approximate weights:	**Normal**	**Obese**	**>100 lbs (Morbidly Obese)**
Childhood (1 - 10 years of age)			
Adolescence (11 - 18 years of age)			
Young adult (18 - 30 years of age)			
Adult (30 - 60 years of age)			
Please indicate approximate weights for the last 3 years:	**year _____**	**year _____**	**year _____**
Average amount of weight gained yearly:	_____ pounds/year	_____ pounds/year	_____ pounds/year
For Women: Weight retained after each pregnancy:	_____ pounds/year	_____ pounds/year	_____ pounds/year

IT IS VERY IMPORTANT TO NOTE MEDICALLY SUPERVISED WEIGHT LOSS ATTEMPTS:

Doctors who have treated you for obesity:	**Programs they had you try:**	**Weight Loss**	**Weight Regained**	**Length of Program**	**Avgerage Cost**
	Optifast				
	Medifast				
	Xenical				
	Phen-Fen				
	Meridia				
	Pondemin				
	Diabetic Education				
	Weight Loss Surgery				

OTHER PROGRAMS YOU HAVE ATTENDED FOR SIX MONTHS OR MORE:

Program	**Date Attended**	**Weight Loss**	**Weight Regained**	**How Many Times**	**Length of Program**	**Estimated Cost**
Weight Watchers						
Overeaters Anonymous						
Diet Centers: Jenny Craig / NutraSystems / etc.						
Susan Powder / Richard Simmons						
Slim Fast						
Health Management Resources						
Ongoing Nutrition Therapy with a Dietitian						
Self-Imposed:						

EXERCISE HISTORY

Program	Date	Weight Loss	Weight Regained	How Many Times	Length of Program	Estimated Cost
Bicycling						
Jogging						
Walking						
Swimming						
Spa membership						
Aerobics						
Video tapes						
Home gym equipment						
Personal trainer						
Other:						

PROTECTED HEALTH INFORMATION:

I have received a copy of the Notice of Privacy Practices for Protected Health Information (the "Notice"). This Notice provides a complete description of the uses and disclosures of my Personal Protected Health Information (PHI). I have had an opportunity to review this information before signing this form. I consent to CHRISTUS Southeast Texas Bariatric Center and/or any physician(s) participating in my care releasing my PHI (either in writing or verbally) to carry out treatment, payment, or health care operations. This includes any medical misinformation (including drug and alcohol abuse treatment information, psychiatric treatment information, and HIV-related information including HIV test result, if applicable), which may be needed to process claims for medical insurance (or managed care) benefits relative to participation in this program (including pre-certification and verification, if necessary), or which may be needed to conduct continued care planning.

_____ _____

Patient Signature Date

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CHRISTUS
Hospital-*St. Elizabeth & St. Mary*

NOTICE OF PRIVACY PRACTICES
Effective 4/14/2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions, please contact our Privacy Office at the address or phone number at the end of this Notice.

WHO WILL FOLLOW THIS NOTICE?

CHRISTUS Hospital-St. Elizabeth & St. Mary provides health care to our patients, residents, and clients in partnership with physicians and other professionals and organizations. The information privacy practices in this Notice will be followed by:

- Any health care professional who treats you at any of our locations;
- All departments and units of our organization, including all off-campus units or departments;
- All employed associates, staff or volunteers of our organization, including staff of CHRISTUS Health Southeast Texas, our regional office, and CHRISTUS Health, our parent organization, with whom we may share information as permitted within our organized health care arrangement;
- Any business associate or partner of CHRISTUS Health Southeast Texas with whom we share health information.

OUR PLEDGE TO YOU.

We understand that medical and billing information about you is personal. We are committed to protecting the privacy of your medical and billing information. We create a designated record of the care and services you receive to provide quality care and to comply with legal requirements. This Notice applies to all of the records of your care that we maintain, whether created by facility staff or your personal doctor. Your personal doctor may have different policies or Notices regarding the doctor's use and disclosure of your medical and billing information created in the doctor's office. We are required by law to:

- keep medical and billing information about you private;
- give you this Notice of our legal duties and privacy practices with respect to your protected health information;
- follow the terms of the Notice currently in effect.

CHANGES TO THIS NOTICE.

We may change our policies and privacy practices at any time. Changes will apply to your protected health information we already hold, as well as new information obtained after the change occurs. When we make a significant change in our policies, we will change our Notice and post the new Notice in waiting areas, exam rooms, and on this Web site.

You can receive a copy of the current Notice at any time. The effective date is listed just below the title. You will be offered a copy of the current Notice each time you register at our facility for treatment. You will also be asked to acknowledge in writing your receipt of this Notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

• We may use and disclose medical and billing information about you for **treatment** (such as sending medical information about you to a specialist as part of a referral); **to obtain payment for treatment** (such as sending billing information to your insurance company or Medicare); and **to support our health care operations** (such as comparing patient data to improve treatment methods).

• We may use or disclose medical and billing information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out protected health information about you without prior authorization for **public health purposes, abuse or neglect reporting, health oversight audits or inspections, research studies, funeral arrangements, organ donation, workers' compensation purposes, or during emergencies.** We may also disclose protected health information **when required by law**, such as in response to a request from law enforcement officials in specific circumstances, or in response to valid judicial or administrative orders.

• We may contact you for **appointment reminders,** or to tell you about or recommend **possible treatment options, alternatives, health related benefits or services** that may be of interest to you, or to support **fundraising efforts.**

• If admitted as a patient, unless you tell us otherwise, we will list in the patient directory your name, location in the hospital, your general condition (good, fair, etc.) and your religious affiliation, and will release all but your religious affiliation to anyone who asks about you by name. Your religious affiliation may be disclosed only to a clergy member, even if they do not ask for you by name.

• We may disclose medical and billing information about you to a friend or family member who is involved in your medical care or to disaster relief authorities so that your family can be notified of your location and condition.

OTHER USES OF MEDICAL INFORMATION.

• In any other situation not covered by this Notice, we will ask for your written authorization before using or disclosing your protected health information. If you choose to authorize our use or disclosure of your protected health information, you can later revoke that authorization by notifying us in writing of your decision.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

• In most cases, you have the right to look at or obtain a copy of medical and billing information contained in the designated record set that we use to make decisions about your care. If you request copies, we may charge a fee for the cost of copying, related supplies or postage.

If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

• If you believe that information in your designated record set is incorrect or if important information is missing, you have the right to request that we correct the records. Your request may be submitted in writing.

A request for amendment must provide your reason for the amendment. We could deny your request to amend a record if the information was not created by us; if it is not part of the medical or billing information maintained by us; or if we determine that the record is accurate.

You may appeal, in writing, a decision by us not to amend a record.

• You have the right to a list of those instances where we have disclosed medical and billing information about you, other than for treatment, payment, health care operations or where you specifically authorized a disclosure. When you submit a written request, the request must state the time period desired for the accounting, which must be less than a six (6)-year period and starting after April 14, 2003. You may receive the list in paper or electronic form. The first disclosure list request in a 12-month period will be provided to you at no cost; other requests will be charged in accordance with our cost to produce the list. We will inform you of the cost before you incur any charges.

• If this Notice was sent to you electronically, you have the right to a paper copy of this Notice.

• You have the right to request that your medical and billing information be communicated to you in a confidential manner, such as sending mail to an address other than your home. You must notify us in writing of the specific way or location for us to use to communicate with you.

• You may request, in writing, that we not use or disclose protected health information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, or when required by law, or in an emergency. We will consider your request but we are not legally required to accept it. We will inform you of our decision.

All written requests or appeals should be submitted to our Privacy Office listed at the end of this Notice.

COMPLAINTS.

• If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy Office (listed below). You may also contact our CHRISTUS Health Integrity Line, available 24-hours, at 1-888-728-8383.

• Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Office will provide you the address upon request.

• Under no circumstance will you be penalized or retaliated against for filing a complaint.

PRIVACY OFFICE CONTACT INFORMATION.

Katerena Byars, RHIA

2830 Calder Street, Beaumont, Texas 77702

Phone: 409.899.8271
Fax: 409.899.8195

Email: katerena.byars@christushealth.org