Surgical Consultants of Dallas, L.L.C

Bariatric Addendum

Patient Name:_____ DOB: _____

Surgeon: ☐ Christopher Bell, M.D. ☐ Michael Sutker, M.D.

I am primarily interested in the following procedure:

☐ Roux-en-Y gastric bypass ☐ Duodenal Switch

☐ Sleeve gastrectomy ☐ Revision

Do you perceive any barriers to having surgery? _____

_____

What is your goal weight? _____

When did your obesity begin? ☐ Childhood ☐ Adolescence ☐ Early Adulthood ☐ Adulthood

What was your lowest adult weight? _____ What year? _____

What was your highest adult weight? _____ What year? _____

What diet or weight loss programs have you tried in the past? (circle all that apply)

☐ Weight Watchers
☐ Jenny Craig
☐ Curves
☐ The Zone
☐ Slim-Fast
☐ Nutrisystem
☐ South Beach Diet
☐ Keto Diet

Other: _____

What was the most weight you ever lost on a diet? _____

Have you ever used diet pills? If so, which ones? _____

Have you ever been treated for an eating disorder? _____

Do you suffer from any of the following obesity related diseases?

☐ Diabetes
☐ Hypertension
☐ Hyperlipidemia
☐ Varicose Veins/Venous Stasis
☐ Intertrigo (yeast infection in skin folds)
☐ GERD
☐ Intracranial hypertension (normal pressure hydrocephalus)
☐ Migraines
☐ Osteoarthritis
☐ Obstructive Sleep Apnea
☐ Fatty Liver disease
☐ Polycystic Ovarian Syndrome
☐ Gout
☐ Asthma
☐ Urinary incontinence
☐ Depression
☐ Blood clots

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Patient Name:_____ DOB: _____

How many hours do you sleep at night? _____

Do you have any family members with obesity? _____

Do you understand how to read food labels? _____

How many meals a day do you eat? _____

How many calories a day do you eat? _____

Do you frequently eat large amounts of food after 8 PM at night? _____

How many days a week do you exercise?_____

How many minutes per week? _____

What is your level of intensity with exercise? ☐ Light ☐ Moderate ☐ Vigorous

Have you ever undergone another evaluation for bariatric surgery? _____

If yes, why did you decide not to proceed with surgery at that time? _____

_____

Previous weight loss surgery:

- ☐ Vertical banded gastroplasty
- ☐ Mini-gastric bypass
- ☐ Sleeve gastrectomy
- ☐ Lap-Band
- ☐ Roux-en-Y gastric bypass
- ☐ Stapling
- ☐ Other

Weight Prior to Previous Weight Loss Surgery: _____

Present Complications due to Previous Weight Loss Surgery: _____

_____

Reason You are in Need of a Revision Weight Loss Surgery:

_____

_____

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Program Expectations and Patient Agreement

Patient Name:_____ DOB: _____

Today's Date: _____

1. I am ready to pursue surgery as an option for treatment of my obesity.
2. I agree to follow the program as prescribed, actively participate in my aftercare, and utilize all resources available and recommended by the surgeon.
3. I agree that I am primarily responsible for obtaining insurance approval for this procedure. I will furnish all records requested by the program in a timely manner. I will follow up and inform the program of any additional information to obtain approval.
4. I realize that I am responsible for charges incurred for my care should my insurer fail to reimburse in an acceptable and timely manner.

Signature: _____

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