

Las Vegas Bariatrics

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6140 S. Fort Apache Rd., Suite #100, Las Vegas, NV 89148

Dear Patient:

The first step to evaluating your candidacy for bariatric surgery is your willingness to complete the following questionnaire. As with all patient records, the information you provide is highly confidential. We are requesting that you answer and complete all the questions that apply to your medical history. If you cannot remember exact dates, please provide approximate dates. This information is very important so that we may provide you with the highest quality of health care. The completion of the worksheet will take approximately forty-five minutes. We would greatly appreciate your efforts in completing the information as soon as possible. Once you have completed the initial patient worksheet, the following steps will need to be taken in preparation for your surgery:

Step 1:

Return the initial patient worksheet in person to the address above.

Or you may return it by mail to 6140 S. Fort Apache Rd. #100, Las Vegas, NV 89148

Step 2:

Once the worksheet is received, the office will contact you to schedule an appointment. A psychological and nutritional consult will also be required prior to requesting insurance authorization.

Step 3:

Following the initial consultation visit, we will submit a letter to your insurance company requesting approval for your surgery.

Step 4:

As soon as we have receive a response from your insurance company, we will notify you by telephone of their decision. Should your request for surgery be approved, we will schedule a surgical date with you. If approval is denied, we will discuss further options with you.

Step 5:

At the time you are scheduled for surgery, we will request that you schedule the specific consultations, diagnostic tests, and lab tests. These particular tests will be ordered based on your individual medical history and physical examination and are required prior to your surgical procedure. The information from these tests is very important for us to become fully aware of your particular medical needs before surgery. Thus, it is imperative that you complete the consultative tests within a two to four week period in order that we may review the results with you.

Thank you for your time and attention. We look forward to working with you and serving your medical needs.

Patient Name: _____

Address: _____

Telephone No. _____

Email Address: _____

MEDICAL HEALTH INFORMATION:

CARDIAC	YES	NO	**OFFICE USE ONLY**
Heart Attack			
Coronary Artery Disease			
Congestive Heart Failure			
High Blood Pressure			
Heart Arrhythmia			
Valvular Heart Disease/ Murmurs			
High Cholesterol/ Triglycerides			
Chest Pain in past 6 months			
Leg/ Ankle Swelling			
Deep Vein Thrombosis (blood clots)			
Peripheral Vascular Disease			
Other			

PULMONARY	YES	NO	**OFFICE USE ONLY**
Sleep Apnea			
COPD (Emphysema)			
Shortness of Breath			
Asthma			
Bronchitis			
Other			

GASTROINTESTINAL	YES	NO	**OFFICE USE ONLY**
Reflux (heartburn/ GERD)			
Ulcers			
Hiatal Hernia			
Gallstones			
Hepatitis			
Inflammatory Bowel (Crohn's/ UC)			
Irritable Bowel Syndrome			
Constipation			

Cirrhosis			
Other			

MEDICAL HEALTH INFORMATION:

ENDOCRINE	YES	NO	**OFFICE USE ONLY**
Diabetes			
Hyperthyroid			
Hypothyroid			
Adrenal (Cushing's)			
Other			

ORTHOPEDIC	YES	NO	**OFFICE USE ONLY**
Chronic Back Pain			
Pain in Weight Bearing			
Joints			
Gout/ Arthritis			
Fibromyalgia			
Other			

RENAL	YES	NO	**OFFICE USE ONLY**
Urinary Stress			
Incontinence			
Kidney Stones			
Kidney Disease			
Other			

NEUROLOGICAL	YES	NO	**OFFICE USE ONLY**
Seizure Disorder			
Stroke			
Headaches			
Other			

BLOOD	YES	NO	**OFFICE USE ONLY**
Abnormal Bleeding			
Anemia			
Other			

MEDICAL HEALTH INFORMATION:

EMOTIONAL	YES	NO	**OFFICE USE ONLY**
Depression			
Anxiety			
Suicidal Attempts			
Bipolar Disorder			
Eating Disorder (Binge)			
Other			

SURGICAL HISTORY:

I have never had surgery.

Type of Surgery	Reason for Surgery	Year

MEDICATION INFORMATION:

Please list any prescription, over the counter, natural, herbal, and vitamin supplements that you are currently using.

Medication	Dose	Times Per Day	Purpose	Year Started

ALLERY INFORMATION:

Please list any allergies that you may have to medications or foods.

1. _____ Reaction:
2. _____ Reaction:
3. _____ Reaction:

4. _____ **Reaction:**

5. _____ **Reaction:**

SOCIAL HISTORY:

Alcohol Use: Never _____Drinks/day _____Drinks/week

Tobacco Use: Never _____/day _____/week

Illicit Drugs: Never _____/day _____/week

FAMILY HISTORY:

Family Member	Approximate Wt (lbs)	Height	Age	Medical Problems
Mother				
Father				
Brothers				
Sisters				

EATING HABITS:

7. How many meals do you eat every day?

8. How many snacks do you eat per day?

List your favorite and most frequently eaten snack foods:

9. How many 12 oz. cans of soda/ pop do you drink every day?