

Kenneth Hollis, M.D., FACS
11914 Astoria Boulevard Ste. 125
Houston, TX 77089
Ph. 281-482-5300

Patient Information

Legal Name – Last: _____ First: _____ M.I. _____
Birth date: _____ - _____ - _____ Age: _____ Home Phone: (_____) _____ - _____
Social Security Number: _____ Email Address: _____
Address: _____ Apt/Unit: _____
City: _____ State: _____ Zip Code: _____ - _____
Sex: **M** **F** Height: _____ Weight: _____
Ethnicity: (Check One): _____ Caucasian _____ Asian _____ African American _____ Hispanic _____ Other
Marital Status (Circle One): Married Single Divorced Widowed Number of children: _____
Email Address: _____ Cell Phone: (_____) _____ - _____
Employer: _____ Phone: (_____) _____ - _____

Primary Insured Information

Legal Name – Last: _____ First: _____ M.I. _____
Birth date: _____ - _____ - _____ Age: _____ Home Phone: (_____) _____ - _____
Social Security Number: _____ - _____ - _____ Email Address: _____
Address: _____ Apt/Unit: _____
City: _____ State: _____ Zip Code: _____ - _____
Relationship to Patient: _____
Employer: _____ Occupation: _____
Employer Address: _____

Spouse Information

Spouse Name: _____ Work Phone: (_____) _____ - _____

Emergency contact (Not living in same household)

Name: _____ Relationship: _____
Contact Phone: (_____) _____ - _____

Insurance Information

Primary Insurance Company: _____
Type of Plan: (circle one) **PPO** **HMO** **EPO** **POS** **OTHER**
ID Number: _____ Group Number: _____
Secondary Insurance Company: _____
Type of Plan: (circle one) **PPO** **HMO** **EPO** **POS** **OTHER**
ID Number: _____ Group Number: _____

Patient Name: _____

How many years have you been overweight? _____

Previous Weight Loss Surgery NO _____ YES _____ (please indicate below)

Surgery Type	Date	Surgeon	Weight Loss

Diet Programs and Supplements (please indicate which of the following diet or plans you have attempted)

Programs	Dates	Duration	MD Supervised	Weight Loss
Atkins Diet				
Grapefruit Diet				
Herbalife				
Jenny Craig				
Liquid Diets				
Medifast				
Metabolife				
Nutri- System				
Optifast				
Pritikin Diet				
Slim Fast				
Tops				
Weight Watchers				
Other				

Weight Loss Medication History (please indicate which of the following medications you have taken)

Medication	Dates	Dosage	MD Supervised	Weight Loss
Amphetamines				
Phentermine (Adipex, Fastin, Pondimin)				
Phen – Fen				
Redux (Dexafenflouramine)				
Xenical (Olistat)				
Meridia (Sibutramine)				
Other Diet Medication				

Non – Dietary Therapies (please indicate if you have attempted any of the following weight loss treatments)

Therapy	Dates	Duration	MD Supervised	Weight Loss
Regular Exercise				
Hypnosis				
Behavior Modification				
Acupuncture				

Patient Name: _____

Social History

Do you use tobacco? **YES** **NO**
Number of packs per day: _____
Number of years smoking: _____
Do you use alcohol? **YES** **NO**
Amount and Frequency: _____
Have you ever been treated for depression? **YES** **NO**
Are you currently in treatment? **YES** **NO**
If yes, please indicate the name and phone number of your physician or therapist

Have you ever been hospitalized for mental illness? **YES** **NO**
Have you had a GI Dr pass a scope into your stomach to evaluate an ulcer? **YES** **NO**

System Review (please circle all that apply)

Constitutional:	High Blood Pressure	Trouble Starting Urine	Schizophrenia
Fatigue	Abnormal Heartbeat	Kidney Stones	Anorexia
Tiredness	Respiratory:	Bladder Infection	Bulimia
Recent Weight Loss	Shortness of Breath		Binge Eating
Fever	Asthma	Musculoskeletal:	Hospitalization
Night Sweats	Wheezing	Painful Joints	
Abnormal Bleeding	Coughing	Swelling of Joints	Endocrine:
	Bloody Sputum	Muscle Aches	Hyperthyroid
Head and Neck:	Emphysema	Arthritis	Hypothyroid
Blurred Vision	Pneumonia	Painful Hips	Goiter
Double Vision	Bronchitis	Pain in Knees	Previous Radiation
Loss of Vision	Difficulty Sleeping Flat	Pain in Ankles	Diabetes
Loss of Hearing	Waking at Night	Pain in Feet	Adrenal Tumors
Vertigo	Shortness of Breath	Low Back Pain	Previous Steroid Use
Sinus Congestion		Herniated Disk	Swollen Glands
Sinus Infection	Gastrointestinal:	Sciatica	
Runny Nose	Jaundice	Numbness of Legs/Feet	Skin/Breast:
Sneezing	Hepatitis	Abnormal Lumps/Masses	Skin Cancer
Loss of Smell	Cirrhosis		Abnormal Moles
Sore Throat	Vomiting	Neurological:	Burns
Difficulty Swallowing	Nausea	Seizures	Rash
Pain Swallowing	Heartburn	Convulsions	Breast Mass
Hoarseness	Abdominal Pain	Fainting	Nipple Discharge
Lump in Neck	Diarrhea	Vertigo	Mammogram within Year
	Constipation	Light Headedness	
Cardiovascular:	Painful Bowel Movements	Falling	Men:
Chest Pain	Blood in Stool	Muscle Weakness	Discharge from Penis
Pain in Arm/Neck	Hemorrhoids	Numbness	Loss of Erection
Heart Attack	Change in Stool Size	Tremors	
Palpitations	Irritable Bowel	Loss of Consciousness	Women:
Heart Pounding	Colitis		Vaginal Discharge
Stroke		Psychological:	Abnormal Bleeding
Heart Murmur	Genitourinary:	Depression	Irregular Periods
Pain in Legs	Blood in urine	Nervousness	Hysterectomy
Cold Feet	Frequent Urination	Anxiety	Pap Exam within Year
Loss of Pulses	Leakage of Urine	Suicidal Thoughts	
Low Blood Pressure	Painful Urination	Suicide Attempts	

Patient Name: _____

Obesity Related Medical History

Do you have, or have you ever had, any of the following illnesses or symptoms?

Heart Disease	YES	NO	Year of Diagnosis _____
Angina	YES	NO	Year of Diagnosis _____
MI (Heart Attack)	YES	NO	Year of Diagnosis _____
Coronary Bypass Surgery	YES	NO	Year of Diagnosis _____
Palpitations (Abnormal Heart Beat)	YES	NO	Year of Diagnosis _____
Congestive Heart Failure	YES	NO	Year of Diagnosis _____
High Blood Pressure	YES	NO	Year of Diagnosis _____
Elevated Cholesterol	YES	NO	Year of Diagnosis _____
Elevated Triglycerides	YES	NO	Year of Diagnosis _____
Asthma	YES	NO	Year of Diagnosis _____
Reflux	YES	NO	Year of Diagnosis _____
Heartburn	YES	NO	Year of Diagnosis _____
Esophagitis	YES	NO	Year of Diagnosis _____
Hiatal Hernia	YES	NO	Year of Diagnosis _____
Sleep Apnea	YES	NO	Year of Diagnosis _____
Do you use a CPAP/BiPAP Machine?	YES	NO	
Shortness of Breath	YES	NO	
You can walk _____ blocks.			
You can climb _____ flight of stairs.			
Snoring	YES	NO	
Awakening at Night	YES	NO	
Daytime Drowsiness	YES	NO	
Observed Apnea Episodes	YES	NO	
Morning Headaches	YES	NO	
Venous Stasis	YES	NO	
Leg or Ankle Edema	YES	NO	
Leg Ulceration	YES	NO	
Arthritis Pain	YES	NO	
In Ankles	YES	NO	
In Knees	YES	NO	
In Hips	YES	NO	
Limits Ability to Walk	YES	NO	
Limits Ability to Exercise	YES	NO	
Low Back Pain/Sciatica	YES	NO	
Limits Ability to Walk	YES	NO	
Limits Ability to Exercise	YES	NO	

Patient Name: _____

<u>Diabetes</u>	YES	NO	<u>Urinary Incontinence</u>		
Juvenile Onset	YES	NO	Leaking Urine with Coughing	YES	NO
Gestational (Pregnancy)	YES	NO	Leaking Urine with Sneezing	YES	NO
Adult Onset	YES	NO	Leaking Urine with Straining	YES	NO
Diet Controlled	YES	NO			
Oral Medications	YES	NO	<u>Migraine</u>	YES	NO
Insulin Dependent	YES	NO	Frequency _____		
Deep Venous Thrombosis	YES	NO	Pulmonary Embolism	YES	NO
<u>Abdominal Wall Hernia</u>	YES	NO	<u>Have you ever had:</u>		
Incisional	YES	NO	Blood Transfusion	YES	NO
Umbilical	YES	NO	Hepatitis	YES	NO
Number of hernia repairs: _____			Exposure to HIV/AIDS	YES	NO
			Abused Intravenous Drugs	YES	NO

Past Medical History

Please list all other medical conditions, illnesses, or other important information not previously mentioned.

I understand that I am financially responsible for all charges for services to me including the balance remaining after payment of possible insurance benefits. I authorize payment of medical benefits to BayChoice Bariatric Center. I authorize the release of any medical information necessary to process all claims.

Signature of patient or responsible party, if patient is a minor

Date