NHSA
General & Weight Loss Surgery

Northwest Houston Surgical Association

Dr. Ayyar Dr. Leiva Dr. Ziad Amr

Thank you for choosing our office. In order to serve you properly, we need the following information. Please print. All information will be confidential

PATIENT INFORMATION

Patient Name / Nombre de Paciente: _____

Birthdate/Fecha de Nacimiento : _____ **Age/**Edad : _____ **Gender/**Sexo M/F : _____

Marital Status/Estado Marital **:** _____ **SS#/**Seguro Social_____

Address/Domicilio : _____ **City/**Ciudad : _____

Zip Code/Codigo Postal: _____ **E-mail/**Correo Electronico : _____

Home Phone/Telefono Domicilio : _____ **Cellular/**Celular **:** _____

Employer/Lugar de Empleo : _____ **Work Phone/**Telefono de Trabajo:_____

Employer Address/Direccion de Empleo : _____

Reason for visit/Razon de su visita**:** _____

Whom may we thank for referring you/A quien le agradecemos por referirlo**? :** _____

Dr's Phone number/Telefono: _____

Primary Care Physician?/Doctor General **:** _____ **Phone/**Telefono?**:**_____

In case of Emergency, Notify/En caso de emergencia Norificar A?**:** _____

Relationship to patient?/Relacion al paciente?:_____ **Phone/**Telefono: _____

Parent name if patient is a Minor/Persona responsible si el paciente es menor de edad**?** _____

MEDICATION AND PHARMACY INFORMATION

Are you allergic to any medication?/Alergico a Medicamento? **List/**Lista: _____

Reaction/Reaccion alergica: _____ **Allergic to Latex?/**Alergico a Latex?_____

☐ **No Known Drug Allergies** ☐ No Soy Alergico a Ningun Medicamento

Do you take blood thinners?/Toma algun anticoagulants? _____ Aspirin / Cuomadin / Plavix / Pradaxa **Other/**Otro?:_____

***Pharmacy Name/**Nombre de Farmacia**:**_____ **Phone Number/**Telefono: _____

List ALL Medications Below / Including Over-the-Counter /Vitamins/Herbal Supplements

Name of Medication / Nombre de Medicamento	**Dosage / Dosis**	**Frequency / Cuantas veces al dia**	**Why do you take this Medication? / Razon de tomar esta medicina**	**MD Who Prescribed / Nombre del Medico**	**COMMENTS / Comentarios?**

*******If the patient has a HMO insurance, a referral from the PCP is required to allow the patient to be seen by our group. If the patient does not have a valid referral at the time of the appointment, we will offer to reschedule the appointment until a referral is obtained or see the patient on a self-pay basis.***

Primary Insurance: _____ **ID#** _____**Group#**_____

Subscriber's Name_____ **Subscriber SS#**_____/_____/_____ **Subscriber Date of Birth**____/____/____

Subscriber's Employer: (□ same as above) _____**Work Phone:** _____

Claims Address: _____

Ins. Phone#_____ **Subscriber Relation to Patient:** _____

Secondary Insurance: _____**ID#**_____ **Group#**_____

Subscriber's Name_____ **Subscriber SS#**_____/_____/_____**Subscriber Date of Birth**_____/_____/_____

Subscriber's Employer: (□ same as above) _____**Work Phone:** _____

Claims Address: _____

Ins. Phone#_____ **Subscriber Relation to Patient:** _____

I authorize release of any information concerning my (or my child's) health care, advice and treatment for the purpose of evaluating and treating, obtaining clinical information and results from previous physicians and or healthcare facilities. As well as administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the Physician.

_____ _____

Signature **Date**

INFORMACION DE SU SEGURO MEDICO

Si el paciente tiene un seguro HMO, se requiere una referencia del PCP para permitir que el paciente sea visto por nuestro grupo. Si el paciente no tiene una referencia válida en el momento de la designación, ofreceremos a reprogramar la cita hasta que se obtiene una referencia o podemos ver al paciente si ellos pagan por la consulta en efectivo.

Seguro Primario: _____ **ID#** _____**Grupo#**_____

Nombre del Suscriptor: _____ **Suscriptor SS#**_____/_____/_____
Fecha de nacimiento del Suscriptor: _____/_____/____

Empleador del Suscriptor: _____**Teléfono del Trabajo:** _____

Dirección de las Reclamaciones: _____

Telefono de Seguro #_____ **Parentesco del Suscriptor con el paciente:** _____

Seguro Secundario: _____**ID#**_____ **Grupo#**_____

Nombre del Suscriptor: _____ **Suscriptor SS#**_____/____/____
Fecha de nacimiento del Suscriptor: _____/_____/_____

Empleador del Suscriptor: _____ **Teléfono del Trabajo:** _____

Dirección de las Reclamaciones: _____

Telefono de Seguro #_____ **Parentesco del Suscriptor con el paciente:** _____

Autorizo el hacer disponible informacion sobre mi salud, consejo medico y tratamiento (o el de mi hijo/hija) con el proposito de evaluar y administrar beneficios de seguro. Autorizo pago de beneficios de seguro al Medico.

_____ _____

Firma **Fecha**

NHSA Disclosure Acknowledgement

The undersigned certifies that He / She is the patient or is duly authorized by the patient as the patient's general agent to execute and accept these terms.

Date	**Patient, Patients Agent or Représentative**
Witness	**Relationship to Patient**

Acknowledgement of Review of
Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Date	**Signature of Patient or Personal Representative**
Name of Patient or Personal Representative	**Description of Personal Representative's Authority**

NHSA Financial Policy

I authorize release of any information concerning my (or my child's) health care, advice and treatment for the purpose of evaluating and treating, obtaining clinical information and results from previous physicians and or healthcare facilities. As well as administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the Physician.

Date	**Patient, Patients Agent or Représentative**
Witness	**Relationship to Patient**

Regarding Your Medication History

I authorize NHSA to access my patient medication history.

Date	**Patient, Patients Agent or Représentative**
Witness	**Relationship to Patient**

Northwest Houston Surgical Association
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MEDICAL RECORDS RELEASE REQUEST

I _____ hereby authorize release of my medical records.
(Printed name of patient)

Furnished to: **Northwest Houston Surgical C/O BARIATRICS**
21216 Northwest Freeway #250
Cypress, TX 77426
Tel# 713-426-2400 Fax# 713-426-3204

_____

_____

_____

_____ _____ _____
(Signature of Patient) **(Date of Birth)** **(Date)**

Please List:
Any and all physicians and/or specialists seen within the last five years:

_____ (Physician)	_____ (Phone Number)	_____ (Fax Number)
_____ (Physician)	_____ (Phone Number)	_____ (Fax Number)
_____ (Physician)	_____ (Phone Number)	_____ (Fax Number)
_____ (Physician)	_____ (Phone Number)	_____ (Fax Number)
_____ (Physician)	_____ (Phone Number)	_____ (Fax Number)

NOTE TO PATIENTS:
In some cases your insurance company will request information relating to physician. Supervised weight loss programs you may have attempted within the last 2 years. We will be happy to send this records release to the physician(s) or facility(s) of your choice. We encourage you to follow-up with each of them to make sure that we receive the records. Your insurance company will not approve your surgery until all requested information has been received.

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PHOTOGRAPHY RELEASE FORM

I, _____ (PATIENT NAME) authorize Northwest Houston Surgical Association (NHSA), representatives and their employees the right to take photographs of me and my property.

I authorize Northwest Houston Surgical Association, its assigns and transferees to copyright, use and publish the same in print and/or electronically.

I agree that Northwest Houston Surgical Association may use such photographs of me with or without my name and for any lawful purpose, including publicity, illustrations, advertising, and Web content.

I have read and understand the above:

Signature: _____

Printed Name: _____

Address: _____

_____ **Date: _____**

If you wish to decline please check below and initial.

☐ I decline to release my photography for any publicity, advertising or web content. I understand that any photograph taken in the office will be for my file only.

Initials: _____

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Please Circle C for Current Medical History / Circle P for Past Medical History					
☐Angina	C / P	☐Excessive Bleeding	C / P	☐Kidney Stones	C / P
☐Apnea	C / P	☐Fatty Liver	C / P	☐Leg Swelling	C / P
☐Asthma	C / P	☐Gallstones	C / P	☐Liver Disease	C / P
☐Arthritis	C / P	☐Gout	C / P	☐Lung Disease	C / P
☐Back Pain	C / P	☐Heart Disease	C / P	☐Malnutrition	C / P
☐Cancer	C / P	☐Heart Attacks	C / P	☐PCOS	C / P
☐Crohn's Disease	C / P	☐High Blood Pressure	C / P	☐Pseudotumor Cerebri	C / P
☐Diabetes	C / P	☐High Cholesterol	C / P	☐Plantar Fascitis	C / P
☐Depression	C / P	☐Hepatitis	C / P	☐Stomach Ulcer	C / P
☐Dyspnea (shortness of	C / P	☐Irritable bowel syndrome	C / P	☐Stroke	C / P
breath)	C / P	☐Irregular Menses	C / P	☐Thyroid Disease	C / P
☐Diverticulosis	C / P	☐Joint Pain	C / P	☐Ulcerative Colitis	C / P
☐Endometriosis	C / P	☐Kidney Disease	C / P	☐Urinary Leakage	C / P
☐Epilepsy/Seizures	C / P	Other:_____		Other:_____	

Surgical History	Year	Surgical History	Year
☐Abdominal Exploration		☐Colonoscopy	
☐Appendectomy		☐Upper Endoscopy	
☐Bowel Resection ☐Small bowel ☐Colon		☐Hernia Repair ☐Groin ☐Abdominal ☐Hiatal	
☐Cancer Surgery For:		☐Back Operation / Laminectomy	
☐Breast Biopsy ☐Benign ☐Cancerous		☐Joint Replacement ☐Hip(s) ☐Knee(s)	
☐Caesarian Section		☐Knee arthroscopy (exploratory surgery)	
☐Tubal Ligation ☐Hysterectomy ☐Oophorectomy		☐Operation for Reflux/GERD (Lap-Nissen)	
☐Mastectomy/operation for breast cancer		☐Cholecystectomy (Gallbladder Removal)	
☐Heart angioplasty and/or stent		☐ Open ☐ Laparoscopic	
☐Heart Catheterization		☐Other Operations:	
☐Other Heart Procedure			

Family History / Please mark ✓										
Family Member	**High Blood pressure**	**Heart Disease**	**Heart Attack Before 50**	**Stroke**	**Diabetes**	**Cancer**	**Blood Clots**	**Obese**	**Morbidly Obese**	**Obesity Surgery**
Mother										
Father										
Maternal Grandmother										
Maternal Grandfather										
Paternal Grandmother										
Paternal Grandfather										
Sibling 1 ☐M ☐F										
Sibling 2 ☐M ☐F										
Sibling 3 ☐M ☐F										
Adopted ☐										

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Social History

Gender: ☐ Male ☐ Female **Marital Status**: ☐Single ☐Married ☐Divorced ☐Domestic Partner ☐Widowed ☐Separated

Race: ☐African American ☐Asian ☐Caucasian ☐Hispanic ☐Native American or Alaska Native ☐Native Hawaiian or other Pacific Islander ☐Other: _____

Children?: _____

Employment Status: ☐Full Time ☐Part Time ☐Self Employed ☐Retired ☐Homemaker ☐Student ☐Disability ☐Unemployed ☐Not Specified **Occupation:** _____

Who will support you during and after your surgical weight loss process and relationship to you?

Tobacco Use*	**Substance Abuse***	**Alcohol Use***	**Caffeine***
☐ Never smoker	☐None	☐None	☐Caffeine-Coffee
☐Former Smoker/ yr?_____	☐Rare	☐Rare	☐1-2 cups a day
☐Current every day smoker	☐Occasional	☐Occasional	☐3-5 cups a day
☐Current someday smoker	☐Frequent	☐Frequent	☐Other Caffeine
☐Heavy Tobacco smoker	☐History of binge drinking	☐Moderate	☐_____
☐Light Tobacco smoker	☐Other:_____	☐_____	
☐Vapor			

Highest Weight History

2011: _____ **2012:** _____ **2013:** _____ **2014:** _____ **2015:** _____ **2016:** _____

Weight Loss Attempts

☐**Weight Watchers / Duration:**	☐6 months or more	☐3 months or less	☐Within the last 2 years	☐Over 2 years ago
☐**Nutri-System / Duration:**	☐6 months or more	☐3 months or less	☐Within the last 2 years	☐Over 2 years ago
☐**Jenny Craig / Duration:**	☐6 months or more	☐3 months or less	☐Within the last 2 years	☐Over 2 years ago
☐**Atkins / Durations:**	☐6 months or more	☐3 months or less	☐Within the last 2 years	☐Over 2 years ago
☐**Medically Supervised:**	☐6 months or more	☐3 months or less	☐Within the last 2 years	☐Over 2 years ago
☐**Exercise Programs:**	☐6 months or more	☐3 months or less	☐Within the last 2 years	☐Over 2 years ago

☐**Other Diet Programs:** _____

Printed Name: DOB: Signature: Date:

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Respiratory Disease

☐ **Sleep Apnea:** ☐Apnea symptoms but negative study ☐C-PAP USE ☐BI-PAP ☐Hypoxemia ☐Pulmonary Hypertension ☐Obesity Hypoventilation ☐Pulmonary Hypertension ☐Shortness of breath, dizziness ☐History of Pneumonia ☐Asthma ☐History of Tuberculosis ☐Chronic cough ☐ If you use a c-pap/Bi-pap indicate settings: _____

Sleep Evaluation

S. Manny Ayyar, M.D. **Jorge I. Leiva, M.D.** **Ziad Amr, M.D.**

Name:	
Height:	
Weight:	

Do you snore?	☐ YES	☐ NO
Do you gasp or pause in your Breathing during the night?	☐ YES	☐ NO
Frequent movement at night or Restless legs?	☐ YES	☐ NO
Do you still feel exhausted after 8 hours of sleep?	☐ YES	☐ NO
Do you have excessive daytime Sleepiness?	☐ YES	☐ NO
Do you fall asleep while driving or Stopped at light?	☐ YES	☐ NO
Do you awaken with headaches or Dry mouth?	☐ YES	☐ NO
Do you have high blood pressure?	☐ YES	☐ NO
Do you feel fatigue during the day?	☐ YES	☐ NO
Do you sweat excessively at night?	☐ YES	☐ NO
Do you often have trouble staying asleep throughout the night?	☐ YES	☐ NO
Does it often take you an hour or more before I fall asleep?	☐ YES	☐ NO
Do you feel paralyzed when I am waking up or falling asleep?	☐ YES	☐ NO

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HEALTH QUESTIONAIRE

Cardiovascular

☐ **Hypertension:** ☐Borderline ☐No medication ☐Treated with multiple medications ☐Poorly controlled
☐ Other, explain: _____

☐ **Ischemic Heart Disease:** ☐Abnormal EKG ☐History of heart attack ☐Arrhythmia ☐Pacemaker
☐Atrial Fibrillation ☐Episodes of fast heart beat without exercise ☐ Other: _____

☐ **Coronary Artery Disease:** ☐ Heart Bypass ☐Heart Stent ☐Heart valve Type: _____ ☐ Blood Thinner
☐Oxygen for heart or lungs ☐ Other, explain: _____

☐ **Pulmonary Embolism:** ☐ DVT associated with (trauma or surgery) but resolved with blood thinning medication
☐ Recurrent DVT ☐ Previous blood clot ☐ Recurrent pulmonary embolism
☐ Other, explain: _____

☐ **Leg Edema:** ☐ Lower extremity edema with no medical treatment ☐ Stasis dermatitis, pigmentation, cellulitis
☐ Disability, decreased function or past hospitalization ☐ Other, explain: _____

☐ **Stroke** ☐ **Chest Pain** ☐ **Lupus** ☐ **Heart Murmurs** **Other, Explain: _____**

Endocrine Disease

☐ **Diabetes:** ☐Diabetes controlled with oral medication ☐Diabetes controlled with insulin ☐Poorly controlled
☐ Other, explain: _____

☐ **Dyslipidemia**(elevated cholesterol/triglycerides)**:** ☐Controlled with medication ☐Not controlled ☐Other, explain:_____

☐ **Thyroid, Explain:** _____ ☐ Controlled with medication ☐Not controlled ☐Other:_____

Musculoskeletal

Back Pain: ☐Symptoms not requiring prescription ☐Symptoms requiring medication ☐Operation ineffective

Joint Pain: ☐Pain with exercise ☐Pain with daily activities ☐Joint replacement or disability ☐Hips ☐Knees ☐Ankles

Fibromyalgia: ☐Treatment with exercise ☐Treatment with narcotics ☐Other, explain: _____

☐Arthritis ☐Rheumatoid Arthritis ☐Numbness in limbs ☐Lupus ☐Fractures ☐Other, explain: _____

Initials:_____ Date:_____

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Gastrointestinal Disease

Reflux: ☐None ☐Symptoms no medication ☐Over the counter medication ☐High dose (Nexium, Protonix ect.) ☐Lap Nissen ☐Only with certain foods

Other G.I. Problems: ☐Rectal Bleeding ☐Changes in bowel movement ☐Blood in stool ☐Constipation ☐Diarrhea ☐Hemorrhoids ☐Ulcers ☐Crohn's disease ☐Nausea or Vomiting ☐Other, explain: _____

Abdominal Hernia: ☐ No hernia ☐Symptomatic hernia with or without incarceration ☐Recurrent Hernia

Hiatal Hernia: ☐Small ☐Large ☐Difficulty swallowing ☐Other, explain: _____

Liver Disease: ☐Modest liver enlargement, normal liver function ☐Moderate with liver enlargement, mild inflammation ☐Definite cirrhosis, NASH, liver dysfunction ☐Liver failure, transplant indicated or done

Neurological

Pseudotumor cerebri: ☐ Headaches and visual symptoms ☐PTC controlled with oral diuretics ☐Other, explain: _____
☐ Tremors ☐Seizures ☐Paralysis ☐Disorientation ☐Changes in speech ☐Migraine Headaches

Skin: ☐Abdominal skin or Pannus ☐Rash in skin folds ☐Recurrent cellulitis and skin ulcers ☐Skin interferes with walking

Hematologic: ☐Slow to heal cuts ☐Anemia ☐Past Transfusion ☐Bruises easily ☐History of Anemia ☐Other:_____

Psychiatric

☐ Presently confirmed seeing a mental health professional ☐ Hospitalizations ☐ Anxiety ☐Bipolar Disorder ☐Psychosis

☐ History of suicide attempts ☐Personality disorder ☐Depression ☐Nervousness ☐Other: _____

Genitourinary

☐Urination Frequency ☐Painful Urination ☐Blood in urine ☐Urinary leakage when laughing/coughing/sneezing ☐Lack of Bladder control

Menstrual Irregularities: ☐ Yes ☐ No ☐No periods ☐Abnormal and heavy periods ☐Irregular or Infrequent periods ☐Prior total Hysterectomy ☐ Hot Flashes

Initials: _____ Date: _____