HOUSTON surgical specialists

Robert G. Marvin, M.D.
4120 Southwest Frwy Ste. 230
Houston, Texas 77027
Phone: 713-993-7124 Fax: 713-963-0476

PATIENT INFORMATION

The information provided in this form is vitally important in the planning of your surgical care. Omission of complete and accurate information to the physician could result in the delay or cancellation of your surgery as well as jeopardize the ability of the physician to provide the best possible care.

NAME: _____ DOB: ____/____/_____ AGE: _____
FIRST MIDDLE LAST
SS#: _____/___/_____ MALE/FEMALE RACE: _____ MARITAL STATUS: S M W D

ADDRESS: _____
STREET APT# CITY STATE ZIP
HOME PHONE: _____WORK PHONE: _____
CELL PHONE: _____ EMAIL: _____
OCCUPATION: _____ EMPLOYER: _____
ADDRESS: _____
STREET CITY STATE ZIP

PRIMARY INSURANCE INFORMATION: Please include the front and back copy of your insurance card(s).

INSURANCE PROVIDER: _____PROVIDER PHONE #: _____
MEMBER ID #: _____ GROUP#: _____

POLICY HOLDER'S INFORMATION (If different than pt.):

NAME: _____ DOB: _____/_____/_____ SS#: _____/____/_____
EMPLOYER: _____ PHONE: (____) _____-_____ ADDRESS: _____

SECONDARY INSURANCE INFORMATION:

INSURANCE PROVIDER: _____PROVIDER PHONE #: (___) ____-_____
MEMBER ID #:_____GROUP#: _____

POLICY HOLDER'S INFORMATION: NAME: _____
DOB: ____/____/_____ SS#_____/_____/_____
EMPLOYER: _____PHONE: (___) ____-_____ ADDRESS: _____

ARE YOU RECEIVING DISABILITY BENEFITS? ☐ **No** ☐ **Yes** IF YES, LIST REASON(S):

_____

Print Patient Name _____

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EMERGENCY CONTACT: _____ HOME PHONE #: (____) _____-_____

MOBILE #: (_____) _____-_____ RELATIONSHIP: _____

TRAVEL COMPANION OR <u>TRANSPORT</u> SERVICE FOR OUT-OF-TOWN PATIENTS ONLY

For your safety, the facility may not allow you to leave alone or drive yourself for any procedure requiring anesthesia. If you do not have an adult over the age of 18 to stay with you, the facility may cancel your surgery.

HSS is not responsible for travel expenses if the surgery is cancelled or rescheduled for any reason.

NAME: _____ PHONE #: (____) _____-_____

PRIMARY CARE PHYSICIAN: _____ PHONE #: (____) ____-_____

ADDRESS: _____

STREET CITY STATE ZIP

HOW DID YOU HEAR ABOUT DR. MARVIN?

☐ Web Search _____ ☐ Social Media _____ ☐ Friend/Family _____

☐ MD Referral (name) _____ Phone # _____

☐ A patient of Dr. Marvin (name) _____

WHAT IS THE PROCEDURE OF INTEREST?

____ Endoscopic Sleeve Gastroplasty **____ Gastric Bypass (Roux-en-y)**

____ Dual Gastric Balloons **____ Laparoscopic Sleeve Gastrectomy**

____ Gastric Lap-Band **____ Unsure**

_____ _____

SIGNATURE DATE

_____ _____

PARENT SIGNATURE (if patient under 18 years of age) DATE

Print Patient Name _____

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COMPLETE MEDICAL HISTORY

What is your current weight? _____LBS **What is your current height? _____FT_____IN**

Have you had previous weight loss surgery? ☐ No ☐ Yes

If Yes, Please provide following information.

Name of Surgeon _____ Surgery date _____ Procedure performed _____

List any medical **problems** you have for which you have seen a doctor or been **hospitalized**.

ILLNESS	DATE	TREATMENT	OUTCOME

Have you been diagnosed or treated for high blood pressure?	☐ No ☐ Yes
Have you been diagnosed or treated for diabetes?	☐ No ☐ Yes
Do you have high blood cholesterol?	☐ No ☐ Yes
Do you have high blood fats or triglycerides?	☐ No ☐ Yes
Have you ever had a Heart Attack?	☐ No ☐ Yes
Have you had an Irregular Heartbeat (arrhythmia)?	☐ No ☐ Yes
Have you had stents placed in your heart arteries?	☐ No ☐ Yes
Have you ever been diagnosed with asthma?	☐ No ☐ Yes
Have you been diagnosed or treated for Sleep Apnea?	☐ No ☐ Yes
Do you sleep with a CPAP or BiPAP machine?	☐ No ☐ Yes
Have you been diagnosed or treated for heartburn or gastro esophageal reflux (GERD)?	☐ No ☐ Yes
Have you ever had stomach ulcers?	☐ No ☐ Yes
Have you ever had blood clots in your leg veins?	☐ No ☐ Yes
Have you ever had a blood clot to the lung (pulmonary embolus or PE)	☐ No ☐ Yes
Have you been diagnosed with Polycystic Ovarian Syndrome (PCOS)?	☐ No ☐ Yes
Have you had problems with infertility?	☐ No ☐ Yes
Do you have irregular menstruation?	☐ No ☐ Yes
Have you been treated for Arthritis or Joint Pain?	☐ No ☐ Yes
Have you been treated for Back Pain or Sciatica?	☐ No ☐ Yes
Have you ever been diagnosed or treated for Gout?	☐ No ☐ Yes
Are you ever incontinent of urine when coughing or straining?	☐ No ☐ Yes
Have you ever been anemic?	☐ No ☐ Yes
Have you ever had iron deficiency or taken iron?	☐ No ☐ Yes
Have you ever been diagnosed with Hypothyroidism?	☐ No ☐ Yes
Have you ever had thyroid surgery?	☐ No ☐ Yes
Do you take thyroid replacement medication?	☐ No ☐ Yes

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Have any of your close relatives been treated for the following:

High blood pressure?	☐ No ☐ Yes
High Cholesterol?	☐ No ☐ Yes
Diabetes?	☐ No ☐ Yes
Heart Attack or Heart Disease?	☐ No ☐ Yes
Stroke?	☐ No ☐ Yes

List all surgeries and specify if done open or laparoscopic.

SURGERY	DATE	REASON	OPEN OR LAP

Have you had your gallbladder removed?	☐ No ☐ Yes
Have you had a hysterectomy?	☐ No ☐ Yes
Have you had a tubal ligation or had your "tubes tied"?	☐ No ☐ Yes
Have you had a hiatal hernia repair or Nissen Fundoplication?	☐ No ☐ Yes
Have you had any operation on your stomach?	☐ No ☐ Yes
Have you had a repair of an abdominal wall hernia?	☐ No ☐ Yes

List all current medications, including prescriptions, vitamins, over-the-counter, and intermittently used drugs. *PLEASE PRINT.*

NAME	STRENGTH	FREQUENCY	PURPOSE	STARTED	DAILY?	AS NEEDED

Do you take aspirin?	☐ No ☐ Yes
Do you take Plavix (Clopidogrel)?	☐ No ☐ Yes
Do you take Coumadin or Warfarin?	☐ No ☐ Yes
Do you take Plaquinel or Methotrexate?	☐ No ☐ Yes
Do you take any type of platelet inhibitor (i.e. effient or persantine)?	☐ No ☐ Yes
Do you take any oral or injectable blood thinner?	☐ No ☐ Yes
Do you take Prednisone or Dexamethasone?	☐ No ☐ Yes

List any allergies to medication and explain reactions you experienced.

_____

_____

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Do you get chest pain when exercising?	☐ No ☐ Yes
Do you get short of breath at rest?	☐ No ☐ Yes
Do you experience irregular or excessively strong heartbeats?	☐ No ☐ Yes
Do you sleep lying flat?	☐ No ☐ Yes
Do you wake up at night short of breath?	☐ No ☐ Yes
Have you had any blackouts?	☐ No ☐ Yes
Do you get swollen ankles?	☐ No ☐ Yes
Have you had easy or excessive bleeding from surgery or minor injuries?	☐ No ☐ Yes
Have you had easy bruising?	☐ No ☐ Yes
Do you have heavy periods?	☐ No ☐ Yes
Are you still having periods?	☐ No ☐ Yes

Do you drink alcohol?	☐ No ☐ Yes
How much alcohol do you drink a week?	_____
Do you use recreational drugs?	☐ No ☐ Yes
Have you ever smoked tobacco products?	☐ No ☐ Yes
If yes, how many years?	_____
How many packages of Cigarettes a day?	_____

Have you been diagnosed or treated for depression?	☐ No ☐ Yes
Have you been diagnosed or treated for Bipolar Disorder?	☐ No ☐ Yes
Have you been diagnosed or treated for Schizophrenia?	☐ No ☐ Yes
Have you ever received Psychiatric treatment?	☐ No ☐ Yes

What was the diagnosis? _____
When was your last treatment? _____
Who were you treated by? Psychiatrist, Psychologist, or Physician (circle one)
Physicians Name _____
Physicians Telephone _____
Physicians E-mail _____

Does your religion prohibit you from receiving blood products?	☐ No ☐ Yes
If you answered yes, would you consent to any of the following?	
Autotransfusion with your own blood (i.e. sell saver)	☐ No ☐ Yes
IV infusion of Albumin	☐ No ☐ Yes
Transfusion of Platelets	☐ No ☐ Yes
Transfusion of Plasma	☐ No ☐ Yes

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Sleep Apnea Self-Test

The quiz is designed to alert you to any problems resulting from poor sleep. Please answer the questions below. If you have had any symptoms in the past year, mark the box below and add up the total.

(20) _____ 1. I have been told that I snore or I know that I snore.
(-50) _____ 2. I definitely do not snore.
(10) _____ 3. I have been told that I stop breathing when I sleep.
(10) _____ 4. I wake up choking.
(5) _____ 5. I sweat excessively at night.
(-5) _____ 6. (If female and above is true) I have hot flashes related to my cycle.
(2) _____ 7. I am tired and sleepy during the day even after 8 hours of sleep.
(2) _____ 8. I wake up tired and unrested.
(10) _____ 9. I suddenly wake up unable to breath.
(5) _____ 10. I have fallen asleep while driving.
(5) _____ 11. I am a restless sleeper (toss and turn a lot).
(20) _____ 12. My neck circumference is more than 17 inches. (Ask office staff to measure if unknown)
(5) _____ 13. I frequently have morning headaches.

_____ Total (more than 30 points suggests that you have SLEEP APNEA.)

DIETARY HISTORY

Medically Supervised Diet Programs
Check All that Apply

M.D. Name _____ **Office Phone** _____

☐ Medi-Fast
☐ Opti-Fast
☐ Mayo Clinic
☐ Physician or Registered Dietician Specific Diet Program
Shots: ☐ B-6
☐ B-12
☐ Other
Pills: ☐ Lasix (diuretic)
☐ Xenical
☐ Meridia
☐ Other_____

NON M.D. SUPERVISED
☐ Weight Watchers
☐ Nutri-Systems
☐ Jenny Craig
☐ Diet Center

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AUTHORIZATION FORM
FOR RELEASE OF PROTECTED HEALTH INFORMATION

By signing this form, I authorize Dr. Robert G. Marvin to use and disclose the protected health information described below regarding my case for medical or financial purposes.

Patient Name: _____

Social Security: _____ **D.O.B** _____

Name (if different from patient): _____

Phone: _____ **Work:** _____

Address: _____ **City:** _____

State: _____ **Zip Code:** _____

The type of health information you may release subject to this authorization is as follows:

Non-Medical Individuals (Family/Friends) I authorize my Protected Health Information to are as follows:

Name: _____ **Relationship:** _____

Release my protected health information to the following person(s)/ entity:

Houston Surgical Specialists
4120 Southwest Freeway Ste. 230
Houston, TX 77027
Office: 713-993-7124
Fax: 713-963-0476

HIV / AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical record.

Signature: _____ **Date:** _____

Print Patient Name _____

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PLEASE USE THIS FORM AS A TEMPLATE FOR YOUR INSURANCE CARD

PROVIDE A FRONT AND BACK COPY

THEY MUST BE READABLE

Front Copy

Back Copy

Print Patient Name _____