LAS PALMAS DEL SOL

BARIATRIC CLINIC

A Department of Las Palmas Del Sol Healthcare

Dear Potential Bariatric Patient:

Thank you for choosing Del Sol Bariatrics for your weight loss needs!

Attached is a patient application that must be completed and delivered to the Del Sol Bariatric Center **2 weeks** prior to your initial appointment.

Mail: Attention: Del Sol Bariatric Center
10175 Gateway West, Suite 130
El Paso, Texas 79925

Fax: Attention: Del Sol Bariatric Center
915.599.4100

Email: dsmc.bariatric@hcahealthcare.com (This email is for applications only, please call the office for any questions or concerns.)

Please note:

If the application has not been received by the bariatric center prior to your appointment, we will cancel your visit and you will be rescheduled.

Completely fill out application.

I have read and understood the information provided above.

_____ _____

Patient Signature Date

Please contact the bariatric office at 915.263.6950 for all questions or concerns.

American College of Surgeons
Bariatric Surgery Center Network

10175 Gateway West, Suite 130 • El Paso, Texas 79925
Phone: 915-263-6950 • Fax: 915·599-4254
www.delsolmedicalcenter.com

LAS PALMAS DEL SOL

BARIATRIC CLINIC

A Department of Las Palmas Del Sol Healthcare

EL PASO, TX 79925
TELEPHONE: (915) 263-6950
FAX NUMBER: (915) 599-4254

Dear patient:

We welcome you as a patient to the Del Sol Bariatric Center. We appreciate the opportunity to provide you with our services.

In order to provide you with the best possible service, please submit this packet at least two (2) weeks prior to your scheduled appointment. You may mail it, fax it or drop off at the bariatric office. Your appointment is at the Del Sol Bariatric Center located at the East Medical Plaza #2, 10175 Gateway West, Suite 130, El Paso, TX 79925.

PLEASE NOTE: Your initial evaluation can take up to four hours. Please make sure to eat breakfast or lunch prior to your appointment. However, once we start with class we will ask you not to eat or drink.

FULLY COMPLETE:

☐ The Patient Information Packet.

☐ Documented weight loss attempts (EXAMPLE: physician supervised weight programs, Weight Watchers, Jenny Craig, etc.).

☐ A two-day food diary, enclosed in this packet.

If you have any questions please contact the Bariatric Center at (915) 263-6950

THANK YOU,

Jorge Acosta M.D.
Medical Director

PATIENT INFORMATION SHEET

Appt. Date:_____

PATIENT'S FULL NAME:_____ M / F

DATE OF BIRTH:_____ AGE:_____ SOCIAL SECURITY NO.:_____

☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED NO. OF CHILDREN:_____

RELIGION:_____ RACE:_____

*WEIGHT:_____ *HEIGHT:_____ *(Please do not leave blank)

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

HOME PHONE:_____ WORK PHONE:_____ CELL PHONE:

_____ FAX:_____ E-MAIL:_____

EMPLOYMENT INFORMATION

EMPLOYER:_____ OCCUPATION:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

SPOUSE INFORMATION

NAME:_____ DOB:_____ SS#:_____

EMERGENCY CONTACTS

NAME:_____ RELATIONSHIP TO PATIENT:_____

PHONE NO.:_____ ADDRESS:_____

NAME:_____ RELATIONSHIP TO PATIENT:_____

PHONE NO.:_____ ADDRESS:_____

DO YOU GIVE PERMISSION TO SHARE MEDICAL INFORMATION WITH EMERGENCY CONTACT(S)?

YES OR NO

☐ ☐

INSURANCE INFORMATION

PRIMARY INSURANCE:_____

ADDRESS:_____

PHONE:_____

SUBSCRIBER NAME AND RELATION:_____

SUBSCRIBER DATE OF BIRTH:_____

SUBSCRIBER SOCIAL SECURITY NUMBER:_____

SUBSCRIBER EMPLOYER NAME, ADDRESS, AND PHONE NUMBER:

_____

SUBSCRIBER ID NUMBER:_____

GROUP NAME/NUMBER:_____

SECONDARY INSURANCE:_____

ADDRESS:_____

PHONE:_____

SUBSCRIBER NAME AND RELATION:_____

SUBSCRIBER DATE OF BIRTH:_____

SUBSCRIBER SOCIAL SECURITY NUMBER:_____

SUBSCRIBER EMPLOYER NAME, ADDRESS, AND PHONE NUMBER:

_____

SUBSCRIBER ID NUMBER:_____

GROUP NAME/NUMBER:_____

REFERRED BY:

- ☐ PHYSICIAN:_____ADDRESS:_____ZIP:_____
- ☐ SELF
- ☐ ADVERTISEMENT
- ☐ WEB
- ☐ FRIENDS

PREVIOUS BARIATRIC SURGERY VISIT: ☐ YES ☐ NO

DATE:_____DOCTOR:_____

DID YOU ANSWER YES? IF SO PLEASE OBTAIN MEDICAL RECORDS AND PROVIDE TO CLINIC PRIOR TO INITIAL VIST. IF YOU NEED AN ORDER FOR CURRENT UPPER GI OR ABDOMINAL ULTRASOUND PLEASE CONTACT CLINIC.

Initials:_____

PREFERRED SURGEON:

- ☐ DR. JORGE ACOSTA
- ☐ DR. MICHAEL D. LARA

PROCEDURE PREFERENCE:

- ☐ ROUX-EN-Y- GASTRIC BYPASS
- ☐ SLEEVE GASTRECTOMY
- ☐ UNDECIDED

MEDICAL HISTORY

NAME OF PRIMARY CARE PHYSICIAN:_____

ADDRESS:_____

_____

PHONE#:_____

FAX#:_____

OTHER PHYSICIANS:
(CARDIOLOGIST / PULMONOLOGIST)

_____ PHONE:_____ FAX:_____

_____ PHONE:_____ FAX:_____

_____ PHONE:_____ FAX:_____

CURRENT MEDICATIONS:

(PRESCRIPTIONS, OVER THE COUNTER, VITAMINS, HERBAL, PROTEIN SUPPLEMENTS, ETC.)

DRUG NAME:	DOSAGE/FREQUENCY:	REASON:

PREFERRED PHARMACY _____

Initials:_____

PAST SURGICAL HISTORY

DATE:	PROCEDURE:	COMPLICATIONS (I.E. BLOOD CLOTS, INFECTIONS, RESPIRATORY / BLOOD PRESSURE PROBLEMS)

ANY PROBLEMS WITH ANESTHESIA? (IF SO, WHAT TYPE OF PROBLEMS?)

_____

_____

_____

_____

ALLERGIES

DO YOU HAVE A LATEX ALLERGY? ☐ YES ☐ NO ☐ DON'T KNOW

DO YOU HAVE ANY MEDICATION ALLERGIES? ☐ YES ☐ NO ☐ DON'T KNOW

IF SO, LIST ALL ALLERGIES BELOW TYPE OF REACTION

_____

_____

SOCIAL HISTORY

SMOKING HISTORY:

CURRENTLY SMOKE? ☐ YES ☐ NO NUMBER OF PACKS(S) PER DAY: _____

HOW LONG SINCE YOU QUIT? _____

YEARS AS SMOKER? _____

ALCOHOL CONSUMPTION: ☐ YES ☐ NO FREQUENCY: _____

QUANTITY: _____

Initials: _____

HISTORY OF SUBSTANCE ABUSE ❑ YES ❑ NO

IF YES, GIVE DETAILS OF TREATMENT:_____

FAMILY HISTORY

(CHECK THOSE THAT APPLY TO EACH FAMILY MEMBER)

MEDICAL CONDITION	MOTHER	FATHER
MORBID OBESITY		
HYPERTENSION		
DIABETES		
HEART DISEASE		
CANCER		
DEATH (CAUSE & AGE)		

DO YOU HAVE A HISTORY OF CANCER? ❑ YES ❑ NO

IF SO, WHERE IN YOUR BODY AND WHEN WERE YOU DIAGNOSED:_____

Have you tested positive for COVID-19?

❑ **If Yes, when? Do you have any side effects?** _____

_____

❑ **No**

Initials:_____

WEIGHT RELATED ILLNESSES

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING ILLNESSES OR SYMPTOMS?
WRITE IN ANY ADDITIONAL PROBLEMS. PLEASE BE AS SPECIFIC AS POSSIBLE:

***DIAGNOSED BY A PHYSICIAN**

CARDIOVASCULAR HISTORY

YES	NO	
☐	☐	HIGH BLOOD PRESSURE WHAT IS YOUR BLOOD PRESSURE NORMALLY:_____
☐	☐	PALPITATIONS
☐	☐	HEART ATTACK
☐	☐	ABNORMAL ELECTROCARDIOGRAM (Arrhythmias)
☐	☐	CONGESTIVE HEART FAILURE
☐	☐	HIGH CHOLESTEROL
☐	☐	HIGH TRIGLYCERIDES
☐	☐	HAVE YOU EVER HAD BLOOD CLOTS ON YOUR LOWER EXTREMITIES/Deep Venus Thrombosis (DVT)?
☐	☐	HAVE YOU EVER HAD CLOTS DISLODGED INTO YOUR LUNGS/Pulmonary Embolism (PE)?
☐	☐	HAVE YOU EVER USED ANTICOAGULATION MEDICATION? (Blood Thinners)

PULMONARY HISTORY

YES	NO	
☐	☐	ASTHMA / EMPHYSEMA MEDICATION:_____
☐	☐	SHORTNESS OF BREATH (SOB) NUMBER OF STAIRS BEFORE SOB? _____ HOW FAR WALKING ON FLAT LAND BEFORE SOB? _____
☐	☐	COPD (CHRONIC OBSTRUCTIVE PULMONARY DISEASE)
☐	☐	WHEEZING / COUGH
☐	☐	ARE YOU ON OXYGEN TREATMENT? HOW OFTEN OR HOURS PER DAY. _____

Initials:_____

ENDOCRINE HISTORY

YES	NO	HAVE YOU BEEN DIAGNOSED
☐	☐	DIABETES

DATE OF ONSET:_____

INSULIN / ORAL MEDS:_____

☐	☐	THYROID DISEASE
☐	☐	ADRENAL GLAND TUMOR

MUSCULOSKELETAL HISTORY

YES	NO	
☐	☐	JOIN PAIN? (KNEES, HIPS, ANKLES, FEET)
☐	☐	DEGENERATIVE JOINT DISEASE (WHERE) _____
☐	☐	ARTHRITIS (WHERE/JOINT LOCATION):_____
☐	☐	BACK PAIN
☐	☐	FIBROMYALGIA
☐	☐	CORRECTIVE TISSUE DISEASE (LUPUS, SCLERODERMA)

OTHER:_____

GASTROINTESTINAL HISTORY

YES	NO	
☐	☐	HEARTBURN / INDIGESTION
☐	☐	GERD (GASTROESOPHAGEAL REFLUX DISEASE)
☐	☐	HAVE YOU EVER HAD A LOWER ENDOSCOPY (COLONOSCOPY)
☐	☐	HAVE YOU EVER HAD AN UPPER ENDOSCOPY (EGD)
☐	☐	INTESTINAL OR GASTRIC ULCERS
☐	☐	GALLBLADDER STONES
☐	☐	DIARRHEA
☐	☐	CONSTIPATION
☐	☐	NAUSEA / VOMITING

GASTROINTESTINAL HISTORY

YES	NO	
☐	☐	STRESS URINARY INCONTINENCE (LEAKAGE OF URINE WITH LAUGHING,COUGHING, OR SNEEZING)
☐	☐	KIDNEY STONES
☐	☐	CHRONIC KIDNEY DISEASE
☐	☐	BLADDER PROBLEMS, SPECIFY:_____
☐	☐	DO YOU HAVE FREQUENT URINARY TRACT INFECTIONS?

REPRODUCTIVE HISTORY

DATE OF LAST PAP SMEAR:_____

DATE OF LAST MAMMOGRAM:_____

RESULTS: NORMAL ~ ABNORMAL _____

Initials:_____

SLEEP DISORDERS SCREENING QUESTIONNAIRE

EPWORTH SLEEPINESS SCALE

HOW LIKELY ARE YOU TO DOZE OFF OR FALL ASLEEP IN THE FOLLOWING SITUATIONS, IN CONTRAST TO JUST FEELING TIRED? THIS REFERS TO YOUR USUAL WAY OF LIFE IN RECENT TIMES. EVEN IF YOU HAVE NOT DONE SOME OF THESE THINGS RECENTLY, TRY TO WORK OUT HOW THEY WOULD HAVE AFFECTED YOU? USE THE FOLLOWING SCALE TO CHOOSE THE MOST APPROPRIATE NUMBER FOR EACH SITUATION:

0 = WOULD NEVER DOZE
1 = SLIGHT CHANCE OF DOZING
2 = MODERATE CHANCE OF DOZING
3 = HIGH CHANCE OF DOZING

SITUATION

1) SITTING AND READING.	0
2) WATCHING TELEVISION.	0
3) SITTING INACTIVE IN A PUBLIC PLACE (e.g., theatre).	0
4) AS A PASSENGER IN A CAR FOR AN HOUR WITHOUT A BREAK.	0
5) LYING DOWN TO REST IN THE AFTERNOON WHEN CIRCUMSTANCES PERMIT.	0
6) SITTING AND TALKING TO SOMEONE.	0
7) SITTING QUIETLY AFTER LUNCH WITHOUT ALCOHOL.	0
8) IN A CAR, WHILE STOPPED FOR A FEW MINUTES IN TRAFFIC.	0
TOTAL SCORE	0

YES	NO	HAVE YOU BEEN DIAGNOSED
☐	☐	DO YOU HAVE SLEEP APNEA
☐	☐	HAS ANYONE EVER TOLD YOU THAT YOU SNORE?
☐	☐	HAS ANYONE EVER TOLD YOU THAT YOU STOP BREATHING WHILE SLEEPING?
☐	☐	DO YOU WAKE UP WITH A HEADACHE?
☐	☐	DO YOU FEEL RESTED WHEN YOU WAKE UP IN THE MORNING?
☐	☐	HAVE YOU EVER HAD A SLEEP STUDY? WHEN? WHERE?
☐	☐	DO YOU USE A BI-PAP OR C-PAP MACHINE?

_____

(NAME) _____

Initials:_____

PSYCHOLOGICAL SYMPTOM CHECKLIST

HAVE YOU EVER BEEN HOSPITALIZED FOR EMOTIONAL PROBLEMS? IF APPLICABLE, WHEN AND WHERE:

_____

NAME OF DOCTOR WHO IS TREATING OR TREATED YOU:_____

INSTRUCTIONS: FOR EACH SYMPTOM IN THE FOLLOWING LIST, PLACE AN "X" IN ONE OF THE BOXES (NOT PRESENT, MILD, MODERATE, SEVERE, EXTREME). TRY TO AVERAGE OUT HOW YOU HAVE BEEN FEELING OVER THE PAST WEEK WHEN YOU MAKE THE RATINGS. BE SURE TO CHECK ONE OF THE BOXES FOR EVERY ONE OF THE 15 SYMPTOMS.

SYMPTOMS	NOT PRESENT	MILD	MODERATE	SEVERE	EXTREME
ANXIETY					
DEPRESSION					
LOSS OF ENERGY					
LOSS OF INTEREST IN USUAL ACTIVITIES					
GUILTY THOUGHTS OF LOW SELF-ESTEEM					
DIFFICULTY CONCENTRATING					
FEELING SPEEDED UP OR TOO "HIGH"					
CONFUSION					
HAVING UNREAL OR STRANGE THOUGHTS					
HALLUCINATIONS (HEARING VOICES OR "SEEING THINGS")					
ANGER OR HOSTILITY TOWARDS OTHERS					
FEELING OR PHYSICALLY TENSE OR "KEYED UP"					

Initials:_____

WEIGHT HISTORY

LIST YOUR WEIGHT FOR EACH OF **THE LAST FIVE YEARS**:

YEAR	HIGHEST	LOWEST

APPROXIMATE AGE WHEN YOU FIRST SERIOUSLY DIETED:_____

DIET ATTEMPTS (MOST INSURANCE PLANS REQUIRE 2 DIET ATTEMPTS)

	# ATTEMPTS	WHAT YEAR?	HOW LONG? #Weeks or Months	POUNDS LOST	POUNDS REGAINED
MEDIFAST					
OPTIFAST					
FEN/PH EN					
REDUX					
MERIDIA					
BEHAVIOR MODIFICATION					
HYPNOSIS					
PSYCHOTHERAPY					
ACUPUNCTURE					
DIETITIAN RECOMMENDED					
WT. WATCHERS					
NUTRI-SYSTEMS					
JENNY CRAIG					
TOPS					
OVEREATERS ANONYMOUS					
LOW CAL. DIET					
LOW FAT DIET					
HIGH PROTEIN					
SELF IMPOSED FAST					
RICHARD SIMMONS					
SUSAN POWLER					
METABOLIFE					
MAYO CLINIC					
HERBAL LIFE					
ATKINS					
SOUTH BEACH					
SLIM FAST					
OTHERS					
OTHERS					
OTHERS					

Initials:_____

Keeping a Food Diary

A food diary is simply a complete list of **ALL** foods and beverages that have been consumed. It is **MANDATORY** for you to keep it for **TWO** days with one of those days being a weekend day. Application will not be considered complete without your food diary.

Tips for Keeping a Diary

1. **Write down everything.** Keep your form with you all day and write down everything you eat or drink including sips & nibbles! A piece of candy, a handful of pretzels, or a can of soda may not seem like much at the time, but it all needs to be written down.
2. **Do it now.** We have a short memory for foods we eat, so we ask you not to rely on memory but instead record as you go so we get the most accurate information possible.
3. **Be specific.** Make sure you include “extras”, such as gravy on your meat or cheese on you vegetables.
4. **Estimate amounts.** If you had a piece of cake, estimate the size (2”x1”x2”). If you had mashed potatoes, record how much you ate - ¼ cup or 2 cups? When eating meat, remember that a 3-ounce cooked portion is about the size of a deck of cards.

What information should be included in a food diary?

How much? In this space you’ll indicate the amount of a particular food item you ate. Estimate the size (inches), the volume (1/2 cup), the weight (2 ounces) and/or the number of items (12) of that type of food.

What kind: In this column, write down the type of food you ate. Be as specific as you can and remember to include salad dressings, butter, sour cream, etc.

Time: Write the time of day you ate the food.

Where: Write what room or part of the house you were in when you ate. If you went out to eat, record the name of the restaurant.

Alone or with someone: If you ate by yourself, write “alone” or indicate if you were with friends or family.

Activity: In this column, list any activities you were doing while you were eating such as watching T.V., talking on the phone, or working.

Mood: How were you feeling while you were eating? White down if you were sad, happy, bored, depressed, etc.

Exercise: At the bottom of the food diary there is a place to record any exercise you engaged in during the day including the length of time you exercised such as a 15 - minute walk or 10 minutes on the exercise bike.

Initials:_____

FOOD DIARY **DAY:**_____ **DATE:**_____

HOW MUCH	WHAT KIND	TIME	WHERE	WHO	ACTIVITY	MOOD

EXERCISE:

_____

_____

Initials:_____

FOOD DIARY **DAY:**_____ **DATE:**_____

HOW MUCH	WHAT KIND	TIME	WHERE	WHO	ACTIVITY	MOOD

EXERCISE:

_____

_____

Initials:_____

How much water do you drink? _____

How many sodas (☐ regular or ☐ diet) do you drink at an average per week? _____

Do you drink caffeinated coffee or iced tea? ☐ yes ☐ no Decaffeinated ☐ yes ☐ no

Do you skip meals? ☐ yes ☐ no ☐ Breakfast ☐ Lunch ☐ Dinner

Are you lactose intolerant? ☐ yes ☐ no

How many times do you go out to eat or take out per week? _____

What type of food do you eat? (Is it fast food restaurant?) _____

_____

If you eat fast food, where and what exactly do you normally eat? _____

What size are your first serving portions? Large_____ Small_____ Standard_____

How often do you return for second servings? Rare_____ Sometimes_____ Always_____

If you do go back for seconds, what do you go back for (a little of everything, starches, sweets, etc.)?

_____

Do you consider your diet high in fats? ☐ yes ☐ no

Do you consider your diet high in carbohydrates? ☐ yes ☐ no

Are you a sweet eater?_____If so, what exactly do you like to eat? (bread, chocolate, candies, ice cream, etc.)?

_____

Do you consider yourself an emotional eater? _____

More when you are: Depressed_____ Angry_____ Happy_____ Sad_____

Other:_____

Do you eat because you are hungry or because it is “time” to eat? _____

History of eating disorder (Ex. Binge eating, bulimia, anorexia, etc.)?_____

Is there something in your eating pattern that was not asked and you would like to share for your evaluation?

_____

Initials:_____