McCARTY
WEIGHT LOSS CENTER

(Please print legibly and detail as much as possible)

PLEASE LIST YOUR FULL LEGAL NAME:

LAST: _____ FIRST: _____ MIDDLE: _____

Street Address: _____

City, State, ZIP: _____

Please enter all information below and select the best way to contact you:

○ Home Phone #: _____ ○ Cell Phone #: _____

○ Pharmacy Name & #: _____ ○ E-Mail: _____

SSN: _____ Date of birth: _____ Age: _____ Gender: M☐ F☐

Marital Status (Optional): **Married ○ Divorced ○ Widowed ○ Single ○ Other:** _____

Ethnicity (Optional): _____

Employer: _____

Employer Address: _____

Name of Spouse/Responsible Person: _____

Relationship: _____ Date of Birth: _____ SSN (If you are insured under their plan): _____

Employer: _____ Address: _____

Daytime Phone #: _____ E-Mail: _____

Emergency Contact: _____ Phone #: _____

Relationship: _____ Does emergency contact share your address? ☐ **YES** ☐ **NO**

Emergency contact may receive information about your medical condition? ☐ **YES** ☐ **NO**

PRIMARY CARE PHYSICIAN/REFERRING DOCTOR: _____

Phone: _____ **Fax:** _____

My physician may receive information regarding my surgery? ○ YES NO ○

INSURANCE INFORMATON (Please be very detailed-incomplete data may delay verification of insurance.)

Insurance Name: _____ Plan Type: _____

Address: _____ I.D. #: _____

Group #: _____ Phone #: _____

Name of Insured: _____ DOB: _____

Secondary Insurance: _____ Plan Type: _____

Address: _____ I.D. #: _____

Group #: _____ Phone #: _____

Name of Insured: _____ DOB: _____

HEALTH AND MEDICAL HISTORY (Fill out as completely as possible.)

Name: _____

HEIGHT: _____ CURRENT WEIGHT: _____ BMI: _____

PAST SUGERIES (Please check each that apply)

- ☐ GALLBLADDER SURGERY YEAR_____ TYPE_____
- ☐ SPLEEN SURGERY YEAR_____ TYPE_____
- ☐ ESOPHAGUS SURGERY YEAR_____ TYPE_____
- ☐ STOMACH SURGERY YEAR_____ TYPE_____
- ☐ HERNIA REPAIR SURGERY YEAR_____ TYPE_____
- ☐ CESAREAN SURGERY YEAR_____ TYPE_____
- ☐ ABDOMINAL SURGERY YEAR_____ TYPE_____
- ☐ OTHER SURGERY YEAR_____ TYPE_____

PREVIOUS WEIGHT LOSS SURGERY:

- ☐ _____Vertical Banding Gastroplasty YEAR_____
- ☐ _____Lap-Band YEAR_____
- ☐ _____Roux-en-Y Gastric Bypass YEAR_____
- ☐ _____SLEEVE Gastrectomy YEAR_____
- ☐ _____Revision Surgery YEAR_____
- ☐ _____Stapling (Other restrictive procedure) YEAR_____
- ☐ _____Other (Please List):_____

Weight prior to previous weight loss surgery: _____

Complications due from previous weight loss surgery:
(REVISION PATIENTS ONLY)

_____

_____

PLEASE SELECT THE PROCEDURE YOU ARE INTERESTED IN:

_____**Mini Sleeve** _____ **Roux-en-Y Gastric Bypass** _____**Revision** _____**Lap Band** _____**Band Fill**

MEDICALLY SUPERVISED TREATMENT REGIMENS:

Please list all diets and medications for weight loss that you have used and the treating physician(s):

- ☐ FEN-PHEN ○ YES ○ NO YEAR:_____ PHYSICIAN:_____
- ☐ REDUX ○ YES ○ NO YEAR:_____ PHYSICIAN:_____
- ☐ ADIPEX ○ YES ○ NO YEAR:_____ PHYSICIAN:_____
- ☐ OTHER ○ YES ○ NO YEAR:_____ PHYSICIAN:_____

OTHER WEIGHT LOSS METHODS ATTEMPTED:

PROGRAM	YEAR	PROGRAM	YEAR	PROGRAM	YEAR
WEIGHT WATCHERS		JENNY CRAIG		ATKINS DIET	
SLIM FAST		METABOLIFE		DEXATRIM	
MEDIFAST		OPTIFAST		CAMBRIDGE	
NUTRISYSTEMS		LARRY NORTH		MERIDIA	
SUGAR BUSTERS		XENICAL		OVEREATERS AN	
HERBALIFE		SOUTH BEACH		TOPS	
ADVOCARE		GRAPEFRUIT DIET		PRITIKIN DIET	

MAXIMUM WEIGHT LOST ON ANY PROGRAM_____ **YEAR**_____

Have any positive and/or negative responses from prior obesity treatments? Explain:

_____

_____

Have you ever been treated for an eating disorder? ○YES ○ NO (Describe treatment, duration and year)

_____

_____

HEALTH AND WELLNESS INFORMATION ("Yes" answers list a treating physician)

DESCRIPTION	YES	NO	YEAR	DIAGNOSING PHYSICIAN
Shortness of Breath	☐	☐	_____	_____
Snoring	☐	☐	_____	_____
Sleep Apnea Syndrome	☐	☐	_____	_____
CPAP	☐	☐	_____	_____
Shortness of Breath	☐	☐	_____	_____
Asthma	☐	☐	_____	_____
Indigestion/Heartburn	☐	☐	_____	_____
Gastroesophageal Reflux	☐	☐	_____	_____
Degenerative Joint Disease Pain	☐	☐	_____	_____
Lower Back	☐	☐	_____	
Hips	☐	☐	_____	
Knees	☐	☐	_____	
Ankles	☐	☐	_____	
Edema/Swelling Legs	☐	☐	_____	_____
Ankles	☐	☐	_____	_____
Congestive Heart Failure	☐	☐	_____	_____
Stroke	☐	☐	_____	_____
Chest Pain	☐	☐	_____	_____
Hypertension (High Blood Pressure)				
☐ Self	☐	☐	_____	_____
Family History	☐ Mother		☐ Father	☐ Sibling
Diabetes ☐ Self	☐	☐	_____	_____
Family History	☐ Mother		☐ Father	☐ Sibling
High Cholesterol	☐	☐	_____	_____
Hyperlipidemia	☐	☐	_____	_____
Hernia Repair History	☐	☐	_____	_____
Irregular Menstruation	☐	☐	_____	_____
Infertility	☐	☐	_____	_____
Fibrocystic Breast Disease	☐	☐	_____	_____
Depression	☐	☐	_____	_____
Chronic Fatigue	☐	☐	_____	_____
Urinary Incontinence (Leaking when you cough or sneeze)	☐	☐	_____	_____

Do you have any underlying medical conditions? ○YES ○NO

Please Describe: _____

Do you have a Heart Condition? ○ YES ○ NO Describe: _____

Is your mother living? _____YES _____NO CAUSE OF DEATH_____

Is your father living? _____YES _____NO CAUSE OF DEATH_____

OTHER FAMILY MEMBERS WHO ARE OBESE?

_____

_____

RECENT TESTING:

PHYSICAL	☐ YES	☐ NO	Date: _____
CHEST X-RAY	☐ YES	☐ NO	Date: _____
UPPER G.I.	☐ YES	☐ NO	Date: _____
ECHOCARDIOGRAM	☐ YES	☐ NO	Date: _____
EKG	☐ YES	☐ NO	Date: _____

INDICATE ANY NEGATIVE RESULTS: _____

_____

LIST ALL CURRENT MEDICATIONS:

Name/ Strength	Route	Dose	Purpose	Date Started
OVER THE COUNTER MEDICATIONS				

DO YOU HAVE ANY MEDICATION ALLERGYS? ☐ YES ☐ NO

NAME OF MEDICATIONS: _____

LATEX ALLERGY: ☐ YES ☐ NO

GENERAL AND LIFESTYLE INFORMATION:

DO YOU SMOKE? ☐ YES ☐ NO HAVE YOU IN THE PAST? ☐ YES ☐ NO YEAR QUIT: _____

DO YOU USE ALCOHOL? ☐ YES ☐ NO

HOW OFTEN? ☐ DAILY ☐ WEEKLY ☐ OCCASIONALLY ☐ RARELY

HAVE YOU EVER HAD A SUBSTANCE ABUSE? ☐ YES ☐ NO

IS YOUR SPOUSE/PARTNER SUPPORTING OF WEIGHT LOSS SURGERY? ☐ YES ☐ NO

IS YOUR FAMILY SUPPORTIVE OF WEIGHT LOSS SURGERY? ☐ YES ☐ NO

24 HOUR DIET RECALL: (What you ate yesterday)

Breakfast: _____

Lunch: _____

Dinner: _____

Beverages/ Snacks: _____

EXERCISE

Type: _____ how long? _____Min. _____ Hrs. Number of times a week? _____

Patient Name: _____ DOB:_____

Hiatal Hernia Questionnaire

1. Have you noticed any acid reflux symptoms?
☐Yes ☐No How long have you had these symptoms?

_____

2. Please list all the symptoms you've experienced.

_____

_____

3. Have you used OTC medication to treat your acid reflux?
☐Yes ☐No Please indicate on next page.

_____

4. Do you take any prescription medication for your acid reflux? (Prilosec, Aciphex, etc.)
☐Yes ☐No Please list:

_____

_____

5. Have you changed your diet due to your acid reflux?
☐Yes ☐No How have you changed it?

_____

6. Does anything you ingest worsen your symptoms? (spicy food, caffeine, alcohol, etc.)
☐Yes ☐No Comments:

_____

7. Does Italian (tomato-based foods} or Mexican food aggravate your symptoms?
☐Yes ☐No Comments:

_____

8. What other methods have you tried to reduce your acid reflux? (changing bed positions, bought new bed, etc.)

_____

9. Do you experience night-time acid reflux?
☐Yes ☐No Comments:

_____

10. Does lying down or bending over worsen your symptoms?
☐Yes ☐No Comments:

_____

11. Do you ever experience any pain/tenderness in the upper central abdominal area?
☐ Yes ☐No Comments:

12. Have you had an EGD (Esophagogastroduodenoscopy) or Colonoscopy in the past 6 months? Please explain why.
☐ Yes ☐No Comments:

Instructions: please check the box to the right of each question using the scale below.

SCALE

0- No Symptoms
1- Symptoms noticeable but not bothersome
2- Symptoms noticeable and bothersome, infrequent
3- Symptoms bothersome everyday
4- Symptoms affect daily activity
5- Symptoms interfere with daily activities

Question	1	2	3	4	5
How bad is your heartburn?	☐	☐	☐	☐	☐
Heartburn when lying down?	☐	☐	☐	☐	☐
Heartburn when standing up?	☐	☐	☐	☐	☐
Heartburn after meals?	☐	☐	☐	☐	☐
Does heartburn change your diet?	☐	☐	☐	☐	☐
Does heartburn wake you from sleep?	☐	☐	☐	☐	☐
Do you have difficulty swallowing?	☐	☐	☐	☐	☐
Do you have pain when swallowing?	☐	☐	☐	☐	☐
If you take medication, does this affect your daily life?	☐	☐	☐	☐	☐
How bad is regurgitation?	☐	☐	☐	☐	☐
Regurgitation when lying down?	☐	☐	☐	☐	☐
Regurgitation when standing up?	☐	☐	☐	☐	☐
Regurgitation after meals?	☐	☐	☐	☐	☐
Does regurgitation change your diet?	☐	☐	☐	☐	☐
Does regurgitation wake you from sleep?	☐	☐	☐	☐	☐

Instructions: please indicate which medications you have attempted in the past by <u>checking</u> the duration of therapy.

Medication	5 yrs	10 yrs	15+ yrs	Other	Medication	5 yrs	10 yrs	15+ yrs	Other
Pepcid					Aciphex				
Famotidine					Rabeprazole				
Prilosec					Prevacid				
Omeprazole					Lansoprazole				
Dexilant					Zegerid				
Dexlansoprazole					Sodium Bicarb				
Protonix					Tums				
Pantoprazole					Rolaids				
Zantac					Pepto Bismol				
Ranitidine					Other Medication				

Patient Signature:_____ Date:_____

McCARTY
WEIGHT LOSS CENTER

Upper GI/Lap Band Consent Form

Please complete the checked sections:

_____**Upper GI Consent**:

I, _____, consent to the Upper GI procedure. This is a diagnostic x-ray.

_____**Women Age 18-50, please complete this section**:

The radiation used in flouro exams may be harmful to unborn children. The following information will help us avoid exposing an unknown pregnancy. In emergency cases with a known pregnancy, techniques will be used to obtain an essential exam with as little risk as possible.

Beginning last menstrual period: _____

- Could be pregnant? O YES O NO
- Have you had a hysterectomy? O YES O NO
- Have you had a tubal ligation? O YES O NO
- Are you currently breastfeeding? O YES O NO

_____**Lap-Band Adjustment Consent**:

I, _____, consent to the fluoroscopy guided adjustment or filling of my adjustable gastric band, as many times, deemed necessary to achieve weight loss.

This procedure is performed with a needle which is used to access the port reservoir for the purpose of adding or sustaining fluid. Normal saline is used. An Upper GI is a procedure used to determine the flow of the liquid through the band.

Potential Complications:

- Band Over fill-may result in chest pain, tightening or heaviness accompanied by nausea and vomiting. This may occur immediately after band fills, or over several days later. If this occurs, the fluid will be removed as soon as possible. I understand this is not life threatening.
- Gastro-esophageal reflux-pharmacotherapy may be given.
- Band Under fill- the patient may not attain sufficient restriction.
- Port Infection-this may require removal of the complete band system, port replacement, or antibiotics.
- Port perforation- this may require port replacement.
- Pain from the needle used for the adjustments.
- Bleeding and/or bruising at the port sight.

All patients please sign below:

_____ _____

Patient Signature **Date**

McCARTY
WEIGHT LOSS CENTER

Weight Loss Consent Form

This very low calorie and/or low carbohydrate plan will be medically supervised. Some of our plans are designed to promote rapid weight loss. Therefore the benefits, adverse effects, and risks are explained below.

Health Benefits:

- Weight loss improves obesity-related conditions such as diabetes, high blood pressure, high cholesterol, sleep apnea, arthritis, depression, etc.

Potential Adverse Effects and Risks:

- Fatigue/Weakness
- Constipation
- Nausea
- Diarrhea
- Lightheadedness/Dizziness
- Headache
- Increased risk of pregnancy: Your current form of birth control: _____
- Menstual Irregularities
- Acne
- Muscle Cramps
- Arrhythmias
- Electrolyte imbalances (potassium, sodium, magnesium, etc.)
- Gout
- Pancreatitis
- Gallstones
- Hair Loss
- Brittle nails
- Dry skin
- Halitosis (bad breath)

By signing below, you understand, agree, and desire to proceed with one of our four prescribed diet plans.

Print Name: _____

Signature: _____ Date: _____

McCarty Weight Loss
12222 N. Central Expressway #300
Dallas, TX 75243
Phone: 469-547-6170
Fax: 469-547-6180

Authorization to Release Healthcare Information

Patient's Name: _____ Date of Birth: _____

Maiden/Alias Name: _____ Social Security #:_____

I request and authorize _____to release healthcare information of the patient named above to:

Dr. Leah Dill
12222 N. Central Expressway #300,
Dallas, TX 75243

The request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:
_____

☐ All healthcare information

☐ Other:_____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes Herpes, HPV, Genital Wart, Chlamydia, Condyloma, Syphilis, VDRL, HIV, AIDS and Gonorrhea.

☐Yes ☐No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐Yes ☐No I authorize the release of any records regarding drug, alcohol or mental health treatment to the person(s) listed above

Patient Signature: _____ Date: _____

**The Authorization Expires 90 days after date of signature. **

McCarty Weight Loss
12222 N. Central Expressway #300
Dallas, TX. 75243
Phone: 469-547-6170
Fax: 469-547-6180

Authorization to Receive Healthcare Information

**McCarty Weight Loss Center will not disclose any information in regards to appointments, records, or any other information pertaining to your treatment unless listed below. Please include any emergency contacts that you wish to receive information on your behalf.

Patient Name:_____ Date of Birth:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Disclosure of Information

☐ I authorize the person(s) listed above to receive all Healthcare Information about appointments, treatments and/or other information pertinent to my healthcare including payment information.

☐ I DO NOT authorize any information to be disclosed to any other parties except to me as the patient.

You may revoke or terminate this authorization by submitting a written revocation to our office to the attention of the Privacy Official or other Authorized Representatives. However, your decision to revoke the authorization will not affect or undo any use of disclosure information that occurred before you notified us of your decision.

☐ I have received the information Entitled- Notice of Privacy and Practices

Patient Signature: _____ Date: _____

CANCELLATION/RESCHEDULING SURGERY POLICY

McCarty Weight Loss Center
12222 N. Central Expressway Suite 300
Dallas, TX, 75243

We are so excited to help you reach your goals! However, We understand that emergencies and unplanned issues can arise and that you may need to cancel or reschedule. If that happens, we respectfully ask that you call at least within 2 weeks of your scheduled Pre-op/Surgery. Our Physician and Facilities want to be available for your needs and the needs of all of our patients. Once a Pre-op/Surgery appointment Is scheduled, we are unable to offer those times to other potential patients.

I _____ understand that I will be charged a $200.00 scheduling fee upon scheduling my Pre-op and Surgery appointments. I understand that if I do not cancel/reschedule that this fee will apply to the total cost due for surgery. I also understand that if I cancel/reschedule after the requested time frame that this fee is non-refundable.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. If you have any questions, Please feel free to contact our surgery scheduler Whitney at 469-547-6170 option 6.

Patient name (Please Print) _____ Date: _____

Signature of patient _____

B LD

BOLD™ Study Patient Information Sheet

Surgical Review Corporation (SRC), a nonprofit healthcare organization, is conducting a study about bariatric/weight-loss surgery. SRC developed the BOLD™ database to support surgeons' decisions regarding patient care and to track outcomes of bariatric surgeries. BOLD is now the world's largest database for bariatric surgery, containing information on hundreds of thousands of patients.

WHY IS THIS STUDY BEING DONE?
The purpose of this study is to record and investigate the short-term and long-term results of different types of bariatric surgery. SRC will compare the surgical procedure performed with the health of patients for at least five years after surgery. This information will enable us to learn about the types of surgery that are most effective for weight loss and managing conditions related to obesity.

WHAT ARE THE BENEFITS OF THE STUDY?
The information and knowledge gained from the BOLD study will help surgeons improve the way bariatric surgical care is delivered and better understand the risks and benefits of each type of bariatric surgery.

WHO IS TAKING PART IN THE STUDY?
All patients who have bariatric surgery performed by a surgeon who utilizes the BOLD database are included in the BOLD study.

HOW IS THE STUDY CONDUCTED?
As part of your surgeon's involvement in the BOLD study, he/she collects the following information for every bariatric surgery patient and enters it into the BOLD database:

Personal information: gender, race, employment status, insurance status, medical record number, year of birth, height, weight and prior surgeries. Your surgeon has the option of entering your name for internal tracking purposes.
Information about your surgery: date of admission, date of surgery and date of discharge.
Information about your medical condition before, during and after your surgery.

Data that is used for research does not include your name or medical record number. Information about your surgery will be combined with data from all other study participants in a separate research database, and SRC research staff will analyze this combined information. The results of the study will be reported or published for the total population – no individual patient information will be published.

WHAT ABOUT MY CONFIDENTIALITY?
Your information is entered into BOLD through a secure website and permanently stored in a database that is managed by SRC. This database is secure and meets the requirements for the protection of patient confidentiality as required by the Health Insurance Portability and Accountability Act (HIPAA).

Your privacy is further protected by a Certificate of Confidentiality from the National Institutes of Health. This certificate means that SRC and surgeons submitting data to BOLD cannot be forced to disclose information that may identify you, even by a court subpoena, in any federal, state or local legal proceeding. However, the certificate does not restrict you from voluntarily disclosing your information.

WHAT ARE THE RISKS OF THE STUDY?
There are no physical risks associated with this study. However, there is a slight risk of loss of confidentiality. Every effort is made to keep your information confidential, but this cannot be guaranteed.

WHAT ARE THE COSTS?
There are no costs to you or your insurance provider for participating in the BOLD study, and no additional medical or surgical procedures or tests are performed as part of the study. You will not be paid for participating in the study, and SRC assumes no responsibility for paying, discounting or providing free medical care before, during or after your surgery.

WHAT ARE MY RIGHTS?
Your participation in the BOLD study is voluntary. You do not have to take part in this study in order to have bariatric surgery. You may withdraw from the study at any time. If you withdraw from the study, your data will not be used for research purposes. Your decision to not participate in or to withdraw from the study will not affect your medical care in any way. If you decide to withdraw from the study, you will need to let your surgeon know in writing.

You are not required to sign a consent form to participate in this study. However, you must let your bariatric surgeon or his/her staff know if you **do not wish to participate** either before you leave the office today or prior to your surgery.

You will receive a copy of this information to take home with you. If you are a minor, this information is being provided to you and your parent or legal guardian.

If you have any questions about the BOLD study, please visit www.surgicalreview.org/bold/bariatric or call SRC Support at 1-866-790-4772.

X _____

MEDIA RELEASE AND REFERRAL FORM

Media Release

I, _____, grant permission to McCarty Weight Loss Center to use my image (photographs and/or video) for use in Media publications including:

(Check All That Apply)

❏- Videos ❏- Marketing Materials ❏- General Publications

❏- Website and/or Affiliates (i.e. Private Facebook Group)

❏- Other:_____

I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image.

Signature: _____ Date:_____

Name (please print): _____

Address: _____

Referral

When researching and finding a Bariatric Surgeon that fits your needs, sometimes speaking with past patients can help with making a decision. McCarty Weight Loss Center provides a supportive network that helps offer patient experiences and testimonies. If you would be willing to act as a referral to future patients, please provide your information below. Your contact information will not be posted, however will be given to serious inquires upon request only and you will be notified.

Phone Number:_____ Email Address:_____

Signature:_____

Should you wish to not be a part of any publications, we do understand! Instead, please leave us a review on Google, Yelp, Facebook, or Real Self in order to help others find us at McCarty Weight Loss Center. We appreciate your decision to have Dr. Dill and her staff help you along this exciting journey!