Carlos A. Ferrari, M.D., F.A.S.M.B.S., P.A.
Minimally Invasive Obesity and General Surgery
915 Gessner, Suite 375
Houston, TX 77024

NEW PATIENT FORM

Patient Information

☐ Female ☐ Male ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Name _____

Date of Birth _____Age_____SSN _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____

Email _____

Employer _____

Address _____

City _____ State _____ Zip _____

Work phone _____

Insurance Information

Name of Primary insurance _____

Name of insured _____SSN _____

Policy/Member number _____ Group number _____

Address _____

City _____ State _____ Zip _____

Phone _____

Name of second insurance _____

Name of insured _____ SSN _____

Policy/Member number _____ Group number _____

Address _____

City _____ State _____ Zip _____

Emergency Information

Name _____ Relation to you _____

Address _____

Phone _____

MEDICAL HISTORY

Allergies

Please list any drug allergies you have

_____

_____

Are you allergic to latex? ☐ Yes ☐ No

Medications

Please list medications are you CURRENTLY taking

Name *Reason* *How long?*

_____

_____

_____

_____

Please list medications you hold prescriptions for but are not taking

Name *Reason*

_____

_____

_____

Surgery History

Date *Surgery* *Doctor*

_____

_____

_____

_____

_____

_____

_____

Nonsurgical Hospitalizations (deliveries, dehydrations, etc.)

Date *Reason* *Hospital*

_____

_____

_____

_____

Have you ever received a blood transfusion? ☐ Yes ☐ No
If yes, please answer the following questions.
Year _____

Where _____

Reason _____

Health Habits
Please check the substances you use and indicate how much you use.

☐ Caffeine _____

☐ Tobacco _____

☐ Alcohol _____

☐ Recreational drugs _____

☐ Sweets _____

Family Medical History
Please check if a family member has suffered from any of the following medical conditions.

	Obesity	*Heart Disease*	*Hypertension*	*Diabetes*	*Other*
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Sibling(s)	☐	☐	☐	☐	☐
Grandmother(s)	☐	☐	☐	☐	☐
Grandfather(s)	☐	☐	☐	☐	☐
Aunt(s)	☐	☐	☐	☐	☐
Uncle(s)	☐	☐	☐	☐	☐

If any of the following family members are deceased, please indicate cause of death.

Mother _____

Father _____

Sibling(s) _____

Grandmother(s) _____

Grandfather(s) _____

Aunt(s) _____

Uncle(s) _____

OBESITY HISTORY

The information obtained in this section may be requested by your insurance company to preauthorize your surgery. Please be as detailed as possible.

How long have you been obese? _____

At what age did you start you first diet? _____

Have you previously seen a doctor for morbid obesity? ☐ Yes ☐ No

If yes, who and when?_____

Do your family members know that you are considering having surgery to lose and control your weight? ☐ Yes ☐ No

Do your family members support your decision to have this surgery? ☐ Yes ☐ No

Have you read any information or literature about bariatric surgery? ☐ Yes ☐ No

If yes, how did you obtain this information?

- ☐ Internet
- ☐ Dr. Ferrari's web site
- ☐ Another Doctor
- ☐ Other_____

Are you currently taking any weight loss medication? ☐ Yes ☐ No

If yes, Please list

_____

Have you ever taken prescribed weight loss medication in the past? ☐ Yes ☐ No

If yes, *please list them*.

_____

_____

Have you ever tried any supervised weight loss programs? ☐ Yes ☐ No

If yes, please list them below.

Year Diet program/doctor Start & end weight How long Medication

_____

_____

_____

_____

_____

_____

_____

Have you ever tried any of the following weight loss methods? ☐ Yes ☐ No

Please check those that apply.

☐ Hypnosis	☐ Injections	☐ Acupuncture
☐ Amino acids	☐ Liquid protein	☐ Exercise tapes
☐ Slimfast	☐ Metabolife	☐ Exercise

☐ Other _____

How Does Being Overweight Affect You?

Please check if you suffer from any of the following problems.

☐ Heartburn/reflux	☐ Infertility	☐ Loud snoring
☐ Leak of urine	☐ Trouble fitting in chairs	☐ Trouble finding clothes
☐ Trouble sitting in planes	☐ Rashes between thighs	☐ Rashes between folds
☐ Low self esteem		

☐Other _____

Please state your reason(s) for wanting bariatric surgery

_____

_____

_____

_____

_____

_____

_____

I certify that the above information is correct to the best of my knowledge. I will not hold Carlos A. Ferrari, M.D. or any members of his staff responsible for any errors or omissions that I may make in the completion of this form.

_____ _____

Patient Name Date

_____

Patient Signature