SSM DePaul Health Center
12266 DePaul Drive, Suite 310
St. Louis, Missouri 63044
314-344-6800 Phone
314-344-6801 Fax
ssmweightloss.com

Mario Morales, MD
Andrew Wheeler, MD

PATIENT REGISTRATION

PATIENT INFORMATION

LAST NAME _____ FIRST NAME & INITIAL _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ PAGER _____

HOME PHONE _____ CELL PHONE _____ E-MAIL _____

DATE OF BIRTH _____ SEX: ☐ M ☐ F AGE: _____ MARITAL STATUS: ☐ Married ☐ Single RACE: _____

REFERRING PHYSICIAN _____ PRIMARY PHYSICIAN _____

SPOUSE'S NAME _____ SPOUSE'S DOB _____ SPOUSE'S WORK PHONE _____

EMERGENCY CONTACT _____ PHONE _____ RELATIONSHIP _____

PATIENT SOCIAL SECURITY # _____ SPOUSE'S SOCIAL SECURITY # _____

PATIENT EMPLOYER _____ EMPLOYMENT STATUS: ☐ Full Time ☐ Part Time ☐ Retired

EMPLOYER ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMPLOYER PHONE _____ EXT. _____

GUARANTOR

RESPONSIBLE PARTY LAST NAME _____ FIRST NAME & INITIAL _____ RELATIONSHIP _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ RESPONSIBLE PARTY SOCIAL SECURITY # _____ DOB _____

RESPONSIBLE PARTY EMPLOYER _____

EMPLOYER ADDRESS _____ EMPLOYER PHONE _____

INSURANCE INFORMATION

1. MEDICARE OR INSURANCE #1 NAME _____

MEDICARE OR INSURANCE #1 ADDRESS _____ MED. OR INS. #1 PHONE _____

POLICYHOLDER LAST NAME _____ FIRST NAME _____ RELATIONSHIP _____

CERTIFICATE NO. _____ GROUP NO. _____ MEMBER NO. _____

2. MEDICARE OR INSURANCE #2 NAME _____

MEDICARE OR INSURANCE #2 ADDRESS _____ MED. OR INS. #2 PHONE _____

POLICYHOLDER LAST NAME _____ FIRST NAME _____ RELATIONSHIP _____

CERTIFICATE NO. _____ GROUP NO. _____ MEMBER NO. _____

I request payment of authorized Medicare, Medigap or any other insurance benefits be made on my behalf to Weight Loss Institute for any services furnished to me by that provider. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents or to other insurers any information needed to determine benefits payable for services from the provider. I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

FINANCIAL LIABILITY: I understand I am fully responsible for all Physician charges. If I have insurance that will cover a portion of my bill, I agree to pay the patient's portion of the bill and understand I may be required to make a deposit toward the amount and the balance. The fact I may be covered by insurance does not relieve my personal obligations to pay all charges. I agree to assure payment of all charges by Weight Loss Institute.

All of the above information I have given is to the best of my knowledge correct.

SIGNATURE _____ **DATE** _____

SSM Weight-Loss Institute

PATIENT LABEL

SSM DePaul Health Center
12266 DePaul Drive, Suite 310
St. Louis, Missouri 63044
314-344-6800 Phone
314-344-6801 Fax
ssmweightloss.com

Mario Morales, MD
Andrew Wheeler, MD

PATIENT MEDICAL QUESTIONNAIRE

Please complete this questionnaire in its entirety.
Please be sure to mark the your choice of surgical tool at the top of the page and include all medications and physician information.

LAST NAME _____ FIRST NAME _____

DATE OF BIRTH _____ GENDER _____

HEIGHT _____ WEIGHT_____

HOW LONG AT CURRENT WEIGHT _____ OCCUPATION _____
FULL TIME PART TIME

Which weight loss option are you interested in?
Surgical Non-surgical Both
Roux-en-y Divided Gastric Bypass Adjustable Gastric Band
Sleeve Gastrectomy Revision – please obtain medical records from previous surgeon

How did you hear about the SSM Weight Loss Institute? _____

Surgeon requested: Dr. Mario Morales Dr. Andrew Wheeler

CURRENT MEDICATIONS

INCLUDING VITAMINS, OVER-THE-COUNTER MEDICATION, AND INTERMITTENTLY USED DRUGS.
(Please list prescription medication first)

Name	Strength	Frequency	Purpose	When Started

ALLERGIES

LIST ALL DRUG ALLERGIES:

Drug Name	Reaction

PATIENT LABEL

SSM DePaul Health Center
12266 DePaul Drive, Suite 310
St. Louis, Missouri 63044
314-344-6800 Phone
314-344-6801 Fax
ssmweightloss.com

Mario Morales, MD
Andrew Wheeler, MD

PATIENT MEDICAL QUESTIONNAIRE

LAST NAME _____ FIRST NAME _____ DATE OF BIRTH _____

PAST MEDICAL HISTORY

WHAT MEDICAL PROBLEMS ARE CURRENTLY BEING TREATED?

Illness	Date	Treatment	Outcome

PAST SURGICAL HISTORY

LIST ANY SURGERIES:

Surgery	Date	Reason	Physician

PRIMARY HEALTH CARE PROVIDER

NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: _____

OTHER HEALTH CARE PROVIDER(S), INCLUDING SPECIALISTS

NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: _____ SPECIALTY: _____

NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: _____ SPECIALTY: _____

PATIENT LABEL

SSM DePaul Health Center
12266 DePaul Drive, Suite 310
St. Louis, Missouri 63044
314-344-6800 Phone
314-344-6801 Fax
ssmweightloss.com

Mario Morales, MD
Andrew Wheeler, MD

PATIENT MEDICAL QUESTIONNAIRE

LAST NAME _____ FIRST NAME _____ DATE OF BIRTH _____

REVIEW OF SYMPTOMS

Cardiac:

Have you ever been told you have coronary atherosclerotic disease? **Y** **N**
Have you ever had a heart attack? **Y** **N**
If yes, when _____ Stent **Y** **N** Bypass Surgery **Y** **N**
Have you ever had congestive heart failure? **Y** **N**
Have you ever had any heart rhythm abnormalities? **Y** **N**
Have you ever had Rheumatic Fever? **Y** **N**
Do you have a pacemaker or defibrillator? **Y** **N**
If yes, will require impant information: _____

Pulmonary:

Do you experience shortness of breath with physical activity? **Y** **N**
When do you have to stop and rest _____ Steps/Flights *(Circle one and enter number)*
Do you have asthma? **Y** **N**
Do you have COPD or emphysema? **Y** **N**
Do you smoke? **Y** **N**
Do you use oxygen at home? **Y** **N**
Do you have Sarcoidosis? **Y** **N**

Sleep:

Have you been diagnosed with sleep apnea? **Y** **N**
If yes - Do you currently use a CPAP/BiPAP? **Y** **N**
If yes - Are you compliant with using your CPAP/Bipap? **Y** **N**
Do you snore loudly? **Y** **N**
Do you often feel tired, fatigued, or sleepy during the daytime? **Y** **N**
Has anyone ever observed you stop breathing during your sleep? **Y** **N**

In addition, please complete the Epworth sleepiness scale and total your score:

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you have not done some of these things recently, try to work out how they have affected you. Use 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 dozing

Sitting and Reading _____
Watching T.V. _____
As a passenger in a car for an hour without a break _____
Lying down to rest in the afternoon _____
Sitting, talking with someone _____
Sitting, inactive in a public place _____
Sitting quietly after lunch without alcohol _____
In a car, while stopped for a few minutes in traffic _____
Total _____

PATIENT LABEL

SSM DePaul Health Center
12266 DePaul Drive, Suite 310
St. Louis, Missouri 63044
314-344-6800 Phone
314-344-6801 Fax
ssmweightloss.com

Mario Morales, MD
Andrew Wheeler, MD

PATIENT MEDICAL QUESTIONNAIRE

LAST NAME _____ FIRST NAME _____ DATE OF BIRTH _____

REVIEW OF SYMPTOMS

Hepatic:

Have you ever had hepatitis?	**Y**	**N**
Have you been told you have cirrhosis of the liver?	**Y**	**N**
Have you ever been told you have a fatty liver disease?	**Y**	**N**
How much alcohol do you drink? _____		
Have you ever had problems with alcohol?	**Y**	**N**
If yes, when: _____		

Renal:

Are you on Dialysis?	**Y**	**N**
Have you ever had any kidney problems?	**Y**	**N**
If yes, when: _____		

Neurological:

Have you ever had a stroke?	**Y**	**N**
Do you have Multiple Sclerosis, Parkinson's disease, or any other neurological disease?	**Y**	**N**
If so, what disease? _____		
Do you have Pseudotumor Cerebri?	**Y**	**N**
Do you use a *wheelchair OR cane*?		

Gastrointestinal:

Have you ever had (please check all that apply):

Gallstones *Hiatal Hernia* *Diarrhea* *Hernia* *Blood in stool*
Hemorrhoids *Ulcer Disease* *Crohn's Disease*

Do you have heart burn?	**Y**	**N**
Have you ever had surgery for the treatment of reflux disease?	**Y**	**N**
Have you had any previous weight loss surgery?	**Y**	**N**

Endocrine:

Do you have thyroid disease?	**Y**	**N**
Check which type you have: *Hyper (high)* *Hypo (Low)*		
Are you *diabetic* or *insulin resistant* or do you have *metabolic syndrome* (check)	**Y**	**N**
Do you have high cholesterol or high lipids?	**Y**	**N**
Are you treating your high cholesterol?	**Y**	**N**

Bone or Joint Problems:

Have you ever been told you have degenerative joint changes, or arthritic changes in your joints?	**Y**	**N**
Has treatment included use of steroids?	**Y**	**N**

PATIENT LABEL

SSM DePaul Health Center
12266 DePaul Drive, Suite 310
St. Louis, Missouri 63044
314-344-6800 Phone
314-344-6801 Fax
ssmweightloss.com

Mario Morales, MD
Andrew Wheeler, MD

PATIENT MEDICAL QUESTIONNAIRE

LAST NAME _____ FIRST NAME _____ DATE OF BIRTH _____

REVIEW OF SYMPTOMS

Psychiatric:

Current Psychiatric treatment? **Y** **N**
Treated by: **Psychiatrist** **Therapist** **Psychologist**
Current Psychiatric Hospitalization (last 12 months): **Y** **N**
Treated by: **Psychologist** **Psychiatrist**
Have you ever been diagnosed with an eating disorder? **Y** **N**

Past Treatment:

Were you ever hospitalized for Psychiatric treatment? **Y** **N**
When was your treatment? _____
Where was your treatment? _____
What was your treatment for? _____

Current Treatment:

Whose care are you under? _____
Current medications and dosages: _____
Current diagnosis and reason for treatment? _____
_____

Vascular:

Do you have hypertension? **Y** **N**
Have you ever had a blood clot? **Y** **N**
If yes, when _____
What form of treatment _____
Have you ever had a Pulmonary Embolus? **Y** **N**
Do you have a family history of Pulmonary Embolisms or DVT? **Y** **N**
If yes, where was your treatment? _____
Do you get significant swelling in your legs? **Y** **N**
Have you ever had leg ulcers? **Y** **N**
Have you ever been treated for cellulites of the lower extremities? **Y** **N**
Have you ever been told you have peripheral vascular disease? **Y** **N**
Do you have any history of abnormal bleeding? **Y** **N**

Infection:

History of MRSA? **Y** **N**
Do you have an autoimmune disease? **Y** **N**
If yes please specify: Lupus HIV Aids Rheumatoid Arthritis
Other (please list) _____

PATIENT LABEL

SSM DePaul Health Center
12266 DePaul Drive, Suite 310
St. Louis, Missouri 63044
314-344-6800 Phone
314-344-6801 Fax
ssmweightloss.com

Mario Morales, MD
Andrew Wheeler, MD

PSYCH EVAL BACKGROUND INFORMATION

The following information is considered confidential and will be handled as such.

Patient Name _____ DOB _____ Age _____ Male Female
Your city and state _____ Highest education level_____

Are you seeking: Banding Bypass Sleeve Revision Height _____ Weight _____
Married? _____ How long? _____
Which marriage (2nd, etc.) _____ Single Widowed Divorced Separated
Who lives in your home? (wife, kids, etc.) _____ # of children born? _____
Employed where? _____ Job/position? _____ For how long? _____

What do you attribute your excess weight to? (e.g. poor food choices, genetics, large portions, etc.)

_____
At what age or grade were you initially overweight? _____ Highest weight ever? _____
Age or grade you made first dieting attempt _____
If you recall, what did you weigh when you graduated high school? _____
Date of most recent dieting attempt (last year, currently dieting, etc.) _____
Do you binge eat or consider yourself to be a compulsive eater? _____
Are you a grazer (consistent snacker or picker)? _____
Do you eat to compensate for stress _____ boredom _____ emotional comfort _____?
If yes to any of these, how do you plan on controlling these behaviors following weight loss surgery?

_____
_____

Have you ever had a suicide plan or attempt? Yes No If so, when? _____
List any current mental health diagnoses, such as depression, anxiety, etc. and any related medications:

_____
Who prescribes the Rx and what is their phone number? _____
How many cigarettes do you smoke per day? _____
How much alcohol do you drink and what type (beer, etc.) _____
List any prior addictions _____
Ever been hospitalized for a psychiatric disorder? _____
Briefly describe your childhood when growing up (chaotic, stable, problematic, etc.) _____
Do you *regularly* feel anxious nervous sad flat down helpless worthless guilty
Ever have a visual or auditory hallucination? _____ Trouble sleeping? _____
Does the desire to eat remain about the same over time? _____
Currently under extreme stress? _____ Ever treated for a eating disorder? _____

Medical reasons for seeking bariatric surgery _____
_____

How long have you been thinking about having a weight loss procedure? _____
Ways you have researched the surgery _____
Any other family members who had bariatric surgery? Yes No
Who referred you for surgery (self/doctor) _____
Briefly list the surgical risks of the procedure you are seeking _____
_____
What is the most you could weigh and feel like your surgery has still been successful? _____

SSM DePaul Health Center
12266 DePaul Drive, Suite 310
St. Louis, Missouri 63044
314-344-6800 Phone
314-344-6801 Fax
ssmweightloss.com

Mario Morales, MD
Andrew Wheeler, MD

To be completed by your primary care physician

PRIMARY CARE PHYSICIAN REQUEST FORM

This form can be forwarded to your physician and requested to be faxed to the fax number listed at the top of the page when complete. You do not need to wait for this form to be completed to return the rest of the packet. We will match all items in the office once received.

Dear SSM Weight Loss Institute,

I am referring my patient _____, date of birth _____, to you for your opinion regarding the possibility of weight loss options, including surgery. The patient's current weight is: _____, height is: _____, BMI is: _____. The patient has been morbidly obese for _____ years.

The patient's five (5) year weight history:

(1) Yr: _____ Wt: _____ (2) Yr: _____ Wt: _____ (3) Yr: _____ Wt: _____

(4) Yr: _____ Wt: _____ (5) Yr: _____ Wt: _____

The patient suffers from the following co-morbid conditions associated with morbid obesity which include:
(Please check all that apply)

Type 2 diabetes –
Need most recent HGBA1C drawn attached
Obstructive sleep apnea
Coronary artery disease
Valvular heart disease
Hypertension
Dyslipidemia
Stress incontinence
GERD
Heart burn
Arthritis
History of medical non-compliance
_____
_____

The patient also has the following conditions that are associated with morbid obesity:

_____ _____ _____

_____ _____ _____

The patient's previous weight loss attempts:

_____ _____ _____

_____ _____ _____

TSH Required. Other tests listed optional, please provide results if applicable.

Laboratory testing such as lipid panel, HGB A1C, TSH (Required)
Sleep Study
Exercise stress test
Pulmonary function test
Venous duplex
Other: _____

This patient has attempted other weight reduction alternatives and has been unsuccessful in maintaining adequate weight loss. I recommend this patient for weight loss surgery.

Sincerely,

_____ _____ (____)_____
Physician Signature (Required) Date Phone

_____ _____
Printed Name

_____

_____
Address (Required)

SSM Weight-Loss Institute

SSM DePaul Health Center
12266 DePaul Drive, Suite 310
St. Louis, Missouri 63044
314-344-6800 Phone
314-344-6801 Fax
ssmweightloss.com

Mario Morales, MD
Andrew Wheeler, MD

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

I have received on this visit/admission or a previous one, the Notice of Privacy Practices that explains how the facility may use my information. The Notice of Privacy Practices is also available on the SSM Health Care website. As explained in the Notice of Privacy Practices, the facility will only obtain my written authorization to release information about me if it is not permitted or required by law to disclose this information without authorization.

First Name MI Last Name Date of Birth

Signature of Patient/Parent or Legal Guardian Date

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request restriction on disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI may be made by alternative means such as: sending correspondence to the individual's office or cell phone, instead of the individual's home phone.

PLEASE CHECK *ALL* THAT APPLY
(Indicate with a *"P"* primary method of communication)

HOME TELEPHONE:
☐ Leave message with detailed information
☐ Leave message with call back number only

WRITTEN COMMUNICATION:
☐ OK to mail to:_____
☐ OK to fax to: _____

MY CHART:
☐ OK to send message with detailed information: _____

WORK TELEPHONE:
☐ Leave message with detailed information
☐ Leave message with call back number only

CELL PHONE:
☐ Leave message with detailed information
☐ Leave message with call back number only

OTHER (list below):

_____

I give consent to SSM WLI to release/discuss details of my medical care, including test results, medications, appointments, and other information with the persons listed below:

NAME	RELATIONSHIP	PHONE NUMBER

THIS DOCUMENT WILL BE A PART OF YOUR MEDICAL RECORD

For Office Use:

Entered into system by Date

SSM Weight-Loss Institute