



WELCOME TO THE DAVIS CLINIC!

We are thrilled that you have chosen to commit yourself to a healthier lifestyle and are honored to share in your journey to freedom from obesity. We very much look forward to taking excellent care of you!

Your trust in us as surgeons and staff means a lot to us and, as such, our goal is to provide the best care possible. As a practice, we have been blessed with a high demand for our services. Due to this, our practice is very busy, so please be patient with us and our staff, as we will do everything we can to take care of you as timely as possible. Due to the high call volume we encounter, our staff will reply to non-emergent calls and emails within two business days. Of course, urgent medical issues will always be handled immediately.

Your personal journey will be unique, but as someone participating in our program, there will be aspects of your journey that are the same as each individual going through our program. **Specifically, in order to get you through the program as quickly and medically safe as possible, you will need to follow the enclosed checklist, paying special attention to the instructions provided to you.** This allows us to prepare you for surgery in an efficient and safe manner. It also allows us the best opportunity to get you approved for surgery through your insurance policy.

If at any time you encounter a bump in the road, we want you to be able to contact us so that we can help keep you on the right path towards a healthier life. Please direct your non-emergent concerns via email as follows:

Clinical Concerns	Clinical Director	Jamie J. Carr, RN	Jamie.Carr@thedavisclinic.com
Administrative Concerns	Administrative Director	Kimberly P. Taylor	Kimberly.Taylor@thedavisclinic.com

Again, welcome to The Davis Clinic! We look forward to sharing in your amazing journey!

Sincerely,

Dr. Robert Davis
Dr. Garth Davis
Dr. John A. Primomo
The Davis Clinic Staff

Bariatric Program Checklist

This checklist will help get you approved as quickly as possible for surgery. Please complete each step in order to insure the best possibility of insurance approval.

AT YOUR FIRST CONSULTATION, YOU WILL BE TESTED FOR H-PYLORI BACTERIA, A BACTERIA KNOWN TO CAUSE ULCERS. FOR THIS TEST, YOU MUST BE OFF ALL ACID-REDUCING MEDICATIONS AT LEAST TWO WEEKS PRIOR TO THIS TEST. IF YOU ARE ON ANY ANTIBIOTICS, YOU MUST BE OFF OF ALL ANTIBIOTICS AT LEAST TWO WEEKS PRIOR TO THIS TEST AS WELL. YOU CANNOT HAVE ANYTHING TO EAT OR DRINK AT LEAST ONE HOUR PRIOR TO YOUR APPOINTMENT.

___ Attend initial consultation with surgeon.

___ Schedule your Psychological Evaluation. **Please contact PSY-MED, Inc. at (866) 786-2373.** All appointments will be handled directly through PSY-MED's office. You will need to provide your insurance information to them for verify your benefits. **NOTE: Most insurance accepted. All appointments will be held at The Davis Clinic.**

___ Your insurance coordinator will schedule your nutritional evaluation **TWO WEEKS AFTER** your initial consultation. **Insurance requirements will not allow your nutritional consultation to occur any earlier than 30 days AFTER your initial consultation. Please do not call to request your nutritional evaluation to be scheduled, as your coordinator will call you to make sure insurance requirements are met.**

Cost for group classes are \$75 each. Individual consults are \$150. The number of monthly classes will be determined by your specific insurance policy requirement. When we call you to schedule your nutrition evaluation, we will let you know the number of classes required by your insurance policy.

___ If age 50 or over, you must get a cardiac clearance. If you do not have a cardiologist, please call Dr. El-Hafi (713-465-3535) and have him or any other cardiologist within his office obtain your cardiac clearance. **We must receive an EKG as well as a letter of clearance at least two weeks prior to your surgery date.**

___ **CARDIAC CLEARANCE MUST BE RECEIVED BY OUR OFFICE IN ORDER FOR YOUR SURGERY TO BE SCHEDULED. Fax to (713) 464-6002. FOR DR. ROBERT DAVIS, PLEASE SEND FAX TO ATTN: NANCY; FOR DR. GARTH DAVIS, PLEASE SEND FAX TO ATTN: ZINTIA; FOR DR. PRIMOMO, PLEASE SEND FAX TO ATTN: NAOMI.**

___ Upon receipt of insurance approval for surgery, we will contact you to schedule your surgery date, pre-op visit appointment, and first post-op appointment.

___ Begin attending support groups and get involved in our online message boards! Our support group schedules are posted on our website at www.thedavisclinic.com under myDavisClinic on the left-hand side of the web page. For message board membership, click on Message Boards and follow the steps for registration.



Name _____ SS# _____ Date _____

Address _____
 Street _____ City, State, Zip _____

Home Phone _____ Work _____ Cell _____

May we leave a message at work? Yes _____ No _____ At home? Yes _____ No _____ Cell? Yes _____ No _____

Email Address _____ May we contact you via email? Yes _____ No _____

DOB _____ Age _____ Gender _____ Marital Status _____

Employer _____

Address _____
 Street _____ City, State, Zip _____

Insured's Name _____ SS# _____ DOB _____

Insured's Employer's Name _____

Insured's Address _____
 Street _____ City, State, Zip _____

Emergency Contact _____
 Phone _____ Relationship _____

How did you hear about The Davis Clinic? _____

Primary Insurance _____ Telephone _____

Address _____ Group # _____
 Street _____

_____ ID# _____
 City _____ State, Zip _____

Secondary Insurance _____ Telephone _____

Address _____ Group # _____
 Street _____

_____ ID# _____
 City _____ State, Zip _____

Please remember that your insurance coverage is a contract between you and your insurance carrier. It is YOUR RESPONSIBILITY to pay any deductible, co-insurance, and any other balance not paid by your insurance. If this account is assigned to collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of my records. I hereby assign all medical and surgical benefits to Dr. Robert Davis/Dr. Garth Davis/Dr. John A. Primomo. This assignment will remain in effect until revoked by me in writing. I certify that the above information provided is complete and correct.

Signed _____ Date _____

If you are using a BIPAP or CPAP machine, you do not have to complete this questionnaire.

CATEGORY I

- 1. Do you snore?
 - YES**
 - No
 - Don't know

- 2. If you snore, your snoring is:
 - Slightly louder than breathing
 - As loud as talking
 - LOUDER THAN TALKING**
 - VERY LOUD**

- 3. How often do you snore?
 - ALMOST EVERY DAY**
 - 3-4 TIMES A WEEK**
 - 1-2 times a week
 - Never or almost never

- 4. Does your snoring bother others?
 - YES**
 - No

- 5. Has anyone noticed that you quit breathing during your sleep?
 - ALMOST EVERY DAY**
 - 3-4 TIMES A WEEK**
 - 1-2 times a week
 - Never or almost never

CATEGORY II

- 6. Are you tired after sleeping?
 - ALMOST EVERY DAY**
 - 3-4 TIMES A WEEK**
 - 1-2 times a month
 - Never or almost never

- 7. Are you tired during wake time?
 - ALMOST EVERY DAY**
 - 3-4 TIMES A WEEK**
 - 1-2 times a month
 - Never or almost never

- 8. Have you ever nodded off or fallen asleep while driving?
 - YES**
 - No

- If yes, how often does it occur?
- EVERY DAY**
 - 3-4 TIMES A WEEK**
 - 1-2 times a week

CATEGORY III

- 9. Do you have high blood pressure?
 - YES**
 - No

RESULTS:

- CATEGORY I: Two or more positive responses in BOLD CAPS = High Risk**
- CATEGORY II: Two or more positive responses in BOLD CAPS = High Risk**
- CATEGORY III: If response is yes and/or BMI >30 = High Risk**

FINAL RESULT: TWO OR MORE CHECKED CATEGORIES INDICATES A HIGH LIKELIHOOD OF SLEEP APNEA
 REFER PATIENT FOR PULMONARY SCREENING/SLEEP STUDY?

Health Questionnaire

Name: _____ Date: _____

Date of birth: _____ Age: _____ Birthplace: _____

Race: ___Caucasian ___Asian ___African American ___Hispanic ___ other: _____

Religious Preference: _____ Emergency Contact: _____

Relationship: _____ Address: _____

Phone: (____) _____ Cell: (____) _____

Referring Physician: _____

Address: _____

Phone: (____) _____ Fax: (____) _____

Primary Care Physician: _____

Address: _____

Phone: (____) _____ Fax: (____) _____

What procedure are in interested in? ___Gastric Bypass ___Gastric Band ___Sleeve ___Revision

When did your obesity start? ___Childhood ___Puberty ___Pregnancy ___Adult ___After Traumatic Event

Other: _____

Medically supervised weight loss attempts: _____

Weight loss programs: _____

Diets: _____

Height: _____ Highest adult weight: _____ Year: _____

Lowest weight: _____ Year: _____ Most weight lost: _____

Taste habits: Sweet Salty Fast food Comfort Foods Other: _____

Eating habits: Binge eater Stress Boredom Loneliness Other: _____

Do you eat three meals per day? Yes No What meals do you tend to skip? _____

Do you eat most of your calories at dinner or after dinner? _____

Check the type of foods you and your family eat and how many times in a typical week:

Ready-made foods (boxed, heat and serve meals) _____

Home-cooked meals _____

Fast food _____

Do you exercise? Yes No What type? _____

If no, what interferes with establishing and maintaining regular exercise? _____

What is your average daily intake of the following in ounces?

Water _____

Coffee _____

Juice _____

Tea _____

Soda _____

Alcohol _____

Food Recall: 1 Weekday – Please list the time of day, food and beverage consumed and location where each meal or snack is eaten

Meal	Time	Food or Beverage	Amount (ounces)	Location
Breakfast				
Morning Snack				
Lunch				
Afternoon Snack				
Dinner				
Evening Snack				

Please list all previous surgeries and hospitalizations:

Procedure	Date	Hospital

Obesity Related Conditions – Please check if you have any of the following:

- | | |
|--|---|
| <input type="checkbox"/> Reflux/belching of sour fluid | <input type="checkbox"/> Bulimia/excessive vomiting |
| <input type="checkbox"/> Coughing or choking at night | <input type="checkbox"/> Daily headaches |
| <input type="checkbox"/> Daytime falling asleep | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gallbladder disease |
| <input type="checkbox"/> Gout | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Hiatal hernia |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> High lipids |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Leakage of urine |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Swollen ankles/feet | <input type="checkbox"/> Skin rash |

Other conditions: _____

Habits

Do you smoke?	Yes	No	Packs/day: _____
Have you ever been a smoker?	Yes	No	Age started: _____ Age quit: _____
Do you consume alcohol?	Yes	No	Drinks/day: _____ Type: _____
Do you use recreational drugs?	Yes	No	Type/frequency: _____

Women only

Date of last menstrual period: _____ Are they regular? _____

Do you use birth control? Yes No What type? _____

Number of pregnancies: _____ Number of live births? _____

Infertility problems: _____ Polycystic Ovary Disease? Yes No

Please check "Yes" if you have had any of the following medical conditions:

Condition	Yes	Comment
Allergies		
Anemia		
Asthma		
Bladder/kidney infections		
Blood transfusions		
Cancer		
Colitis or Irritable Bowel Syndrome		
Easy bruising		
Epilepsy/seizures		
Excessive/heavy bleeding		
Fainting		
Frequent nausea		

Heart attack		
Heart failure		
Heart murmur		
Heart palpitations		
Heavy/excessive drinking		
Hemorrhoids		
Hepatitis		
Kidney stones		
Leg-cramping		
Liver disease		
Lung disease/Pneumonia		
Migraine/severe headaches		
Rheumatic fever		
Stroke		
Thyroid problems		
Tuberculosis		
Tumors		
Ulcers		
Varicose veins		

Family History – Please check all that apply:

Condition	Mother	Father	Sibling	Grandparent	Aunt/Uncle
Diabetes					
Sleep Apnea					
Gallbladder Disease					
High Blood Pressure					
Obesity					
Stroke					
Heart Disease					
Cancer					

Please list any concerns that you have regarding bariatric surgery:

Please do not write below this line

Surgeon notes:
