

Kenneth Hollis, M.D., FACS  
11914 Astoria Boulevard Ste. 125  
Houston, TX 77089  
Ph. 281-482-5300

**Patient Information**

Legal Name – **Last:** \_\_\_\_\_ **First:** \_\_\_\_\_ **M.I.** \_\_\_\_\_  
Birth date: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Age: \_\_\_\_\_ Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt/Unit: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ - \_\_\_\_\_  
Sex: **M F** Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Ethnicity: (Check One): \_\_\_ Caucasian \_\_\_ Asian \_\_\_ African American \_\_\_ Hispanic \_\_\_ Other  
Marital Status (Circle One): Married Single Divorced Widowed Number of children: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Employer: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Occupation: \_\_\_\_\_ Full time \_\_\_ Part time \_\_\_  
Social History: Do you use tobacco? Yes No Packs/Day \_\_\_\_\_ # of years \_\_\_\_\_  
Do you use alcohol? Yes No Amount \_\_\_\_\_ Frequency \_\_\_\_\_ Beer \_\_\_ Wine \_\_\_ Hard liquor \_\_\_  
Have you ever been treated for depression? Yes No Are you currently in treatment? Yes No  
If yes, please indicate the name and phone number of your physician or therapist.

---

**Primary Insured Information**

Legal Name – Last: \_\_\_\_\_ First: \_\_\_\_\_ M.I. \_\_\_\_\_  
Birth date: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Age: \_\_\_\_\_ Home Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email Address: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt/Unit: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ - \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer Address: \_\_\_\_\_

**Spouse Information**

Spouse Name: \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Emergency contact (Not living in same household)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Contact Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Insurance Information**

Primary Insurance Company: \_\_\_\_\_  
Type of Plan: (circle one) **PPO HMO EPO POS OTHER**  
ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Secondary Insurance Company: \_\_\_\_\_  
Type of Plan: (circle one) **PPO HMO EPO POS OTHER**  
ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Patient Name: \_\_\_\_\_

**System Review** (please circle all that apply)

**Constitutional:**

Fatigue  
Tiredness  
Recent Weight Loss  
Fever  
Night Sweats  
Abnormal Bleeding

**Head and Neck:**

Blurred Vision  
Double Vision  
Loss of Hearing  
Constipation  
Sinus Congestion  
Sinus Infection  
Lump in Neck  
Hoarseness  
Runny Nose  
Sneezing  
Sore Throat  
Loss of Smell  
Difficulty Swallowing  
Pain Swallowing

**Cardiovascular:**

Chest Pain  
Pain in Arm/Neck  
Heart Attack  
Palpitations  
Heart Pounding  
Stroke  
Heart Murmur  
Pain in Legs  
Cold Feet  
Loss of Pulses  
Low Blood Pressure  
Pulmonary Emboli  
Leg or ankle edema  
Congestive Heart Failure  
Leg Ulceration  
Deep Vein Thrombosis  
High Blood Pressure  
Abnormal Heartbeat

**Respiratory:**

Shortness of Breath  
Asthma  
Wheezing  
Coughing  
Bloody Sputum  
Emphysema  
Pneumonia  
Bronchitis  
Difficulty Sleeping  
Waking at Night  
Use of CPAP/BIPAP  
Sleep Apnea  
Morning Headaches  
Snoring  
Daytime Drowsiness

**Gastrointestinal:**

Jaundice  
Hepatitis  
Cirrhosis  
Vomiting  
Nausea  
Heartburn  
Reflux  
Abdominal Pain  
Esophagitis  
Diarrhea  
Light Headedness  
Painful Bowel Movements  
Blood in Stool  
Hemorrhoids  
Change in Stool Size  
Irritable Bowel  
Colitis

**Genitourinary:**

Blood in Urine  
Frequent Urination  
Painful Urination  
Leakage of Urine with  
Sneezing/Straining  
Trouble Starting Urine  
Kidney Stones  
Bladder Infection

**Musculoskeletal:**

Painful Joints  
Swelling of joints  
Muscle Aches  
Arthritis  
Painful Hips  
Pain in Knees  
Pain in Ankles  
Pain in Feet  
Low Back Pain  
Herniated Disk  
Sciatica  
Numbness of Legs/Feet  
Abnormal Lumps/Masses  
Fibromyalgia

**Neurological:**

Convulsions  
Seizures  
Migraines  
Fainting  
Vertigo  
Headaches w/ dizziness,  
nausea and/ or pain behind  
the eyes, no visual symptoms  
Headaches w/ visual  
symptoms, and/or controlled  
diuretics  
Muscle Weakness  
Numbness  
Tremors  
Loss of Consciousness

**Psychological:**

Depression  
Nervousness  
Anxiety  
Suicidal Thoughts  
Bipolar Disorder  
Schizophrenia  
Anorexia  
Bulimia  
Binge Eating  
Hospitalized for Mental Illness?

**Endocrine:**

Hyperthyroid  
Hypothyroid  
Goiter  
Previous Radiation  
Adrenal Tumors  
Previous Steroid Use  
Swollen Glands

**Malignancy:**

Cancer/ Location: \_\_\_\_\_

**Diabetes:**

Juvenile Onset  
Gestational (Pregnancy)  
Adult Onset  
Diet Controlled  
Oral Medications  
Insulin Dependent

**Men:**

Discharge from Penis  
Loss of Erection

**Women:**

Abnormal Bleeding  
Irregular Periods  
Infertility  
Polycystic Ovarian Syndrome

**Blood:**

Prior blood transfusion  
Exposure to HIV/AIDS  
Abused Intravenous Drugs  
Elevated Cholesterol  
Elevated Triglycerides

**Abdominal Wall Hernia:**

Incisional  
Umbilical  
Number of Hernia Repairs  
Hiatal Hernia Repair



Patient Name: \_\_\_\_\_

**Previous Weight Loss Surgery** NO \_\_\_\_\_ YES \_\_\_\_\_ (please indicate below)

Surgery Type	Date	Surgeon	Weight Loss

**Diet Programs and Supplements** (please indicate which of the following diet or plans you have attempted)

Programs	Dates	Duration	MD Supervised	Weight Loss
Atkins Diet				
Grapefruit Diet				
Herbalife				
Jenny Craig				
Liquid Diets				
Medifast				
Metabolife				
Nutri- System				
Optifast				
Pritikin Diet				
Slim Fast				
Tops				
Weight Watchers				
Other				

**Weight Loss Medication History** (please indicate which of the following medications you have taken)

Medication	Dates	Dosage	MD Supervised	Weight Loss
Amphetamines				
Phentermine (Adipex, Fastin, Pondimin)				
Phen – Fen				
Redux (Dexafenflouramine)				
Xenical (Olistat)				
Meridia (Sibutramine)				
Other Diet Medication				

**Non – Dietary Therapies** (please indicate if you have attempted any of the following weight loss treatments)

Therapy	Dates	Duration	MD Supervised	Weight Loss
Regular Exercise				
Hypnosis				
Behavior Modification				
Acupuncture				

Patient Name: \_\_\_\_\_

**Past Medical History**

Please list all other medical conditions, illnesses, or other important information not previously mentioned.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I have received, read, and acknowledged the Notice of Privacy Policies and Practices for BayChoice Bariatric Center.**

**I understand that I am financially responsible for all charges for services to me including the balance remaining after payment of possible insurance benefits. I authorize payment of medical benefits to BayChoice Bariatric Center. I authorize the release of any medical information necessary to process all claims.**

\_\_\_\_\_  
**Signature of patient or responsible party, if patient is a minor**

\_\_\_\_\_  
**Date**