

Please email your completed paper work to **russell.vieaux@baileymedicalcenter.com** or fax it to **918.550.6632**.

PATIENT REGISTRATION INFORMATION

Patient Name (Last, First, Middle): _____

Social Security #: _____ - _____ - _____ Age: _____ Date of Birth: ____/____/____ Sex: Male Female

Language: _____ Marital Status: _____

Race: _____ Ethnicity: Hispanic or Latino Not Hispanic or Latino

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone #: _____ Cell Phone #: _____

Email Address: _____

Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Employer Telephone #: _____ Extension: _____

Primary Care Physician: _____ Telephone #: _____

Referring Physician: _____ Telephone #: _____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Telephone #: _____ Employer Telephone #: _____

GUARANTOR INFORMATION

Name: _____

Relationship to Patient: _____

Social Security #: _____ - _____ - _____ Age: _____ Date of Birth: _____ / _____ / _____ Sex: Male Female

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone #: _____ Cell Phone #: _____

Employer: _____ Employer Telephone #: _____

PRIMARY INSURANCE

Insurance Name: _____ Insurance Telephone #: _____

ID #: _____ Group #: _____

Claims Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Subscriber's Name: _____ Relationship to Patient: Self Spouse Child

Subscriber's Employer: _____

Subscriber's Address: _____

City: _____ State: _____ Zip Code: _____

Subscriber's Social Security #: _____ - _____ - _____ Subscriber's Date of Birth: _____ / _____ / _____

SECONDARY INSURANCE

Insurance Name: _____ Insurance Telephone #: _____

ID #: _____ Group #: _____

Claims Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Subscriber's Name: _____ Relationship to Patient: Self Spouse Child

Subscriber's Employer: _____

Subscriber's Address: _____

City: _____ State: _____ Zip Code: _____

Subscriber's Social Security #: _____ - _____ - _____ Subscriber's Date of Birth: _____ / _____ / _____

MEDICAL HISTORY

If Over the Age of 50, Have You Had a Colonoscopy? No Yes If Yes, When? _____

FOR MALES ONLY:

Have You Had a Prostate Exam? No Yes If Yes, When? _____

FOR FEMALES ONLY:

Have You Had a Mammogram? No Yes If Yes, When? _____

Have You Had a Pap/Pelvic Exam? No Yes If Yes, When? _____

Is It Possible You are Currently Pregnant? No Yes

Last Menstrual Period: _____ / _____ / _____ Current Contraceptive Method: _____

of Pregnancies: _____ # of Live Births: _____

1st Pregnancy ... Age: _____ Weight Gain: _____ 3rd Pregnancy ... Age: _____ Weight Gain: _____

2nd Pregnancy ... Age: _____ Weight Gain: _____ 4th Pregnancy ... Age: _____ Weight Gain: _____

MEDICAL HISTORY CONTINUED

Illness/Diagnosis (please check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes – requires insulin | <input type="checkbox"/> Chest Pain w/ Activity (Angina) | <input type="checkbox"/> Chronic Back Pain |
| <input type="checkbox"/> Diabetes – requires no insulin | <input type="checkbox"/> Chest Pain at Rest (Angina) | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> HIV Exposure/AIDS | <input type="checkbox"/> Chronic Leg Sores | <input type="checkbox"/> Chronic Joint Pain |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Chronic Headache |
| <input type="checkbox"/> Insulin Resistance | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Irregular Menstrual Periods | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Morbid Obesity – 5+ Years | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Polycystic Ovarian Syndrome | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Irregular Heart Rate or Rhythm | <input type="checkbox"/> Low Self-Esteem |
| <input type="checkbox"/> Blood Clots-DVT | <input type="checkbox"/> Leg Discoloration | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Blood Clots to Lungs-PE | <input type="checkbox"/> Leg Swelling/Edema | <input type="checkbox"/> Drowsy Days |
| <input type="checkbox"/> Emphysema (COPD) | <input type="checkbox"/> Swelling of Ankles/Feet | <input type="checkbox"/> Exercise Limitations-mild |
| <input type="checkbox"/> Lung Disease/COPD | <input type="checkbox"/> Aspiration/Choking | <input type="checkbox"/> Exercise Limitations-moderate |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Chronic Abdominal Pain | <input type="checkbox"/> Exercise Limitations-severe |
| <input type="checkbox"/> Shortness of Breath w/ Activity | <input type="checkbox"/> Heartburn or Reflux | <input type="checkbox"/> Fevers/Chills/Sweats |
| <input type="checkbox"/> Shortness of Breath at Rest | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Frequent Colds |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Nausea | <input type="checkbox"/> Gallbladder Attacks |
| <input type="checkbox"/> Sleep Apnea – CPAP Machine | <input type="checkbox"/> Nausea-Vomiting | <input type="checkbox"/> Gallbladder Disease |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Iron Deficient Anemia |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Trouble Swallowing | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcers/Gastritis | <input type="checkbox"/> Urinary Incontinence |
| | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Vitamin D Deficiency |
| | | <input type="checkbox"/> Cancer |

Please list any other illness/diagnosis:

MEDICAL HISTORY CONTINUED

Physical Limitations/Disabilities (please check all that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> Airline Travel | <input type="checkbox"/> Lifting Objects from Floor | <input type="checkbox"/> Unusual Fatigue |
| <input type="checkbox"/> Caring for Personal Needs | <input type="checkbox"/> Playing with Children | <input type="checkbox"/> Use of Public Seating |
| <input type="checkbox"/> Climbing Stairs | <input type="checkbox"/> Tying Shoes | |

When Exposed to the Following, Do You Have Symptoms Like Red Itchy Eyes, General Itching, Shortness of Breath, Wheezing, Fast Heartbeat, Feeling Faint, Nausea or Vomiting...

- | | |
|--|--|
| Aspirin? <input type="checkbox"/> Yes <input type="checkbox"/> No | Iodine? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Latex? <input type="checkbox"/> Yes <input type="checkbox"/> No | Rubber (Balloons, Band-Aids, Spandex, Tape)? <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please List Any Previous Cardiac Procedures or Testing and Cardiologist Name:

FAMILY MEDICAL HISTORY

Illness/Diagnosis (please check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> No information | <input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diabetes
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____ | <input type="checkbox"/> Liver Disease
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Morbid Obesity
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____ | <input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Heart Disease
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____ | <input type="checkbox"/> Cancer
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____ | <input type="checkbox"/> Clotting Disorder
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Heart Attack
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____ | <input type="checkbox"/> Breast Disease
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Asthma
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____ | <input type="checkbox"/> Stroke
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Emphysema/COPD
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____ | <input type="checkbox"/> Arthritis
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bowel/Colon Disease
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____ | <input type="checkbox"/> Depression/Anxiety
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hepatitis
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

SURGICAL HISTORY

Surgical Procedures (please check all that apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> Back/Neck Surgery | <input type="checkbox"/> Roux-N-Y Gastric Bypass | <input type="checkbox"/> Surgery to the Small Bowel |
| <input type="checkbox"/> Caesarean Section | <input type="checkbox"/> Sleeve Gastrectomy | <input type="checkbox"/> Surgery to the Stomach |
| <input type="checkbox"/> Dilation & Curettage (D&C) | <input type="checkbox"/> Surgery to the Chest or Lung | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Surgery to the Esophagus | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Gastric Banding | <input type="checkbox"/> Surgery to the Heart | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Surgery to the Large Bowel | <input type="checkbox"/> Other: _____ |

Surgical Complications (please check all that apply):

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Anesthesia Problems | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Infections | <input type="checkbox"/> Other: _____ |

Please List Other Significant Conditions or Hospitalizations:

NUTRITIONAL HISTORY

of Meals Per Day: _____ **Do You Eat Between Meals?** Yes No **# of Glasses of Water Per Day:** _____

Food Preferences (please check all that apply):

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Cakes/Pies | <input type="checkbox"/> Cookies | <input type="checkbox"/> Pizza |
| <input type="checkbox"/> Candy | <input type="checkbox"/> Dairy Products | <input type="checkbox"/> Seafood |
| <input type="checkbox"/> Chips/Snacks | <input type="checkbox"/> Fast Food | <input type="checkbox"/> Steak/Red Meat |
| <input type="checkbox"/> Chocolate | <input type="checkbox"/> Fried Food | <input type="checkbox"/> Vegetables |

SOCIAL HISTORY

Do You Use Tobacco? No Yes **If Yes, What Type?** Chew Cigarettes Cigar Pipes

Per Day: _____ # of Years _____ If you Quit, When? _____

Do You Drink Sodas? No Yes **If Yes, What Type?** Diet Regular # Per Day _____

Do You Drink Alcoholic Beverages? No Yes **If Yes, How Many Times Per Week?** _____

Do You Drink Coffee/Caffeine? No Yes **If Yes, How Many Cups Per Day?** _____

Have you Ever Used Marijuana or Other Illicit Drugs? No Yes

Do You Tolerate Physical Exercise? No Yes

Do You Have Trouble Sleeping? No Yes

WEIGHT LOSS HISTORY

Diet	Year(s)	Weight Lost	# of Months on Program
Acupuncture Behavior	_____	_____	_____
Modification Exercise	_____	_____	_____
Fen-Phen	_____	_____	_____
Hypnosis	_____	_____	_____
Injections	_____	_____	_____
Jenny Craig	_____	_____	_____
Meridia	_____	_____	_____
Nutritionist/Dietitian	_____	_____	_____
Psychiatrist/Therapy	_____	_____	_____
Opti-Fast	_____	_____	_____
Overeaters Anonymous	_____	_____	_____
Redux	_____	_____	_____
Richard Simmons	_____	_____	_____
Weight Watchers	_____	_____	_____
Xenical	_____	_____	_____
Physician-Directed Plan(s)			
List: _____	_____	_____	_____
List: _____	_____	_____	_____
Self-Monitored Diet(s)			
List: _____	_____	_____	_____
List: _____	_____	_____	_____

IMPORTANT:
This page must be completed. Insurance requires you document previous attempts at weightloss prior to joining the program. We are unable to move forward without this page completed.

Patient Name: _____ DOB: _____

Previous Sleep Study? Yes No

If yes, when and where:

Current use of CPAP? Yes No

If you have been previously diagnosed with Obstructive Sleep Apnea and instructed to use a CPAP do you use it daily as prescribed? Yes No

Do you have a personal history of any of the following?

1. Yes No Abnormal movement, behavior, emotions, or dreams while sleeping
2. Yes No Previous home sleep study which did not diagnose OSA
3. Yes No Snoring? If yes, has it been witnessed? Yes No
4. Yes No Excessive Daytime Sleepiness
5. Yes No Insomnia? (Inability to sleep)
6. Yes No Has anyone ever told you that you stopped breathing during sleep?
7. Yes No Have you experienced gasping or choking while sleeping?
8. Yes No Do you frequently arouse during sleep?

If you answered yes to any of the above symptoms, how long have you been experiencing them?

Do you have a personal medical history for any of the following?

- 9. Yes No High Blood Pressure
- 10. Yes No Use of three or more medications to treat High Blood Pressure
- 11. Yes No Any head or facial or upper airway soft tissue abnormality
- 12. Yes No Neuromuscular disease
- 13. Yes No Stroke in the past 30 days?
- 14. Yes No “Mini strokes” (Transient ischemic attacks (TIA))
- 15. Yes No Coronary artery disease (CAD)
- 16. Yes No Heart Disease
- 17. Yes No Fast heart rate (tachycardia)
- 18. Yes No Slow heart rate (bradycardia)
- 19. Yes No COPD/Emphysema/Lung Disease/Asthma
- 20. Yes No Congestive Heart Failure (CHF)
- 21. Yes No Restless Leg Syndrome
- 22. Yes No Narcolepsy
- 23. Yes No Nocturnal Seizures
- 24. Yes No Use of home oxygen
- 25. Yes No Use of prescription narcotic pain medication

Please email your completed paper work to ***russell.vieaux@baileymedicalcenter.com*** or fax it to **918.550.6632**.

***** To be filled out by clinic staff only*****

BMI _____

Neck circumference _____ inches