THE CENTER FOR BARIATRICS
AT BAILEY MEDICAL CENTER

Name: _____
DOB: _____

Please email your completed paper work to bariatrics@baileymedicalcenter.com or fax it to 918-550-6503.

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 #:** _____

Name: _____
DOB: _____

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:** ___/___/____

Name: _____
DOB: _____

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: _____

Name: _____
DOB: _____

MEDICAL HISTORY CONTINUED

Illness/Diagnosis (please check all that apply):

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

Please list any other illness/diagnosis: _____

Name: _____
DOB: _____

MEDICAL HISTORY CONTINUED

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

☐ Airline Travel
☐ Caring for Personal Needs
☐ Climbing Stairs
☐ Lifting Objects from Floor
☐ Playing with Children
☐ Tying Shoes
☐ Unusual Fatigue
☐ Use of Public Seating

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? ☐ Yes ☐ No

Iodine? ☐ Yes ☐ No

Latex? ☐ Yes ☐ No

Rubber (Balloons, Band-Aids, Spandex, Tape)? ☐ Yes ☐ No

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

_____

_____

FAMILY MEDICAL HISTORY

Illness/Diagnosis (please check all that apply):

☐ **No information**

☐ **Diabetes**
☐Mother ☐Father ☐Other_____

☐ **Morbid Obesity**
☐Mother ☐Father ☐Other_____

☐ **Heart Disease**
☐Mother ☐Father ☐Other_____

☐ **High Blood Pressure**
☐Mother ☐Father ☐Other_____

☐ **Heart Attack**
☐Mother ☐Father ☐Other_____

☐ **Asthma**
☐Mother ☐Father ☐Other_____

☐ **Emphysema/COPD**
☐Mother ☐Father ☐Other_____

☐ **Bowel/Colon Disease**
☐Mother ☐Father ☐Other_____

☐ **Hepatitis**
☐Mother ☐Father ☐Other_____

☐ **Kidney Disease**
☐Mother ☐Father ☐Other_____

☐ **Liver Disease**
☐Mother ☐Father ☐Other_____

☐ **Bleeding Disorder**
☐Mother ☐Father ☐Other_____

☐ **Cancer**
☐Mother ☐Father ☐Other_____

☐ **Clotting Disorder**
☐Mother ☐Father ☐Other_____

☐ **Breast Disease**
☐Mother ☐Father ☐Other_____

☐ **Stroke**
☐Mother ☐Father ☐Other_____

☐ **Arthritis**
☐Mother ☐Father ☐Other_____

☐ **Depression/Anxiety**
☐Mother ☐Father ☐Other_____

☐ Other: _____
☐ Other: _____
☐ Other: _____

☐ Other: _____
☐ Other: _____
☐ Other: _____

Name: _____
DOB: _____

SURGICAL HISTORY

Surgical Procedures (please check all that apply):

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

Surgical Complications (please check all that apply):

- ☐ Anesthesia Problems
- ☐ Bleeding
- ☐ Blood Transfusion
- ☐ Infections
- ☐ Other: _____
- ☐ 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):

- ☐ Cakes/Pies
- ☐ Candy
- ☐ Chips/Snacks
- ☐ Chocolate
- ☐ Cookies
- ☐ Dairy Products
- ☐ Fast Food
- ☐ Fried Food
- ☐ Pizza
- ☐ Seafood
- ☐ Steak/Red Meat
- ☐ Vegetables

SOCIAL HISTORY

Do you use Nicotine in any form? ☐ No ☐ Yes **If Yes, What Type?** ☐ Chew ☐ Cigarettes ☐ Cigar ☐ Pipes ☐ Vape Pen

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

Name: ____________________
DOB: ____________________

MEDICATIONS

Please list any medication allergies:

____

____

Preferred Pharmacy: ____

Location/Address: ____

CURRENT MEDICATIONS

Medication Name	Strength	Frequency		
______	______	______	☐ Prescription	☐ Over-the-Counter
______	______	______	☐ Prescription	☐ Over-the-Counter
______	______	______	☐ Prescription	☐ Over-the-Counter
______	______	______	☐ Prescription	☐ Over-the-Counter
______	______	______	☐ Prescription	☐ Over-the-Counter
______	______	______	☐ Prescription	☐ Over-the-Counter
______	______	______	☐ Prescription	☐ Over-the-Counter
______	______	______	☐ Prescription	☐ Over-the-Counter
______	______	______	☐ Prescription	☐ Over-the-Counter
______	______	______	☐ Prescription	☐ Over-the-Counter
______	______	______	☐ Prescription	☐ Over-the-Counter
______	______	______	☐ Prescription	☐ Over-the-Counter
______	______	______	☐ Prescription	☐ Over-the-Counter
______	______	______	☐ Prescription	☐ Over-the-Counter
______	______	______	☐ Prescription	☐ Over-the-Counter
______	______	______	☐ Prescription	☐ Over-the-Counter

Name: _____
DOB: _____

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 bariatrics@baileymedicalcenter.com or fax it to 918-550-6503.

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

BMI _____

Neck circumference _____ inches