



THE CENTER FOR BARIATRICS

AT BAILEY MEDICAL CENTER

Name: _____

DOB: _____ / _____ / _____

— NEW PATIENT PAPERWORK —

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: _____

Cell Phone #: _____ 2nd Telephone #: _____

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 #: _____

CURRENT BMI

Height: _____ Weight: _____ BMI: _____

To determine your BMI go to baileybariatrics.com/bmi-calculator

A minimum BMI of 30 is required to participate in weight loss programs at Bailey Medical Center.

PROGRAM SELECTION: Which program are you interested in joining?

☐ Bariatric Surgery

☐ Metabolic Management Program (MMP)

☐ Undecided



THE CENTER FOR BARIATRICS

AT BAILEY MEDICAL CENTER

Name: _____

DOB: _____ / _____ / _____

GUARANTOR CONTACT

Patient Name: Last _____ First _____ Middle _____

Relationship to Patient: _____ Sex: ☐ Male ☐ Female

Social Security #: _____ - _____ - _____ Age: _____ Date of Birth: _____ / _____ / _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone #: _____ 2nd Telephone #: _____

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: _____

Social Security #: _____ - _____ - _____ 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: _____

Social Security #: _____ - _____ - _____ Date of Birth: _____ / _____ / _____



THE CENTER FOR BARIATRICS

AT BAILEY MEDICAL CENTER

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: _____

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

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

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

FOR ALL GENDERS:

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

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



THE CENTER FOR BARIATRICS

AT BAILEY MEDICAL CENTER

Name: _____

DOB: _____ / _____ / _____

MEDICAL HISTORY CONTINUED

Illness/Diagnosis (please check all that apply):

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

Please list any other illness/diagnosis:

1. _____
2. _____
3. _____



THE CENTER FOR BARIATRICS

AT BAILEY MEDICAL CENTER

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



THE CENTER FOR BARIATRICS

AT BAILEY MEDICAL CENTER

Name: _____

DOB: _____ / _____ / _____

SURGICAL HISTORY

Surgical Procedures (please check all that apply):

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

Surgical Complications (please check all that apply):

Anesthesia Problems	Blood Transfusion	Other: _____
Bleeding	Infections	Other: _____

Please List Other Significant Conditions or Hospitalizations: _____

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 _____

Kidney Disease

Mother _____ Father _____ Other _____

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 _____

Hepatitis

Mother _____ Father _____ Other _____

Other: _____



THE CENTER FOR BARIATRICS

AT BAILEY MEDICAL CENTER

Name: _____

DOB: _____ / _____ / _____

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

SOCIAL HISTORY

Do You Use Tobacco? No Yes If yes, What Type? Chew Cigarettes Cigars 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



THE CENTER FOR BARIATRICS

AT BAILEY MEDICAL CENTER

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: _____	_____	_____	_____



THE CENTER FOR BARIATRICS

AT BAILEY MEDICAL CENTER

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?



THE CENTER FOR BARIATRICS

AT BAILEY MEDICAL CENTER

Name: _____

DOB: _____ / _____ / _____

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 send your completed paperwork by clicking the **SUBMIT** button or 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**