LAST: ______________________________
FIRST: ______________________________
MIDDLE: ______________________________
DOB: ________ / ________ / ______________

— NEW PATIENT PAPERWORK —

PATIENT REGISTRATION INFORMATION

Patient Name: Last ______________________ First ______________________ Middle______________

Social Security #: ______- ____ - ________ **Age:** ____ **Date of Birth:** ____ /____ /_________

Sex: O Male O Female **Language:** ______________________ **Marital Status:** ______________________

Race: ____________________________ **Ethnicity:** O Hispanic or Latino O 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?

O Bariatric Surgery O Metabolic Management Program (MMP) O Undecided

LAST: ____________________
FIRST: ____________________
MIDDLE: ____________________
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

LAST: ______________________
FIRST: ______________________
MIDDLE: ______________________
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
- 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:

____

____

____

THE CENTER FOR BARIATRICS AT BAILEY MEDICAL CENTER

LAST: ______________________________
FIRST: ______________________________
MIDDLE: ______________________________
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
- Daytime Drowsiness
- 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:

1. ______________________________
2. ______________________________
3. ______________________________

THE CENTER FOR BARIATRICS AT BAILEY MEDICAL CENTER

LAST: ______________________________
FIRST: ______________________________
MIDDLE: ______________________________
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

LAST: ______________________________
FIRST: ______________________________
MIDDLE: ______________________________
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

LAST: ______________________________
FIRST: ______________________________
MIDDLE: ______________________________
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 Nicotine? No Yes

If yes, What Type? Chew Cigarettes Cigars Pipes Vapes

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

LAST: ____________________
FIRST: ____________________
MIDDLE: ____________________
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: ____________________	______	______	______

LAST: ______________________________
FIRST: ______________________________
MIDDLE: ______________________________
DOB: ______ / ______ / ____________

Previous Sleep Study? Yes No

If yes, when and where:

____

Current use of CPAP? Yes No

If you have been previously dagnosed with Obstructive Sleep Apnea and instructed to use a CPAP do you use it daily as prescriped? 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

LAST: ______________________________
FIRST: ______________________________
MIDDLE: ______________________________
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 Resless 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

Now that your new patient paperwork is completed, please save the form. Once saved, email your completed paperwork to bariatrics@baileymedicalcenter.com or print and fax the completed paperwork to 918-550-6503.

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

BMI ________________

Neck circumference ________________ **inches**

utica park clinic
Oklahoma Heart Institute
SA SURGICAL ASSOCIATES
A Healing Connection Psychological Services PLLC