LAST: ______________________
FIRST: ______________________
MIDDLE: ______________________
DOB: ______ / ______ / ______

— NEW PATIENT PAPERWORK —

PATIENT REGISTRATION INFORMATION

Patient Name: Last ______________ First ______________ Middle ______________

Social Security #: _____- ___ - _____ **Age:** ____ **Date of Birth:** ____ /___ /_____ **Marital Status:**________

Gender at Birth: ○Male ○Female **Identifying as:** ○Male ○Female **Language:** ______________

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 baileymedicalcenter.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

LAST: ______________________
FIRST: ______________________
MIDDLE: ______________________
DOB: _______ / _______ / _______

GUARANTOR CONTACT

Patient Name: Last ______________ First ______________ Middle______________

Relationship to Patient: ______________________ **Sex:** OMale OFemale

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: OSelf OSpouse OChild

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: OSelf OSpouse OChild

Subscriber's Employer: ____

Subscriber's Address: ____

City: ______________ **State:** __________ **Zip Code:** __________

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

A Healing Connection
Psychological Services PLLC

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 ☐ 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

LAST: ______________________

FIRST: ______________________

MIDDLE: ______________________

DOB: ______ / ______ / ______

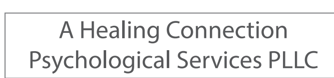
MEDICAL HISTORY CONTINUED

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
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			☐ 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 Surgery / ☐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:

____

____

SOCIAL HISTORY

Do You Use Nicotine? ☐No ☐Yes If yes, When Did You Last Use Nicotine?: ____________________

If yes, What Type? Chew Cigarettes Cigars Pipes Vapes

Per Day: __________ # of Years __________ If You Quit, When? ____________________

Do You Use Nicotine Gum or Patches? ☐ No ☐Yes **If yes, What Type?** Gum Patches

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?** __________

When did you last consume Alcohol? ____________________________________

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 have a Medical Marijuana card? ☐ 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: ______ / ______ / ______

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

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__________

☐ **Colon Disease**
☐ Mother ☐ Father ☐ Other__________

☐ **Kidney Disease**
☐ Mother ☐ Father ☐ Other__________

☐ **Hepatitis**
☐ Mother ☐ Father ☐ Other__________

☐ **Colitis**
☐ 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__________

☐ **Anxiety**
☐ Mother ☐ Father ☐ Other__________

☐ **Depression**
☐ Mother ☐ Father ☐ Other__________

☐ **Irritable Bowel System (IBS)**
☐ Mother ☐ Father ☐ Other__________

☐ **Colon Cancer**
☐ Mother ☐ Father ☐ Other__________

☐ **Other:** ______________________________

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: ______________________	______	________	__________

THE CENTER FOR BARIATRICS
AT BAILEY MEDICAL CENTER

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?

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**

35187 Rev 03/25