

Patient Registration and Medical History for Bariatric Surgery

Surgery Interest Gastric Band Gastric Bypass Gastric Sleeve Uncertain Other _____

PATIENT INFORMATION

Patient's Last Name	First	Middle	Preferred Name to be Addressed
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Social Security Number - -	Age	Patient Birth Date - -	Current Height	Current Weight	Current BMI
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Patient Former Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widow
	Ethnicity <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Native American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Other	

Primary Phone ()	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Other	Alternate Phone ()	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Other
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Patient Mailing Address	City	State	Zip
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Patient Email	Patient Occupation	Employer
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Email may be used for: Appointment Reminders Personal Correspondence HOAB Newsletter & Announcements E-bill (when available)

Emergency Contact Name	Emergency Contact Relationship	Emergency Contact Phone ()
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INSURANCE INFORMATION

PRIMARY Insurance Company	Subscriber ID Number	Group Number	Patient Relationship to Subscriber: <input type="checkbox"/> Self (skip to Secondary Insurance) <input type="checkbox"/> Spouse* <input type="checkbox"/> Child* <input type="checkbox"/> Other*
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*Subscriber Name	*Subscriber Birth Date - -	*Subscriber Social Security Number - -	*Subscriber Employer
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SECONDARY Insurance Company	Subscriber ID Number	Group Number	Patient Relationship to Subscriber: <input type="checkbox"/> Self (skip to next section) <input type="checkbox"/> Spouse* <input type="checkbox"/> Child* <input type="checkbox"/> Other*
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*Subscriber Name	*Subscriber Birth Date - -	*Subscriber Social Security Number - -	*Subscriber Employer
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REFERRAL SOURCE

How did you hear about our practice?	<input type="checkbox"/> Physician <input type="checkbox"/> Friend/Relative <input type="checkbox"/> Web <input type="checkbox"/> Social Media <input type="checkbox"/> Other
	Please Specify:

CONSENT TO RELEASE INFORMATION

The above information is true and complete to the best of my knowledge. I authorize my insurance benefits to be paid directly to Van Wagner, MD or Kumaran Chinnappan, MD for any services furnished to me by that provider. I understand that I am financially responsible for any balance due or if the procedure or service is a denied benefit. I understand that I am responsible to make sure that a referral for office visits are obtained prior to each visit and that the proper copayment is made at the time of each visit. I also authorize Van Wagner or Kumaran Chinnappan, in association with Heart of America Bariatrics, LLC, Surgery Specialists of Missouri, LLC, Arch Bariatrics, LLC or the insurance company to release any protected health information required to process payment, treatment, or other health care operations.

(patient signature)

(date)

PHYSICIAN INFORMATION (Please obtain full information of your Primary Care Physician)

Physician Last Name	First	M.I.	Degree MD DO	Physician Phone ()
Physician Address	City	State	Zip	Physician Fax ()
How long has he/she provided your care?				
Please list the name, phone, and specialty of other Health Care Professionals who treat you:				

PRE-OPERATIVE WEIGHT HISTORY

Please provide a weight history (in pounds).

2012	2013	2014	2015	2016	2017
lbs.	lbs.	lbs.	lbs.	lbs.	lbs.
What was your highest weight ever? lbs.	What age was your highest weight? yrs.	How much did you weight at 14 years of age? lbs.	At 18? lbs.	How many years have you been overweight? yrs.	
What was your lowest weight since you were 18 or older? lbs.	What age was that lowest weight? yrs.	How many years have you tried to lose weight? yrs.	How long have you been considering weight loss surgery?		

MEDICAL PROBLEMS RELATED TO OBESITY

CARDIOVASCULAR DISEASE	Current	Past	Never		Current	Past	Never
High Blood Pressure or Hypertension?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral Vascular Disease or Stroke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower Extremity Edema or Swelling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ischemic Heart Disease or Heart Attack?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leg Blood Clot or Pulmonary Embolus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anginal Chest Pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Stress Test or Heart Catheterization?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
METABOLIC DISEASE	Current	Past	Never		Current	Past	Never
Diabetes Mellitus Type 2 ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insulin Resistance or High Blood Sugar?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus Type 1 ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Elevated Cholesterol or Lipids?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gout or Hyperuricemia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PULMONARY DISEASE	Current	Past	Never		Current	Past	Never
Sleep Apnea?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Hypertension?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C-Pap or Bi-Pap use?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GASTROINTESTINAL DISEASE	Current	Past	Never		Current	Past	Never
Heartburn, Reflux or GERD?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease or Abnormal Liver Tests?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barrett's Esophagitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gallstones or Gallbladder Removal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease or Ulcerative Colitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus or Autoimmune Disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MUSCULOSKELETAL DISEASE	Current	Past	Never		Current	Past	Never
Back Pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain requiring Medical Treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hip, Knee, Joint, or Ankle Pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leg Pain requiring Medical Treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Back Surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
REPRODUCTIVE DISORDERS	Current	Past	Never		Current	Past	Never
Polycystic Ovarian Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Irregularities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infertility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a Hysterectomy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GENERAL	Current	Past	Never		Current	Past	Never
Urinary Stress Incontinence?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pseudotumor Cerebri?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess Abdominal Skin or Pannus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Hernia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous Weight Loss Surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Previous Ulcer or Reflux Surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PSYCHOSOCIAL INFORMATION – MARK ONLY ONE BOX FOR EACH QUESTION

Depression <input type="checkbox"/> No symptoms of depression <input type="checkbox"/> Mild and episodic, not requiring treatment <input type="checkbox"/> Moderate, accompanied by some impairment, may require treatment or medications <input type="checkbox"/> Moderate, with significant impairment, treatment indicated <input type="checkbox"/> Severe, definitely requiring intensive treatment <input type="checkbox"/> Severe, requiring hospitalization		Tobacco/E-cigarette Use <input type="checkbox"/> Never <input type="checkbox"/> Rare <input type="checkbox"/> Occasional <input type="checkbox"/> Frequent <input type="checkbox"/> No longer use – Date Quit: _____	
Confirmed Mental Health Diagnosis <input type="checkbox"/> None <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Anxiety/panic disorder <input type="checkbox"/> Personality Disorder <input type="checkbox"/> Psychosis or schizophrenia	Functional Status (ability to walk) <input type="checkbox"/> No impairment of functional status <input type="checkbox"/> Able to walk 200ft with cane or crutch <input type="checkbox"/> Cannot walk 200ft with cane or crutch <input type="checkbox"/> Requires wheelchair <input type="checkbox"/> Bedridden	Substance Abuse <input type="checkbox"/> None <input type="checkbox"/> Rare <input type="checkbox"/> Occasional <input type="checkbox"/> Frequent	Alcohol Use <input type="checkbox"/> None <input type="checkbox"/> Rare <input type="checkbox"/> Occasional <input type="checkbox"/> Frequent

MEDICAL HISTORY

List ANY OTHER medical problems (like cancer, diverticulitis, etc.) not found above.

FAMILY HISTORY OF MEDICAL PROBLEMS (parents, grandparents, siblings, aunts, uncles) – MARK ALL THAT APPLY

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cancer	<input type="checkbox"/> Stroke	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Unknown
<input type="checkbox"/> Heart Disease or Heart Attack	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Obesity	<input type="checkbox"/> Clotting Disorder	

PRESCRIPTION MEDICATIONS (attach separate list if necessary) -or- If not currently taking any prescription medications, check here

Name	Strength	Frequency	Purpose	When Started

NON-PRESCRIPTION MEDICATIONS AND VITAMINS CURRENTLY TAKING -or- If not currently taking any non-prescription medications, check here

Name	Strength	Frequency	Purpose	When Started

ALLERGIES TO MEDICATIONS, LATEX, OR OTHER SUBSTANCES -or- If no known allergies, check here

Allergic Substance Name	Reaction to Substance

LIST ANY SURGERY (Please write "Lap" if done Laparoscopically) -or- If no surgical history, check here

Surgery	Date	Reason