Mercy Bariatric Services
Registration

(Please PRINT and USE INK PEN)

Today's Date ____/____/____ Referred to our office by: _____ Phone Number: _____

PATIENT INFORMATION

Patient's Last Name First Middle		□ Mr. □ Miss □ Mrs. □ Ms.	Spouse Name		
Is this your legal name? □ Yes □No	If not, what is your legal Name?	(Former Name)	Birth Date / /	Age	Sex □ M □ F

Race (pick 1): □ African American □ Alaska Native □ Asian American □ Hispanic □ Pacific Islander □ White □ Not Specified

Social Security Number	Home Phone No.	Cell Phone No.	Work Phone No.
Street Address/P.O. Box	City	State	Zip Code

Email Address:	Employer	Address	□ Full Time □ Part-Time

Are you: □ Self-Employed? □ Homemaker? □ Retired? □ Disabled? (Reason:) □ Unemployed (looking for work)

Primary Care Physician (PCP): Last Name First Name	Phone No. ( )	Fax No. ( )
PCP Address: City State Zip Code		

INSURANCE INFORMATION (PLEASE PROVIDE COMPLETE INSURANCE INFORMATION)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Occupation	Employer	Employer Address	Employer Phone No. ( )

Primary Insurance	Secondary Insurance
Member Services Phone No. (Primary)	Member Services Phone No. (Secondary)
Subscriber's Name (Primary)	Subscriber's Name (Secondary)
Patient's Relationship to Subscriber: □ Self □ Spouse □ Child □ Other _____	Patient's Relationship to Subscriber: (Secondary) □ Self □ Spouse □ Child □ Other _____
Insurance ID No. (Primary)	Subscriber's Social Security No. or ID No. (Secondary)
Group No. (Primary)	Group No. (Secondary)

EMERGENCY CONTACT INFORMATION

Name of Local Friend or Relative (not living at the same address)	Relationship to Patient	Home Phone No.	Work Phone No.
		( )	( )
		( )	( )
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I have read the financial information included in the packet and understand that I am responsible for any portion not covered by insurance at the time of service and that all fees must be paid in full before surgery can be scheduled. I authorize Mercy NWA to contact my insurance company. I also authorize Mercy NWA Communities or Insurance companies to release any information required to process my claims.

_____ _____
Signature of Patient or Representative if Minor Date

Bariatric Surgical Weight Loss New Patient Form

Have you had a previous weight loss surgery?_____
If you answered "Yes" to previous surgery. We will need 3 years of past medical records, plus operative Report of surgical procedure before you can schedule an appointment.

How did you hear about us? : _____

Current Height: _____ Current Weight: _____

How many years have you been overweight: _____

What has been your highest weight: _____

Have you ever seen a doctor for weight loss: YES NO

If yes, please list the doctor, when, and for how long: _____

Have you ever seen a bariatric surgeon & enrolled in or had a consultation for bariatric surgery program? YES NO

If yes, please list the doctor, when, and for how long:_____

Which procedure do you want to pursue?

Laparoscopic Roux-en-Y Divided Gastric Bypass
Laparoscopic Sleeve Gastrectomy
Laparoscopic Adjustable Band
Medical Weight Loss Only

Diet History (Circle all that apply):				
Nutri-System	Medifast	ABS Diet	Blood Type Diet	Perricone Diet
Diet Center	Over Eaters Anonymous	Mediterranean Diet	Liquid Protein	Atkins Diet
Fit for Life	Gluten Free Diet	Zone Diet	Low Calorie Diet	Low Sugar Diet
Subway Diet	Vegan/Vegetarian Diet	Low Fat Diet	Exercise Videos	Herbal
High Protein	Cabbage Soup Diet	Grapefruit Diet	Jenny Craig	Fitness Centers
Magazine Diet	Self Imposed Fasting	Hypnosis	Body For Life	Belly Off Diet
South Beach Diet	TOPS	Weight Watchers	Eat This, Not That Diet	Flat Belly Diet
Detox Diet	Diabetic Diet	Juice Diet	DASH diet	Spark People Diet
Raw Food Diet	Ornish Diet	Paleolithic Diet	HCG Diet	
Sugar Busters		The Cookie Diet		

Prescription Drug Use (Circle all that apply):			
Phentermine	Phen-Fen (Adipex)	Xenical	Orlistat
Tenuate	Wellbutrin	Ritalin	Topomax
Amphetamine	Bontil	Didrex	Meridia
Qsymia		Belviq	

Over the Counter Medications (Circle all that apply):			
Dexatrim	Cortislin	Relecore	Lipozene
Hoodie	Hydroxycut	Leptopril	Stacker
Metabolife	Nanoslim	Trim Spa	Actislim
Zovetal	MuHaung	Alli	Green Tea Extract
Sensa			

Past Medical History (Circle all those that apply to your personal health and put a line through all those that do not apply to your personal health):

Diabetes: Age of Diagnosis:_____ Last A1C: _____% Any complications: _____

MI/Heart Attack Heart Disease Heart Failure Chest Pain with Activity

Heart Murmur Hypertension (High Blood Pressure) High cholesterol/lipids/triglycerides

Snoring Sleep Apnea Asthma Emphysema/COPD

Shortness of Breath GERD Heartburn Hiatal Hernia

Anemia Stroke/TIA Infertility Fibromyalgia

Poly Cystic Ovary Disease (PCOS) Psoriasis Rheumatoid arthritis

Deep Vein Thrombosis (blood clots in legs) Pulmonary Emboli (blood clot in lungs)

DJD/DDD (Degenerative Joint Disease) Back Pain/Problems Arthritis

Stress incontinence (lose urine while coughing)

Fatty liver disease NASH Hepatitis Cirrhosis

Please list **all** health conditions or hospitalizations you haven not previously addressed:

_____
_____
_____
_____

Past Surgery History (Please include all previous surgical procedures and approximate year):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Sleep History (Circle al that apply):

Morning headaches Insomnia Witnessed Apnea Excessive daytime sleepiness

Night terrors Sleep Apnea with CPAP/BiPAP Choking or gasping during sleep

Teeth Grinding

Use the following scale to choose the most appropriate number for each situation:

0 = would *never* doze or sleep. 1 = *slight* chance of dozing or sleeping 2 = *moderate* chance of dozing or sleeping 3 = *high* chance of dozing or sleeping **Situation:**	**Chance of Dozing or Sleeping**
Sitting and reading	____
Watching TV	____
Sitting inactive in a public place	____
Being a passenger in a motor vehicle for an hour or more	____
Lying down in the afternoon	____
Sitting and talking to someone	____
Sitting quietly after lunch (no alcohol)	____
Stopped for a few minutes in traffic while driving	____

Social History (Circle all that apply):
Do you chew tobacco: YES NO
Smoking History:

Current Smoke Non-smoker (never) Non-smoker (quit) _____Year: _____

How many years have you smoked: _____
How many packs per day to you smoke: _____
Are you exposed to secondhand smoke: YES NO
Alcohol Use: NONE OCCASIONAL REGULAR
(Avg. # of drinks per day)_____
(Avg. # of drinks per week)_____
Do you have a history of alcoholism: YES NO
Do you or have you used recreational drugs: YES NO
Methamphetamine Cocaine Narcotics Prescription Drugs Other:_____
Employed: YES NO Occupation:_____
Are you:
Unemployed Student Retired Disabled (If yes, Reason :_____)

Physical Limitations:

Climbing stairs Use of public seating Tying shoelaces Lifting objects from floor

Playing with children Caring for personal needs Unusual fatigue Airline travel

Family History (Circle all that apply):

Mother or Father: DVT's (blood clots in legs) PE's(blood clots in lungs)

Mother: Living: YES NO Diabetes Hypertension
Heart Disease Stroke Obesity
Cancer- (Type _____)

Father: Living: YES NO Diabetes Hypertension
Heart Disease Stroke Obesity
Cancer- (Type _____)

History of Psychological Health (Circle all that apply):

Bariatric Psychological Screening Done	Yes	No

Anxiety Depression Mania/Bipolar Post Traumatic Stress Disorder(PTSD)

Uncontrolled on Medication	Yes	No
History of suicide attempt	Yes	No
History of psychiatric hospitalizations in last two years	Yes	No
Reside in residential care facility	Yes	No
Disability due to diminished mental capacity	Yes	No
History of incarceration	Yes	No
History of medical non-compliance	Yes	No
Ultra-Morbid Obesity (BMI over 60)	Yes	No
Substance abuse in the past 10 years	Yes	No
History of Anorexia	Yes	No
History of Binging	Yes	No
If yes, please describe:_____		
Laxative Abuse	Yes	No
Induced Vomiting	Yes	No
History of Attention Deficit Disorder	Yes	No
Previous Bariatric Surgery	Yes	No
Consistent difficulty coping with major life changes	Yes	No
Thought Disorder-Schizophrenia psychosis (hallucinations)	Yes	No
Do you see a psychiatrist/psychologist/counselor or social worker regularly:	Yes	No

IF YES WHO:_____

Current Medications: (Please refer to your medication bottle for correct strength and dosing. Please list all vitamins last.)

Name of Medication	Strength (please circle or write in strength)	How many times per day do you take the medication?	Why do you take the medication?
_____	_____mg/mcg	_____per day	_____
_____	_____mg/mcg	_____per day	_____
_____	_____mg/mcg	_____per day	_____
_____	_____mg/mcg	_____per day	_____
_____	_____mg/mcg	_____per day	_____
_____	_____mg/mcg	_____per day	_____
_____	_____mg/mcg	_____per day	_____
_____	_____mg/mcg	_____per day	_____
_____	_____mg/mcg	_____per day	_____
_____	_____mg/mcg	_____per day	_____
_____	_____mg/mcg	_____per day	_____
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_____	_____mg/mcg	_____per day	_____
_____	_____mg/mcg	_____per day	_____
_____	_____mg/mcg	_____per day	_____
_____	_____mg/mcg	_____per day	_____
_____	_____mg/mcg	_____per day	_____

Allergies:

Drug Name	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Current Review of Systems:
(Circle all those that apply to your personal health and put a line through all those that do not apply to your personal health)

EXAMPLE:	**APPLIES**	~~**DOES NOT APPLY**~~

Constitutional
Fever Chills Sweats Weakness Fatigue
Decrease Activity Malaise Appetite Loss Night Sweats

Eyes
Recent Vision Problems Yellowing of the Eyes Discharge from the Eyes
Blurred Vision Double Vision Dry Eyes
Light Insensitivity Eye Pain Red Eye

ENT
Decreased Hearing Active Cavities Difficulty Swallowing
Ear Pain Grinding of Teeth Ringing in the Ears
Nasal Congestion Sinus Pain Sore Throat
Bloody Nose

Dentures
Upper Lower

Respiratory
Shortness of Breath Cough Sputum Production Snoring
Wheezing Stop Breathing While Sleeping
Coughing Blood Shortness of Breath on Exertion
Do You Prop Yourself Up While You Sleep? YES NO

Cardiovascular
Calf Pain: YES NO Chest Pain: YES NO
If yes, where: _____
Palpitations Slow Heartbeat Fast Heartbeat
Poor Exercise Tolerance Leg swelling Blackout
Varicose Veins

Breast
Breast Mass or Lumps: RIGHT OR LEFT
Nipple Discharge Pain Engorgement (Swelling)

Gastrointestinal
Nausea Vomiting Diarrhea Constipation
Heartburn Belching Bloating Difficulty Swallowing
Abdominal Pain: Where:_____ Severity: _____
Throwing up Blood Black Stools Blood in Stools Change in stool color
Hemorrhoids Rectal Pain Rectal Bleeding Jaundice

Do you have a history of any of the following?
Hepatitis A, B or C Inflammatory Bowel Disease
Crohn's Disease Ulcer colitis
Flushing Hyperglycemia Hypoglycemia
Celiac Sprue Fatty Liver Disease or NASH Cirrhosis

History of Immunological
Chemotherapy Steroid Use (Prednisone/Steroid Injections)
Immunocompromised Recurrent Fevers
Recurrent Infections Transplants:_____

Musculoskeletal	Back Pain:	Right	Left	Upper	Lower	Middle
		Mild	Moderate	Severe		
	Joint Paint:	Feet	Ankles	Knees	Hips	Shoulders
		Elbows	Wrists	Hands	Jaw	
	Muscle Pain/Fibromyalgia		Muscle Weakness		Joint Stiffness	
	Joint Swelling		Restless Leg Syndrome		Trauma:_____	
	Gait Disturbance:		Limp	Cane	Walker	Wheelchair
Skin	Rash	Itching	Skin Breakdown/Ulcers		Skin Lesions	
	Skin Cancer	Psoriasis	Other:_____			
Neurological	Abnormal Balance		Numbness	Tingling	Dizziness	Headaches
	Seizures		Tremor	Stroke	TIA	
Hematological/ Lymph	Anemia		Bruising Tendency		Bruising Bleeding	
	Lymphedema		Swollen Lymphnodes			
	History of Blood Transfusion (Year and Reason):_____					
Endocrine	Excessive Thirst		Excessive Urination		Cold Intolerance	
	Heat Intolerance		Hair Loss		Abnormal Hair Growth	
Genitourinary	Pain on Urination		Blood in Urine		Change in Urine Stream	
	Urethra Discharge		Erectile Dysfunction		Excessive Urination	
	Urination at Night: How many times_____				Pelvic Pain	
	Urinary Frequency		Urinary Hesitancy		Urinary Incontinence	
	Urinary Retention		Urinary Urgency		Testicular Pain	
Ob/GYN	Heavy Periods		Prolonged Periods		Painful Periods	
	Irregular Periods		Painful Intercourse		Frequent Yeast	
	Infections		Abnormal Bleeding		Abnormal Discharge	

Medical Records:

☐ All Medical Records are Mercy Provider Records

☐ Some Medical Records are Mercy Provider Records

☐ Is this a Mercy Provider Outside of Arkansas?

- If so where_____

☐ Medical Records with NON-Mercy Provider

- _____