Patient Health History Questionnaire

Bariatric Partners of Oklahoma

The information requested in this questionnaire is very important in order to give you the best care, and to obtain your insurance approval. Please be thorough and answer questions completely.
Blue or black ink only, please.

Name:		Date of Birth
Age:	Gender: male female	Best contact phone number:

How did you hear about Bariatric Partners of Oklahoma/Dr. Le?

Referring Provider:

Primary Care Physician: PCP Phone Number:

Primary Pharmacy: Pharmacy Phone Number:

WEIGHT HISTORY

What has been your heaviest weight?__________lbs.

What is the least you have ever weighed as an adult? __________lbs When? __________

In your own words, please describe what you hope to accomplish, and how you believe your life will be changed by losing weight: ____

____

____

____

Who will support you during and after your surgical weight loss procedure? ________________________________

____

DIETARY HISTORY

Approximate age you first seriously started dieting: __________

Please identify the diets and diet programs you have tried, if any:

Program	Yes	No	Dates	Duration	MD supervised	Max Loss
Jenny Craig						
Nutri-Systems						
Weight Watchers						
OptiFast						
Medi Fast						
Fen/Phen						
Phentermine						
Meridia						
Atkins Diet						
O.A.						
Metabolife						
Self Created Diet						
Other						

Eating Habits: ___ Sweets ___ Salty snacks ___ Skipping meals ___ Portion Control

Present or past history of eating disorders?

Anorexia- fear of weight gain leading to malnutrition and ususally excessive weight loss ___ Yes ___ No
Bulemia- overeating followed by vomiting, laxative/diuretic abuse and/or excessive exercise ___ Yes ___ No
Binge Eating Disorder- consuming a large quantity of food in a short period of time ___ Yes ___ No
Night Eating Disorder- eating very late at night, waking up in the middle of the night to eat. ___ Yes ___ No

If you answered YES to any of the above:

Have you been in treatment for the disorder? ___ Yes ___ No
Do you believe you still have problems with the disorder? ___ Yes ___ No

List any other diets and/or weight loss methods you've tried: ____
____
____
Who does the grocery shopping at home? ____
Who does the cooking at home? ____
How many meals do you eat per day? ____
How many meals do you eat outside the home, **per week**? ____
Do you like/prefer carbohydrates (starches and sweets) over other foods? ___________________________________

MEDICATIONS; PRESCRIPTIONS, OVER THE COUNTER, AND HERBAL

Medication	Strength	Frequency
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		

MEDICATION ALLERGIES

Name of Medication	Type of Reaction
1)	
2)	
3)	
4)	
5)	

Are you allergic to Latex? ___Yes
___No

Are you allergic to Iodine? ___Yes
___No

Are you allergic to surgical tape? ___Yes
___No

MEDICAL HISTORY

Medical Condition	Current	Past	Medical Condition	Current	Past
AIDS			Hemorrhoids		
Alcohol Abuse			Hepatitis A		
Allergies (Seasonal)			Hepatitis B		
Angina			Hepatitis C		
Anxiety			Hernia		
Arthritis			High Blood Pressure		
Asthma			High Cholesterol		
Bleeding Abnormality			High Triglycerides		
Blood Clots			Incontinence		
Bronchitis			Infertility		
Cancer			Irreguar Menses/Periods		
Chronic Cough			Irritable Bowel Syndrome		
Colitis			Kidney Disease		
Crohn's Disease			Kidney Stones		
Deep Vein Thrombosis			Liver Diease		
Depression			Lower Back Bain		
Diabetes I			Lung Disease		
Diabetes II			Mental Illness		
Diverticulitis			MI/Heart Attack		
Emphysema			Neuropathy		
Endometriosis			Plantar Fasciitis		
Epilepsy			Polycystic Ovarian Syndrome		
Fatty Liver			Pulmonary Embolus		
Gallbladder Disease			Rheumatic Fever		
Gestational Diabetes			Shortness of breath		
Gout			Sleep Apnea		
Heart Disease			Stomach Ulcer		
Heart Palpitations			Stroke		
Heart Murmur			Thyroid Problems		
			Venous Stasis Disease		

SURGICAL HISTORY

Check if you have had no prior surgeries. ________

Type of Surgery	Date of Surgery
1)	
2)	
3)	
4)	
5)	
6)	
7)	
8)	
9)	
10)	

FAMILY HISTORY

Additional Family History: (check the ones that apply)

Disease/Problem	**Relationship to patient**
___ Obesity	______
___ Diabetes	______
___ High Blood Pressure	______
___ Heart Disease	______
___ High Cholesterol	______
___ Stroke	______
___ Gallbladder Problems	______
___ Polycystic Ovary Syndrome	______
___ Lung disease Please explain:	______
___ Kidney Disease	______
___ Bleeding tendency/Blood Disorder	______
___ Breast Cancer	______
___ Colon Cancer	______
___ Liver Disease	______
___ Thyroid Disease	______
___ Stomach Cancer	______
___ Esophageal Cancer	______
___ Pancreatic Cancer	______

SOCIAL HISTORY

Marital Status (circle one): Single Engaged Married Partner Separated Divorced Widowed/Widower

Spouse/Partners name: ______

Religious Denomination: ______

Occupation: If retired, what did you do? ______

History of Tobacco use: ___ **Never Smoked**

___ **Current Smoker** Are you willing to quit? ___ Yes ___ No

Year Started: _________

Packs/day: __________

___ **Former Smoker**

Year Started: ________________

Year Quit: ___________________

Packs/day: __________________

___ **Smokeless Tobacco** ___Yes ___No If yes, what product: ______ When did you start: ______

Do you use alcohol? ___Yes ___No If yes, how often: ______ Type of alcohol: ______

Do you currently use recreational drugs? ___Yes ___No

Have you ever been treated for narcotic dependency? ___Yes ___No

REVIEW OF SYSTEMS

Please check all symptoms you are currently experiencing, or have experienced in the past year.

HEAD, EYE, EAR, NOSE & THROAT:

___nasal discharge
___hay fever
___sinus trouble
___earache
___headache
___blurry vision
___double vision
___vision halos
___difficulty seeing at night
___ringing in ears
___discharge from ears
___loss of hearing
___dizziness
___vertigo (spinning dizziness)
___difficulty with balance
___sore throat
___lump in throat
___difficulty swallowing (dysphagia)
___pain with swallowing
___hoarseness
___NONE OF THE ABOVE

RESPIRATORY:

___wheezing
___emphysema
___bronchitis
___cough
___spitting/coughing up blood
___use of two or more pillows at night
___out of breath with exertion
___shortness of breath
___wake up at night short of breath
___NONE OF THE ABOVE

CARDIOVASCULAR:

___palpitations
___pounding heartbeat
___skipping heartbeat
___chest pain or discomfort
___history of heart attack
___abnormal EKG/ECG
___high blood pressure
___pain in legs
___NONE OF THE ABOVE

GASTROINTESTINAL:

___heartburn
___nausea
___vomiting
___choking on food
___food sticking in chest
___burning in stomach
___diarrhea
___constipation
___pain with bowel movement
___blood in stools
___hemorrhoids
___fissures
___gassiness
___frequent bowel movements
___NONE OF THE ABOVE

GENITOURINARY:

___pain with urination
___changes in urinary habits
___small urine stream
___blood in urine
___kidney stones
___bladder stones
___kidney failure
___nephritis
___urinary tract infection
___frequent urination
___getting up at night to urinate
___NONE OF THE ABOVE

ENDOCRINE:

___hypothyroid
___hyperthyroid
___goiter
___diabetes
___adrenal gland tumor
___frequent flushing
___frequent heavy sweating
___NONE OF THE ABOVE

MUSCULOSKELETAL:

___pain in joints
___swelling of joints
___broken bones
___sprains
___herniated disc
___limited joint motion
___NONE OF THE ABOVE

NEUROLOGICAL:

___numbness
___tingling
___weakness of any muscles
___twitching of muscles
___fainting
___convulsions
___NONE OF THE ABOVE

PSYCHOLOGICAL:

___nervousness
___anxiety
___depression
___thoughts of suicide
___suicide attempts
___hospitalization for emotional problem
___psychiatric treatment
___psychological counseling
___memory problems
___mood changes
___NONE OF THE ABOVE

REPRODUCTIVE: (females)

___premenstrual mood swings
___ taking birth control
___hormone replacement therapy
___history of ovarian cyst(s)
___menopause
___abnormal pap smear
___abnormal mammogram
___NONE OF THE ABOVE

ACTIVITY/EXERCISE

To what extent do you enjoy activity/exercise? (circle one) Not at all Slightly Moderately Greatly

Area/Methods Utilized: (check the ones that apply)

___ Health Club ___ Home ___ Outdoors ___ Pool ___ Walking ___ Jogging
___ Other: ____

Current method of exercise: (check the ones that apply)

___ No current method of exercise

___ Resistance/Weight Training
Duration per day: _____________

___ Aerobic/Endurance/Cardio Training
Frequency per week: _______________

SLEEP HISTORY

Have you been diagnosed with sleep apnea syndrome?

___Yes
___No

If yes, year diagnosed: __________________________
Date of last sleep study? ________________________
Do you use a CPAP? ____________________________
If yes, what is your CPAP setting? _______________

Do you have or have you ever had: (check the ones that apply)

___morning headaches ___awakening at night
___restless sleep ___ trouble sleeping

OFFICE USE ONLY	Yes
1. Snoring	
2. Tired	
3. Observed Apnea	
4. HTN/Tx	
5. BMI/35	
6. Age/50	
7. Neck Circum. 16"	
8. Gender/Male	

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)? ___Yes ___No

Do you often feel tired, fatigued, or sleepy during the day? ___Yes ___No

Has anyone observed you stop breathing during your sleep? ___Yes ___No

The above information is true and correct to the best of my knowledge. I understand that the accuracy of the information provided is important, and may affect my medical outcome.

____ ___________________________
Printed name Date

____

BARIATRIC PARTNERS OF OKLAHOMA
PATIENT INFORMATION

Pharmacy Name_______________________________________

Date ____________________ Pharmacy Location____________________________________

Patient Name ____

First Middle Last

Mailing Address ____

City _______________________ State ______ Zip _____________ Email ___________________________

Preferred Phone: ________________________________ Other Phone _______________________________

Birthdate __________________ SSN ________________________ Single Married Widowed Divorced

Age ________ Sex ________ Race __________________ Primary Language ____________________

Employed by ____ Work Phone _____________________

Referred by ____

Do you have an Advanced Directive (Yes/No) __________ If yes, on file with __________________________

Spouse ______________________________ if under 18, Parent ____________________________________

EMERGENCY CONTACT (OUTSIDE THE HOME)

Name ______________________________________ Relationship to patient __________________________

Phone number _______________________________

Please complete below if insured and/or responsible party is DIFFERENT than patient

PERSON RESPONSIBLE FOR BILL **(IF DIFFERENT THAN PATIENT)**

Name ______________________________________ Relationship to patient __________________________

Birthdate __________________ SSN ________________________ Phone __________________________

Mailing Address ____

City ________________________________ State _________________________ Zip _________________

MEDICAL INSURANCE INFORMATION **(IF NO CARD OR PATIENT IS NOT SUBSCRIBER)**

Medical Insurance Carrier ____

ID # __________________________ Group # _________________ Employer________________________

Name of insured (if different than patient) ____

Patient relationship to insured _______________ Insured Sex ______

Insured birthdate ________________ Insured SSN ________________

BARIATRIC PARTNERS OF OKLAHOMA
SURGICAL PARTNERS OF OKLAHOMA
BRADY HAGOOD, M.D. STEPHANIE TAYLOR, M.D.
HAMILTON LE, M.D.

RELEASE OF INFORMATION

(We cannot file insurance without a copy of your insurance card(s) for verification of coverage.)

I hereby authorize my physician to furnish my insurance company or its representative or permit my insurance company or its representative to review any information requested with respect to any illness or accident, medical history or copies of hospital and medical records. A copy of this authorization shall be considered as valid as the original document. I hereby authorize payment directly to my physician for this illness or injury, for the physician's benefits otherwise payable to me, but not to exceed my indebtedness to said physician. I agree to pay the physician for all my charges whether or not covered by the assignment. The responsible party hereby agrees that the physician office or the party responsible for the billing of these services may check credit with a source to obtain credit information. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services. This release may include information about a medical condition that is considered a communicable venereal disease, including, but not limited to diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS). I understand all of the above and hereby state all the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant the request of authorizations. I have been notified that I may receive services from the Nurse Practitioner or Medical Assistance at this office.

Patient or Authorized Person Signature ___________________________________ Date _________________

HIPAA CONSENT

I, ____ (patient or authorized person), give permission to Surgical Partners of Oklahoma and/or staff to leave information pertaining to my health including, but not limited to, dates and times of appointments, lab/x-ray results and other information as they feel necessary, on my answering machine and/or e-mail. I understand this could result in unintentional disclosure of my personal health information

Patient or Authorized Person Signature ___________________________________ Date _________________

If you have any objections to the above, please list ____

I also give permission to Surgical Partners of Oklahoma and/or staff to discuss my health conditions with the following people: (examples: spouse, parent, children, sibling)

Person ____ Relationship _______________________

Person ____ Relationship _______________________

Person ____ Relationship _______________________

Person ____ Relationship _______________________

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices posted in our facility describes how Surgical Partners of Oklahoma may use and disclose your medical information and how you can get access to this information. Please review it carefully.

A complete copy of the Facility's Notice of Privacy Practices is posted in the office. By signing below, you acknowledge the Facility's Notice of Privacy Practices has been made available to you and a copy will be provided to you at your request.

Patient or Authorized Person Signature ___________________________________ Date _________________

If authorized person, relationship to patient _____________________________

SURGERY OPIOID CONSENT FORM

Patient Name:	**Date of Birth:**
The doctor may prescribe Opioids to control and manage post-surgical pain.	
Alternative options to opioids are Over the counter pain medications such as Tylenol, Advil, Excedrin.	

Instructions: *Please review the information listed below and put your initials next to each item when you feel you understand and accept what each statement says.*

	Initials
My surgeon will prescribe an opioid medication to help me control and manage post-surgical pain.	
This medicine is used to decrease and manage my pain but will not take away my pain completely.	
I will stop using the opioid medicine as soon as my pain is manageable and will use over the counter pain relievers if possible to manage the pain.	
I will contact my provider if the medicine does not control my pain when I take it as prescribed or if I have any adverse reactions to it.	
I will follow-up with my provider for post-surgical consultations as instructed or requested by my provider.	
If I do not use all of the medicine prescribed, I will ensure that it is disposed of properly in order to prevent its misuse by someone else.	
I will safely store the medicine to minimize the risk that children or other people will take it.	
When I take this medicine it may not be safe for me to drive a car, operate machinery, or take care of other people. If I feel sedated, confused, or otherwise impaired by these medications, I should not do things that would put other people at risk for being injured.	
When I take this medication, I may experience certain reactions or side effects that could be dangerous, including sleepiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing of my breathing.	
I may become physically or psychologically dependent or addicted to this medicine if I take them continuously so I agree to stop using them at the earliest possible time and to take no more than is necessary to control my pain.	
I have told my provider if I or anyone in my family has had any problems with mental illness or with controlling drug or alcohol use in the past.	
Taking too much of my pain medication, or mixing my pain medications with drugs, alcohol, psychiatric medicine, or other medications that cause sleepiness, such as benzodiazepines, barbiturates, and other sleep aids, could cause me to be dangerously sedated or to overdose and stop breathing.	
It is my responsibility to tell any provider that is treating me or prescribing me medications that I am taking opioid pain medications so that they can treat me safely and do not give me any medicines that may interact dangerously with my pain medicines.	
I will not use any illegal substance, such as cocaine, etc., while taking this medicine.	
If I travel out of the country while taking this medicine, I will notify the appropriate travel authority (usually the consulate website of the country) and obtain a note from my provider before travel, as traveling out of country with opioids may pose problems.	
For females: I understand it is my responsibility to inform my provider if I am pregnant.	

Signature of patient or guardian	**Date**
Printed name of patient or guardian:	

DISCLOSURE OF PHYSICIAN OWNERSHIP
NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

As a prospective patient of Community Hospital or Northwest Surgical Hospital, we are pleased to inform you of the following:

1. Dr. Stephanie Taylor and Dr. Brady Hagood have an ownership interest in Community Hospital and Northwest Surgical Hospital.

2. In addition, other physicians that may treat you at the hospital may have an ownership interest in the hospital.

3. You have the right to choose the provider of your health care services. Therefore, you have the option to use a healthcare facility other than Community Hospital or Northwest Surgical Hospital. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask your physician or any representative of Community Hospital or Northwest Surgical Hospital. For a full list of our physician owners and additional information about our healthcare facilities, please visit our website at communityhospitalokc.com or nwsurgicalokc.com.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Community Hospital and Northwest Surgical Hospital.

______________________________	______________________________
Signature of Patient	Signature of Parent or Guardian (if applicable)
______________________________	______________________________
Print Name of Patient	Print Name of Parent or Guardian

Dated:________________________