Baptist Health Medical Group Floyd Bariatrics
Medical Weight Management New Patient Information Packet

Patient Demographic Information

First Name: ___________________ Last Name: ___________________ Date of Birth: ___________

SSN: _________________________ Marital Status: _________________________ Sex: _________

Ethnicity: _____________________ Race: _________ Email: ______________________________

Mobile Phone: _________________________ Home Phone: ___________________________

Address: ____

City: _________________________ State: _________________________ Zip: ________________

Height: ______________________ Weight: ________________________ BMI: _______________

Please list any special accommodations you may require: ________________________________

Do you use a: ____ Cane ____ Walker ____ Wheelchair ____ Other gait assistive device

Do you have a healthcare companion or caretaker: ____ Yes ____ No

Do you have a medical surrogate, power of attorney, or other representative to make medical decisions for you: ____ Yes ____ No If Yes, who: _____________________________________

Do you have a living will: ____ Yes ____ No

Emergency Contact Information

First Name: __________________________ Last Name: _________________________________

Phone: ______________________________ Relationship to Patient: ________________________

Name: ___________________________________ Date of Birth: ___________________

Employment Information

Employment status (please circle):

Full Time	Part Time	Self-Employed
Homemaker	Retired	Disabled
Leave of absence	Unemployed	Student

Employer: ________________________ Years employed: _______ Occupation: _______________

Insurance Information (Must submit a copy of each insurance card along with this packet)

Primary

Insurance Company: ____

Member ID: ___________________________ Group number: ___________________________

Subscriber name: ______________________ Subscriber Date of Birth: ____________________

Secondary

Insurance Company: ____

Member ID: ___________________________ Group number: ___________________________

Subscriber name: ______________________ Subscriber Date of Birth: ____________________

Prescription Identification Card Information (If applicable)

Prescription Card Company: ____

RxBIN: ____________ RxGRP: ____________ RxPCN: ____________ Issuer: ________________

Member ID: ____

Provider Information

Primary Care Provider: __________________________________ Phone: _____________________

Street Address: ____

City: ____________________________ State: _____________________ Zip: __________________

Name: ___________________________________ Date of Birth: ___________________

Do you currently see any specialty providers? If yes, please list them below.

Provider	Specialty	Phone Number

<u>Medical History Review/Review of Symptoms</u> (Please circle all that apply):

Asthma	Angina	Anemia	Arthritis
Blood Transfusion	Cancer	Cirrhosis	Colitis
Diabetes/Prediabetes	Diverticulosis	Emphysema	Epilepsy
Glaucoma	Heart Murmur	Heart Attack	High Blood Pressure
Hepatitis	Kidney stones	Pancreatitis	Blood Clotting disorder
TB	Rheumatic Fever	Sleep Apnea	Stroke
Thrombophlebitis	Thyroid disease	Ulcers	Constipation
Small bowel obstruction	IBS/IBD	Lupus	PCOS
GOUT	DVT/PE	Endocrine gland tumor	Alcoholism
Substance abuse	Depression	Anxiety	

Other: ____

____

____

Do you or any member of your immediate family have a history of medullary thyroid cancer?

Yes ____ No ____

Do you or any member of your immediate family have a history of multiple endocrine neoplasia type 2?

Yes ____ No ____

Name: ___________________________________ Date of Birth: ___________________

Gynecological:

Are you currently pregnant? Yes ____ No ____

Are you currently trying to conceive? Yes ____ No ____

Are you currently breastfeeding? Yes ____ No ____

Current form of contraception? ____

<u>Surgical history</u> (Please circle all that apply):

Gallbladder	Appendectomy	Hernia Repair	Colon Resection
Heart Surgery	Nissen Fundoplication	Bariatric Surgery	

<u>Weight loss history</u>

How long have you been overweight? ________ years

How long have you been overweight? ________ years

How many serious weight-loss attempts have you made in the past 5 years? 0 1 2 3 4+

What are some barriers that have kept you from losing weight and maintaining weight loss in the past? (e.g., nutritional choices, no time for exercise, health issues) ____________________

____

What is the most weight you've ever lost? ________ pounds

How long did you sustain the weight loss? ____

Was there one program or weight loss attempt that seemed to work best for you? __________

____

Unsupervised Diet Attempts (Please circle all that apply)**:**

None	Richard Simmons	Health Spa	High Protein
HerbaLife	Sugar Busters	Low Carbohydrate	Low Fat
Mayo Clinic	Calorie Counting	Atkins Diet	South Beach
Cabbage Soup	Fasting	Slim Fast	Other:____________

Name: ___________________________________ Date of Birth: ___________________

Supervised Diet Attempts (Please circle all that apply)**:**

None	Nutrisystems	LA Weight Loss
Overeaters Anonymous	Diet Center	Weight Watchers
HMR	Jenny Craig	DASH

Other:__________________

Over the Counter or Prescribed Medications for Weight Loss (Please circle all that apply)**:**

None	Wellbutrin	Xenical	Fen-phen
Dexatrim	Amphetamines	Diuretics	Phentermine/Adipex
Wegovy	Saxenda	Contave	Qsymia

Other:_____________

Behavior Treatments for Weight Loss (Please circle all that apply)**:**

None	Hospitalization
Physical Therapy	Hypnosis
Psychological Therapy	Residential Program

Other:_________________________________

Exercise (Please circle all that apply)**:**

None	Walking/Running	Stationary Bike/Treadmill
Swimming	Team Sports	Weight Training

Other:___________________

Name: ___________________________________ Date of Birth: ___________________

Please tell us how your weight is interfering with your health and life? ____________________

____

If you use eating as an emotional outlet, what will you substitute when your eating is restricted? ____

____

What are your weight-management goals?

Short- term goal(s): ____

Long-term goal(s): ____

<u>Medication Information</u>

List Prescribed Medications and Over the Counter Medications, Supplements and Vitamins:

Medication:	**Taken for What Condition?**	**Dosage/How Often?**

Name: ____________________________________ Date of Birth: ____________________

Pharmacy Information

Current Pharmacy: ____

Address:____

Phone Number:____

Allergies

List any food or medications that you are allergic to and your reaction below.

____

____

____

Name of person completing packet: ____

Relationship to patient: ____

Signature of person completing packet: ____

Signature of patient: ____

Thank you for taking the time to complete our new patient information packet. Please return this packet and a copy of your insurance card(s) front and back to:

Baptist Health Medical Group Floyd Bariatrics
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