Baptist Health Medical Group Weight Management
Select your preferred office.

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Lexington, KY 40509

❑627 Comanche Trail
Frankfort KY, 40601

Phone | 859.639.2060
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BAPTIST HEALTH®
MEDICAL GROUP

NEW PATIENT INFORMATION

Please print legibly.

Name: ______________________________ Date of birth: __________ SSN: __________________________
Home address: ____
City: ________________ State: _____ ZIP code: _______________
Email address: _____________________________

Please indicate which phone number you would like for us to use as your primary number.
❑Home: _______________________ ❑Work:_______________________ ❑Cell:______________________

Primary care physician: _____________________________ Phone:______________________
Pharmacy name:_____________________________ Location:_____________________________
Phone:______________________

Employer name:_____________________________ Phone:______________________
Occupation: _______________________________ Do you have Medicare? ❑Yes ❑No

Emergency contact: _____________________________ Phone:______________________
Relationship: ___________________________________

List your physicians and specialists other than your primary care provider, ex. Dr. Hart, cardiologist.

1.	4.
2.	5.
3.	6.

How did you hear about our clinic?

❑Radio station:_____________
❑TV station:________________
❑Social media:______________
❑Newspaper:_______________
❑Magazine:________________
❑Mailing to my house

❑Former bariatric surgery patient
❑*Patient of Paige Quintero, MD*
❑*Patient of G. Derek Weiss, MD*
❑Other surgeon (name):______________________________
❑Family/friend (name):_____________________________________
❑Physician (name):____

Patient name: ____

PAST MEDICAL HISTORY

Do you have or have you ever had any of the following diagnoses? Check box if yes.

❑Anorexia nervosa
❑Bipolar disorder
❑Bulimia nervosa
❑Binge-eating disorder
❑Gallstones
❑Abnormal ECG/EKG
❑Alcoholism
❑Anemia
❑Asthma
❑Bleeding disorder
❑Blood transfusion
❑Cancer
❑Congestive heart failure
❑Cirrhosis of the liver
❑Kidney stones
❑Arthritis
❑Contraception
❑Thyroid cancer
❑Elevated cholesterol
❑Cushing syndrome
❑Depression
❑Fatty liver
❑Gastric reflux (GERD)
❑Blood clotting disorder
❑COPD
❑Coronary artery disease
❑Deep vein thrombosis
❑Diabetes mellitus
❑Hepatitis
❑HIV/AIDS
❑Kidney disease
❑Pancreatitis
❑Gestational diabetes
❑Glaucoma
❑Gallbladder removal
❑Sleep apnea
❑Thyroid disease
❑Stomach ulcers
❑Low vitamin D
❑Liver disease
❑Heart attack
❑Hypertension
❑Pulmonary arterial hypertension
❑Seizures
❑Sickle cell anemia
❑Stroke
❑Substance abuse
❑Transient ischemic attack
❑Prediabetes
❑Chronic pain
❑Heart disease
❑Hysterectomy
❑Polycystic ovaries (PCOS)

Past surgeries/hospitalizations

Surgery/reason for hospitalization	Surgeon	Date
1.		
2.		
3.		
4.		
5.		
6.		

Patient name: ______________________________

Are you currently experiencing any of the following? Check box if yes.

- ❑Weight gain
- ❑Fatigue
- ❑Throat swelling
- ❑Trouble swallowing
- ❑Snoring
- ❑Shortness of breath
- ❑Wheezing
- ❑Chest pain
- ❑Leg swelling
- ❑Palpitations
- ❑Sleep disturbance
- ❑Self-injury
- ❑Abdominal pain
- ❑Constipation
- ❑Diarrhea
- ❑GERD
- ❑Indigestion
- ❑Nausea
- ❑Cold intolerance
- ❑Heat intolerance
- ❑Excessive thirst
- ❑Excessive hunger
- ❑Excessive urination
- ❑Suicidal ideas
- ❑Menstrual irregularities
- ❑Exercise limitations
- ❑Chronic pain
- ❑Joint stiffness
- ❑Acne
- ❑Dry skin
- ❑Numbness/tingling
- ❑Headaches
- ❑Memory problem
- ❑Depressed mood
- ❑Nervousness/anxiety
- ❑None of the above

FAMILY HISTORY

Indicate if any family members have had the following diagnoses.

	No known problems	Lung cancer	Cancer (indicate form)	Depression	Hypertension	Heart disease
Father						
Mother						
Sister(s)						
Brother(s)						
Daughter						
Son						
Maternal uncle						
Maternal aunt						
Paternal uncle						
Paternal aunt						
Maternal grandmother						
Maternal grandfather						
Paternal grandmother						
Paternal grandfather						
Other						

Patient name: ______________________________

FAMILY HISTORY

Continued

Indicate if any family members have had the following diagnoses.

	Obesity	Sleep apnea	Arthritis	Diabetes	Other condition (list)
Father					
Mother					
Sister(s)					
Brother(s)					
Daughter					
Son					
Maternal uncle					
Maternal aunt					
Paternal uncle					
Paternal aunt					
Maternal grandmother					
Maternal grandfather					
Paternal grandmother					
Paternal grandfather					
Other					

CURRENT MEDICATIONS

Drug allergies ❑Yes ❑No If yes, please list: ______________________________

List any medications you are currently taking, including prescriptions, over the counter, vitamins and supplements.

Name of drug	Dose (strength and frequency)	How long taking?
1.		
2.		
3.		
4.		
5.		
6.		

Patient name: ____

TOBACCO/DRUG USE

Do you smoke? ❑Yes ❑No If yes, how many per day? ______ If yes, what age did you start? ______
If you used to smoke, when did you quit? _____________
Do you use smokeless tobacco? ❑Yes ❑No Do you use any CBD products or marijuana? ❑Yes ❑No

ALCOHOL USE

Check yes or no.

1. Have you ever felt you should cut down on your alcohol consumption? ❑Yes ❑No
2. Have people annoyed you by criticizing your alcohol consumption? ❑Yes ❑No
3. Have you ever felt bad or guilty about your alcohol consumption? ❑Yes ❑No
4. Have you ever had an alcoholic beverage first thing in the morning to steady your nerves or get rid of a hangover? ❑Yes ❑No

EXERCISE

Frequency	Intensity	Duration
❑None	❑None	❑None
❑1 to 2 times/week	❑Light (brisk walking, golfing, doubles tennis)	❑Under 10 minutes
❑3 to 5 times/week	❑Moderate (biking, low-impact aerobics)	❑10 to 20 minutes
❑Daily	❑Moderately hard (running, aerobics, hockey)	❑Over 30 minutes

Comments: ____

____

LIFESTYLE CHALLENGES

Check the items that you feel interfere with your weight loss efforts.

❑Lack of time for planning and self
❑Comfort/stress eating
❑Enjoyment of food
❑Social events
❑Skipping meals
❑Eating late/waking up to eat
❑Liquid calories such as alcohol
❑Specific food cravings, like carbohydrates
❑Mindless eating/eating habits
❑Portion sizes
❑Eating too fast
❑Always hungry
❑Boredom eating
❑Too little protein
❑Poor sleep

Are you ready for lifestyle changes to be a part of your weight-control program? ❑Yes ❑No
If yes, rate on a scale of 1 to 10 (1 being ready, 10 being extremely ready).
Check box: ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Are you willing to keep a food journal? ❑Yes ❑No

Do you make yourself sick because you feel uncomfortably full? ❑Yes ❑No
Do you worry you have lost control over how much you eat? ❑Yes ❑No
Have you recently lost more than 15 pounds in a three-month period? ❑Yes ❑No
Do you believe yourself to be fat when others say you are too thin? ❑Yes ❑No
Would you say that food dominates your life? ❑Yes ❑No

Patient name: ____

Which of the following would help you on your weight-loss journey?

❑Learning how to eat “real food” and being able to make my own healthy choices
❑Food delivered to my door and then eat just that food
❑A program with mainly protein shakes/bars and one sensible dinner
❑Evaluation for an eating disorder
❑Medication to treat obesity
❑Exercise counseling
❑What I really need is: ____

PREVIOUS WEIGHT-LOSS MEDICATIONS

Please indicate which weight-loss medications you have used in the past, when you were on it, why you stopped it, and whether a prior authorization was attempted by the ordering physician. Mark only medications that you have used or were prescribed and denied by your insurance.

Medication	Dates used or prescribed if denied by insurance	Reason discontinued/results	Was prior authorization attempted?
Contrave® (naltrexone/ bupropion)			❑Yes ❑No
Diethylpropion			❑Yes ❑No
Phentermine (Adipex-P, Lomaira)			❑Yes ❑No
Orlistat (alli®, Xenical)			❑Yes ❑No
Qsymia			❑Yes ❑No
Rybelsus®			❑Yes ❑No
Saxenda			❑Yes ❑No
Topimate® (topiramate)			❑Yes ❑No
Wegovy®			❑Yes ❑No
Zepbound™			❑Yes ❑No

Patient name: ________________________________

Are you diabetic? ❑Yes ❑No
If yes, have you ever been prescribed any of the following medications?

Medication	Used this medication	Dates used	Reason discontinued
Metformin	❑Yes ❑No		
Mounjaro™	❑Yes ❑No		
Ozempic®	❑Yes ❑No		
Trulicity®	❑Yes ❑No		
Victoza®	❑Yes ❑No		

Have you tried any over-the-counter weight-loss products? ❑Yes ❑No
If yes, what have you tried?

____
____
____
____

PREVIOUS WEIGHT-LOSS PROGRAM HISTORY

What weight-loss program have you tried in the past? ________________________________
Did you experience any problems with the weight-loss program? ❑Yes ❑No
If yes, what? ________________________________
Why do you think the program did not work? ________________________________
Why do you think you struggle with your weight? ________________________________

FEMALE PATIENTS ONLY

Are you pregnant? ❑Yes ❑No Are you breastfeeding? ❑Yes ❑No
Date of your last period? ____________ Are your periods abnormal? ❑Yes ❑No
Are you menopausal or perimenopausal? ❑Yes ❑No
What form of contraception do you use, including tubal ligation? ________________________________

DIETARY INTAKE

Liquids

How many ounces of the following do you typically consume each day? 8 ounces = 1 cup
Water: _____ Juice: _____ Milk: _____ Soda/diet soda: _____ Sports drinks: _____
Unsweetened tea: _____ Sweetened tea: _____ Coffee: _____ Decaf coffee: _____

Food weaknesses

Check all that apply.
❑Portion sizes ❑Excess carbohydrates ❑Too little protein ❑Skipping meals
Other: ________________________________

Patient name: ______________________________

DAILY DIET

What foods do you typically consume in a day?
Breakfast: ______________________________
Lunch: ______________________________
Dinner: ______________________________
Snacks: ______________________________

Do you have any dietary restrictions? ❑Yes ❑No If yes, please list: ______________________________

Are you struggling with a current stressful situation or emotional upset? ❑Yes ❑No
If yes, please describe: ______________________________

MISCELLANEOUS

What is your lifetime, nonpregnant maximum weight? ____ pounds
What do you consider to be your normal adult weight? ____ pounds
What was your weight:
One year ago ____ pounds Five years ago ____ pounds 10 years ago ____ pounds

Overall goals
What do you wish to accomplish by being here? ______________________________
____

How much weight do you hope to lose? Why? ______________________________
____

Baptist Health Medical Group Weight Management

- For fasting labs, you must fast for eight hours prior to your blood being drawn.
- If you have a morning appointment, new patients can have their labs drawn at our office. New patients who are scheduled for an afternoon appointment can take a lab order with them and have labs drawn before their next appointment.
- You may also have labs drawn with your primary care physician before your appointment and bring a copy of your labs with you on the day of your appointment. Or, ask your PCP to fax a copy to our office prior to your appointment at 859.639.2061.
- New patient labs include a comprehensive metabolic panel, complete blood count, and blood level of the following: thyroid stimulating hormone, vitamin D, insulin, lipids (cholesterol) and hemoglobin A1c.
- Provide a copy of your insurance card(s) and prescription ID card with your new patient packet.

Thank you.