BAPTIST HEALTH®
MEDICAL GROUP

Baptist Health Medical Group – Bariatric Medicine and Surgery
950 Breckenridge Lane, Suite 10, Louisville, KY 40207
Phone: 502-894-9499, Fax: 502-894-9595

Patient Requirements for Medically Supervised Weight Loss:

-A body mass index (BMI) of 30 or above or of 27-29 with a weight related comorbidity such as diabetes, hypertension, hyperlipidemia, sleep apnea, or heart disease

Please call your insurance company to inquire about coverage for medical weight loss visits and or medical weight loss medications prior to your first appointment.

What Happens Next?

Once we have received your, completed, new patient packet, your information will then be reviewed to ensure you meet criteria for medical weight loss. Expect someone from our office to reach out to you within 2 weeks of submission.

What to Expect from our Program:

-Initial appointment: education session lead by our registered dietitian followed by an individual appointment with one of our bariatric nurse practitioners or physician assistants. We will review your medical history, perform a physical exam, order testing such as blood work or referrals for services such as physical therapy, where appropriate, and establish individual goals.

-One on one follow up with a dietitian: (telehealth or in-person) individual dietary evaluation, goal setting, and establishment of a prescriptive diet plan with the help of our bariatric dietitian (dietary plans include: liquid meal replacement plan or a macronutrient plan and tracking)

-Behavioral counseling: support in addressing patterns of thinking, establishing tools to support your mental and emotional health and work towards long term behavioral change

-Monthly follow up: with a bariatric provider for 3-6 months: evaluate progress towards your specific goals, decision support and guidance in finding a sustainable routine to manage long term health. On an individual basis we will establish candidacy for weight loss medication use.
(please call your insurance provider to discuss coverage of medical weight loss medications including cost or ask for a pricing sheet for compounded medications from our office)

Please note, care provided through our program will help address behavioral and medical barriers related to controlling your weight. This is not a replacement for care provided by your primary care provider.

Baptist Health Medical Group Bariatric

Patient Information Packet

Please return completed packet with a copy of your insurance card to our program coordinator:
-Email: karen.barnettsparks@bhsi.com
-Fax: 502-894-9595

Are you able to read, write and communicate in the English Language? ❍ YES ❍ NO

If not, what is your primary language?_____

Patient Information

First Name:_____ Middle Name:_____ Last Name:_____

Social Security Number:_____ Date of Birth:_____ Gender: ❍ Female ❍ Male

What is your height?_____ft _____in **How much do you weigh?**_____lbs. **BMI:**_____

Address Information:

Street Address:_____

City:_____ State:_____ Zip Code:_____

E-mail:_____ Phone (home):_____

Phone (work):_____ Phone (cell):_____

Patient's Current Employer:_____

Patient's Employer's address:_____

Patient's Present or Former Occupation:_____

Insurance Information – (This section must be filled out in addition to sending in a copy of your insurance card)

Payment Type: ❍ Insurance ❍ Self Pay

Primary Insurance -

Insurance Company:_____

Policy Number:_____ Group #:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Customer Service Phone:_____ Provider Phone:_____

Secondary Insurance

Insurance Company:_____

Policy Number:_____ Group #:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Customer Service Phone:_____ Provider Phone:_____

Emergency Contact

First Name:_____ Last Name:_____

Relation to you:_____ Phone:_____

"I hereby authorize Baptist Health Medical Group- Bariatric to discuss my process, diagnostic test results and any scheduled appointments with the following named person(s), and further consent to the staff leaving messages for me on a voicemail/answering machine":

Name:_____ Relation to you:_____

Name:_____ Relation to you:_____

Patient Signature:_____ Date:_____

Please list all Specialist Providers:

Provider Name	Telephone Number	Specialty

Weight Loss History

How long have you been overweight?_____Years How long have you been 35 pounds overweight?_____Years

How long have you been 100 pounds or more overweight?_____Years When did you start dieting?____Age

What is the most weight you have ever lost on a single diet?_____lbs. How did you lose the weight?_____

How long did you sustain the weight loss?_____ ❍ No diet attempts of any kind

Check all that apply:

Unsupervised Diet Attempts: ❍ NONE

❍ Body for Life/Bill Phillips	❍ High Protein	❍ Low Fat	❍ Cabbage Soup
❍ Pritikin	❍ Stillman Diet	❍ Mayo Clinic	❍ Fasting
❍ Gloria Marshall	❍ Herbal Life	❍ Calorie Counting	❍ Scarsdale
❍ Richard Simmons	❍ Sugar Busters	❍ Atkin's Diet	❍ Slim Fast
❍ Health Spa	❍ Low Carbohydrate	❍ South Beach	❍ Other:_____

Supervised Diet Attempts: ❍ NONE

❍ Nutri-System ❍ Overeaters Anonymous ❍ Weight Watchers ❍ Jenny Craig

❍ TOPS ❍ Optifast ❍ HMR ❍ DASH

❍ LA Weight Loss ❍ Diet Center ❍ Other:_____

Over-the-Counter or Prescribed Medications for Weight Loss: ❍ NONE

❍ Acutrim ❍ Dexatrim ❍ Ionamin/Adipex ❍ Phendiet ❍ Prozac

❍ Wellbutrin ❍ Amphetamines ❍ Didrex ❍ Tenuate ❍ Phentrol

❍ Redux ❍ Byetta ❍ Plegine ❍ Sanorex ❍ Meridia

❍ Xenical ❍ Diuretics ❍ Pondimin ❍ Phenteramine

❍ Fen-Phen, # of months:_____ ❍ Other:_____

Behavioral Treatments for Weight Loss: ❍ NONE

❍ Hospitalization ❍ Hypnosis

❍ Physical Therapy ❍ Psychological Therapy

❍ Residential Programs ❍ Other:_____

Exercise: ❍ NONE

❍ Walking or Running ❍ Stationary cycle or treadmill

❍ Swimming ❍ Weight Training

❍ Team Sports ❍ Other:_____

Eating Habits, Do you:

Snack between meals? ❍ Yes ❍ No

Eat a lot of sweets? ❍ Yes ❍ No

Drink caffeine-containing drinks? ❍ Yes ❍ No

●If yes, how many cups per day?_____

Eat large meals? (gorge) ❍ Yes ❍ No

Drink carbonated beverages? ❍ Yes ❍ No

●If yes, how many cans/bottles per day?_____

Drink soda pop? ❍ Yes ❍ No ❍ Diet ❍ Regular

Have you used any of the following to control your weight? (Check all that apply)

❍ Binging and Purging ❍ Binging followed by food restriction ❍ Vomiting

❍ Excessive Exercise ❍ Excessive Calorie Restriction/Fasting

If so, when and how long was this period of behavior? _____

Do you currently force yourself to vomit after eating? ❍ Yes ❍ No

Why do you feel you eat? ❍ Physical Hunger ❍ Loneliness ❍ Anxiousness ❍ Makes me happy ❍ Bored

What reasons do you feel contribute to your weight? ❍ Over Consumption ❍ Inactivity ❍ Emotional Wellbeing

Medical History/Review of Symptoms: (Check all that apply)

General: ☐ NONE

☐ Fevers ☐ Weight Gain ☐ Tired / No Energy

☐ Night Sweats ☐ Insomnia ☐ Hair Loss

☐ Appetite Change ☐ Other:_____

Head and Neck ☐ NONE

☐ Wear contacts / glasses ☐ Vision Problems ☐ Hearing Problems

☐ Sinus Drainage ☐ Nose Bleeds ☐ Hoarseness

☐ Dentures, Partial / Full ☐ Allergies ☐ Glaucoma

☐ Regular Ear Infections ☐ Blurred / Double Vision ☐ Other:

Cardiovascular ☐ NONE

☐ Heart Attack ☐ Chest Pain w/ Activity ☐ Rhythm Changes

☐ Congestive Heart Failure ☐ High Blood Pressure ☐ Palpitations

☐ Varicose Veins ☐ Dyspnea on Exertion ☐ Ankle Swelling

☐ Ankle / Leg Ulcers ☐ Elevated Triglycerides ☐ Phlebitis / DVT

☐ Clogged Heart Arteries ☐ Rheumatic Fever / Valve Damage / MVP ☐ Rapid Heart Beat

☐ Irregular Heart Beat ☐ Cramping in legs when walking ☐ Heart Murmur

☐ Atrial Fibrillation ☐ Elevated Cholesterol ☐ Other:_____

Respiratory ☐ NONE

☐ Asthma ☐ Emphysema / COPD ☐ Bronchitis

☐ Pneumonia ☐ Chronic Cough ☐ Shortness of Breath at Rest

☐ Use of Cpap / Bipap ☐ Use of Oxygen ☐ Snoring

☐ Pulmonary Embolism ☐ Sleep Apnea

Gastrointestinal ☐ NONE

☐ Heartburn ☐ Hiatal Hernia ☐ Ulcers

☐ Diarrhea ☐ Blood in Stool ☐ History of Liver Enzymes

☐ Constipation ☐ IBS ☐ Umbilical Hernia

☐ Difficulty Swallowing ☐ Hemorrhoids ☐ Fissure / Polyps

☐ Rectal Bleeding ☐ Black, Tarry Stool ☐ Ventral Hernia

☐ Abdominal Pain ☐ Enlarged Liver ☐ Cirrhosis / Hepatitis

☐ Gallbladder Problems ☐ Jaundice ☐ Pancreatic Disease

☐ Nausea / Vomiting ☐ GERD ☐ Incisional Hernia

☐ Barrett's Esophagus ☐ Other:_____

Bladder/Kidney ☐ NONE

☐ Kidney Stones ☐ Blood in Urine ☐ Prostate Problems

☐ Kidney Failure / Renal Insufficiency ☐ Leaking urine w/ cough/laugh/sneezing ☐ Men: PSA test in last year?

☐ Trouble starting urine ☐ Burning / Pain on urination ☐ Urinary Urgency/Frequency

☐ Overall Loss of Bladder Control ☐ Other:_____

Gynecologic (for women only) ☐ NONE

☐ Problems Conceiving / Infertility ☐ Currently Pregnant ☐ Uterine / Ovarian Cancer

☐ PCOS ☐ Menstrual Irregularity ☐ Menstrual Pain

☐ Excessively Heavy Periods ☐ Plan to have more children ☐ Post Menopausal

Date of last menstrual period?_____

Breast ☐ NONE

☐ Nipple Discharge ☐ Lumps / Fibrocystic Disease ☐ Other:_____

☐ Pain ☐ Cancer Date of last Mammogram:_____

Musculoskeletal ☐ NONE

☐ Shoulder Pain ☐ Neck Pain ☐ Elbow Pain

☐ Hip Pain ☐ Wrist Pain ☐ Back Pain

☐ Foot Pain ☐ Knee Pain ☐ Ankle Pain

☐ Plantar Fasciitis ☐ Heel Pain ☐ Ball of Foot Pain

☐ Broken Bones ☐ Carpal Tunnel Syndrome ☐ Lupus

☐ Muscle Pain / Spasm ☐ Sciatica ☐ Rheumatoid Arthritis

☐ Fibromyalgia ☐ Other:_____

Neurologic ☐ NONE

☐ Balance Disturbance ☐ Dizziness ☐ Restless Leg Syndrome

☐ Stroke ☐ Seizures or convulsions ☐ Weakness

☐ Knocked Unconscious ☐ Numbness / Tingling ☐ Multiple Sclerosis

☐ Pseudotumor Cerebri (loss of vision from high pressure in brain) ☐ Other:_____

Psychiatric ☐ NONE **Are you currently under the care of a mental health provider? ☐ Yes ☐ No**

☐ Depression

☐ Anxiety

☐ Bipolar Disorder (“manic-depression”)

☐ Borderline Personality Disorder

☐ Dissociative Identity Disorder (Multiple Personality)

☐ Schizophrenia / Schizoaffective
☐ Alcoholism / Substance Abuse
☐ Been in a chemical dependency program
☐ Victim of Mental/Emotional/Sexual/Physical Abuse
☐ Attention Deficit Disorder
☐ Seen a Psychiatrist or Counselor
☐ Been hospitalized for psychiatric problems
☐ Attempted suicide
☐ Other:_____

Endocrine ☐ NONE

☐ Parathyroid ☐ Hypothyroid ☐ Goiter
☐ Low Blood Sugar ☐ Excessive Thirst ☐ Endocrine Gland Tumor
☐ "Pre-Diabetes" ☐ Diabetes (Diet or Pills) ☐ Diabetes (Insulin Shots)
☐ Abnormal Facial Hair ☐ Excessive Urination ☐ Gout
☐ Other:_____

Blood/Lymphatic ☐ NONE

☐ Low Platelets (thrombocytopenia) ☐ Anemia ☐ HIV / AIDS
☐ Bruise Easily ☐ Lymphoma ☐ Swollen Lymph Nodes
☐ Bleeding/Clotting Disorder ☐ Blood thinning medicine use ☐ History of DVT / PE
☐ Prior blood Transfusion ☐ Other:_____

Skin ☐ NONE

☐ Frequent Skin Infections ☐ Keloids (Excessively Raised Scars) ☐ Poor Wound Healing
☐ Psoriasis ☐ Rashes under Breasts / Skin Folds ☐ Rosacea
☐ Hair or Nail Changes ☐ Other:_____

List Prescribed Medications:	Taken for what condition:	Dosage/How Often:
☐ NONE		

_____ _____ _____

_____ _____ _____

List any Over-the-Counter medications, herbal supplements or vitamins that you take on a regular basis.

Product:	Taken for what purpose:	Dosage/How Often:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies ☐ NONE

☐ Latex, Reaction:_____ ☐ Tape (adhesives), Reaction:_____

☐ Iodine, Reaction:_____ ☐ IV Contrast Dye, Reaction:_____

Medications (List any medications that you are allergic to and your reaction):_____

_____

Foods (List foods and the reaction):_____

_____

Surgical Procedure(s):	☐ NONE	Year		Year
Gallbladder	(Open)	_____	Tonsillectomy	_____
Gallbladder	(Laparoscopic)	_____	D & C	_____
Appendectomy	(Open)	_____	Ear Surgery:_____	_____
Appendectomy	(Laparoscopic)	_____	Mouth Surgery:_____	_____
Hysterectomy	(Vaginal)	_____	Heart surgery: CABG/Stents	_____
Hysterectomy	(Abdominal)	_____	Valve Replacement	_____
Ovary Surgery:	❍ Ovaries Removed	_____	Pacemaker	_____

Hernia: ❍ Hiatal ❍ Inguinal ❍ Incisional ❍ Umbilical

Tubal Ligation	_____	Knee: ❍ Right ❍ Left	_____
Cesarean Section	_____	Breast Biopsy: ❍ Right ❍ Left	_____
Colonoscopy	_____	Anti-reflux procedure / Nissen Fundoplication	_____
Hemorrhoidectomy	_____	Kidney Surgery	
Colon Resection	_____	Back:_____	_____
Endoscopy/EGD	_____	Other:_____	_____

Previous Weight Loss Surgery (WLS): _____

(We will need a copy of the Operation Report from your previous weight loss surgery.)

Date of Surgery:_____ Surgeon: _____

Original Weight prior to Surgery: _____ ❍ Estimated ❍ Actual – Lowest Weight Achieved: _____

Social History

Do you smoke now? ❍ Yes ❍ No If yes, how many packs per day?_____

Have you smoked in the past? ❍ Yes ❍ No If you have quit, how many years since?_____

For how many years did you use tobacco? _____Years

Do you use snuff or chew? ❍ Yes ❍ No If yes, how frequently do you use?_____

Do you consume alcohol now? ❍ Yes ❍ No

If yes, how many times per week? _____ If yes, how many drinks each time?_____

Is anyone concerned about the amount you drink? ❍ Yes ❍ No If you have quit, how many years since?_____

Do you have a history of drug use or alcoholism? ❍ Yes ❍ No If yes, what drugs?_____

If yes, how frequently do you use these drugs? _____ If you have quit, how many years since?_____

Family Medical History: (Check all that apply)

Disease	Mother	Father	Siblings (specify brother or sister)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Morbid Obesity							
Diabetes- Age Occurred							
High Blood Pressure							
Stroke- Age Occurred							
Heart Attack- Age Occurred							
Cardiovascular Disease							
Sleep Apnea							
Cancer: Type & Age Occurred							
Death- Age & Cause							
If Still Living, what age							

Please check to make sure that you have completed all the following before sending in your packet:

- ☐ Filled out this form as completely as possible
- ☐ Made a copy of the front and back of your insurance Card
- ☐ Called your insurance and review coverage of medical weight loss visits and medications

Mail completed packet and COPY of Insurance Card to:

Baptist Health Medical Group
- Bariatric
950 Breckenridge Lane, Suite 10
Louisville KY 40207