ST. LOUIS BARIATRICS
1400 U.S. Highway 61, Suite G50
Festus, MO 63028
314.366.4874 TEL 314.366.4875 FAX

St. Louis Bariatrics

New Patient Information Form

Please complete all sections. Your completed form can be sent as email attachment to info@stlouisbariatrics.com or can be printed out then faxed or mailed to the address above. *You must save this document to preserve your data!*

This paperwork is for patients without any previous weight loss procedures. If you have had a previous weight loss procedure, please contact our office to obtain the correct paperwork.

Have you been seen at St. Louis Bariatrics before? ○ Yes ○ No

Procedure of Interest

Surgical (check one)	Medically-Managed Weight Loss Program (Non-Surgical)	Non-Invasive Procedures
☐ Sleeve Gastrectomy	☐ Weight Loss Medications	☐ Balloon
☐ Roux-en-Y Gastric Bypass	☐ Low-Calorie Diets	☐ Endoscopic Sleeve Gastroplasty
☐ Adjustable Gastric Band	☐ Dietitian Appointment	

Demographics

Last Name	First Name	Middle Initial	Preferred Name

DOB	Age	Sex	SSN	Marital Status

Previous Names	Height	Weight	BMI

Ethnicity

○ Caucasian ○ Asian ○ African American ○ Hispanic ○ Native American ○ Other

Contact Information

Mailing Address	City	State	Zip

Primary Phone Number	Alternative Phone	Email Address

Employer Information

Employer	Occupation

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relationship

Referral Source

How did you hear about St. Louis Bariatrics?

☐ Friend	☐ Relative	☐ Physician Referral	☐ Internet	☐ Social Media
			○ Bing ○ Other ○ Google	○ Facebook ○ Instagram

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such care to third party payers and/or other health practitioner. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf. I substantiate that the above rendered information is true and complete to the best of my knowledge and ability.

Patient Signature Date

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Insurance		
Primary Insurance ☐ None		
Who are your primary insurance benefits through? ○ Self ○ Spouse ○ Parent		
Would you like information regarding our low self-pay rate if your insurance does not cover the procedure? ○ Yes ○ No		
Are you currently on COBRA? ○ Yes ○ No		
Is your primary insurance going to expire soon? ○ Yes ○ No If "Yes" date		
Is this insurance coverage through an employer? ○ Yes ○ No If "Yes" name of employer		
Is this insurance coverage through the insurance marketplace or privately purchased? ○ Yes ○ No		
Primary Insurance Company Name	Primary Insurance Provider Services Phone Number	
Subscriber ID Number	Group Number	Are referrals required for specialist visits?
		○ Yes ○ No

Insurance		
Secondary Insurance ☐ None		
Who are your secondary insurance benefits through? ○ Self ○ Spouse ○ Parent		
Is your secondary insurance going to expire soon? ○ Yes ○ No If "Yes" date		
Is this insurance coverage through an employer? ○ Yes ○ No If "Yes" name of employer		
Is this insurance coverage through the insurance marketplace or privately purchased? ○ Yes ○ No		
Secondary Insurance Company Name	Secondary Insurance Provider Services Phone Number	
Subscriber ID Number	Group Number	Are referrals required for specialist visits?
		○ Yes ○ No

Primary Care Provider		
Primary Care First Name	Primary Care Last Name	Credentials
		○ MD ○ DO ○ FNP
Name of Primary Clinic	Primary Care City	Primary Care State

Other Medical Specialists Who Currently Treat You		
Specialist Name	Specialty	Phone
Specialist Name	Specialty	Phone

Weight History				
5 Years Ago	4 Years Ago	3 Years Ago	2 Years Ago	1 Year Ago
lbs	lbs	lbs	lbs	lbs

Highest Weight Since Age 18	Lowest Weight Since Age 18	Age at Lowest Weight Achieved
lbs	lbs	Years Old

How long have you tried to lose weight?	How long have you been researching weight loss procedures?

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Health History		
Have you *ever* been diagnosed with any of these medical problems? Please add details in the space provided.		
		Details
High Blood Pressure	◯ Yes ◯ No	
Congestive Heart Failure	◯ Yes ◯ No	
Heart Attack	◯ Yes ◯ No	
Chest Pain related to your heart	◯ Yes ◯ No	
Heart Catheterization	◯ Yes ◯ No	
Stroke	◯ Yes ◯ No	
Blood clots in your legs or lungs	◯ Yes ◯ No	
Gout	◯ Yes ◯ No	
Lower Extremity Swelling	◯ Yes ◯ No	
Diabetes or High Blood Sugars	◯ Yes ◯ No	
High Cholesterol	◯ Yes ◯ No	
Hyperthyroidism / Hypothyroidism	◯ Yes ◯ No	
Depression, Bipolar, Anxiety Disorder	◯ Yes ◯ No	
Snoring	◯ Yes ◯ No	
Sleep Apnea	◯ Yes ◯ No	
Pulmonary Hypertension	◯ Yes ◯ No	
Asthma	◯ Yes ◯ No	
Back or Leg Pain requiring treatment	◯ Yes ◯ No	
Disorder similar to Lupus or Rheumatoid Arthritis	◯ Yes ◯ No	
Barrett's Esophagus	◯ Yes ◯ No	
Crohn's Disease or Ulcerative Colitis	◯ Yes ◯ No	
Heartburn, Reflux, GERD	◯ Yes ◯ No	
Gastroparesis	◯ Yes ◯ No	
Liver disease or Abnormal Liver Test	◯ Yes ◯ No	
Hepatitis B or Hepatitis C	◯ Yes ◯ No	
Gallbladder Problems	◯ Yes ◯ No	
Polycystic Ovary Syndrome (PCOS)	◯ Yes ◯ No	
Urinary Stress Incontinence	◯ Yes ◯ No	
Are you on disability?	◯ Yes ◯ No	
Can you walk more than 200 ft without assistance?	◯ Yes ◯ No	
Do you use a wheelchair or walker for assistance?	◯ Yes ◯ No	
Are you on chronic Steroids (i.e. Prednisone)?	◯ Yes ◯ No	
Do you know of any problems with your kidneys?	◯ Yes ◯ No	
Are you currently prescribed blood thinners?	◯ Yes ◯ No	
Do you have HIV/AIDS?	◯ Yes ◯ No	
Have you previous had a Weight Loss Procedure?	◯ Yes ◯ No	
Previous surgery on your stomach or esophagus?	◯ Yes ◯ No	
Do you take estrogen or testosterone supplements?	◯ Yes ◯ No	
Do you take oral contraceptives?	◯ Yes ◯ No	
Have you had postoperative nausea and vomiting in the past?	◯ Yes ◯ No	
Are you on or expecting to go on dialysis?	◯ Yes ◯ No	
Previous anesthesia complications	◯ Yes ◯ No	

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Medical History
List below any other medical problems not previously discussed
☐ None

Surgical History
List below any prior surgeries you have undergone
☐ None

Family History				
Which illnesses run in your family				
☐ High Blood Pressure	☐ Heart Disease or Heart Attack	☐ High Cholesterol	☐ Stroke	☐ Obesity
☐ Colon or Rectal Cancer	☐ Stomach or Esophageal Cancer	☐ Bleeding or Clotting Disorder	☐ Diabetes	

Social History
Do you use **ANY** nicotine products? Cigarette, vapor cigarette, smokeless tobacco, cigars, nicotine patches, nicotine gum, etc.
◯ Yes ◯ No If "Yes" Quantity: Quit Date:
Do you consume alcohol?
◯ Yes ◯ No
Do you have history of prescription or non-prescription substance abuse?
◯ Yes ◯ No

Medications
List below **ALL** current medications
☐ I take no medications

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Medication Allergies
List below medication allergies and reaction experienced (rash, throat, swelling etc.)
☐ No allergies
Optional
Why do you want weight loss surgery?