Patient Information – General Surgery

Program: Baptist Health Lexington (formerly Central Baptist Hospital) and Baptist Physician Surgery Center - Lexington, Kentucky

Reason for request:

_____

Surgeon
G. Derek Weiss, MD

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

If not, what is your primary language?_____

Please list any other barriers to communication, or special accommodations that you require:_____

Patient Information:

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

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

Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Separated ❍ Partnered ❍ Widow(er)

How many children do you have (please list ages)?_____

Ethnicity: ❍ African American ❍ Hispanic ❍ Native American or Alaska Native ❍ Choose not to specify
❍ Asian ❍ Caucasian ❍ Native Hawaiian / Other Pacific Islander ❍ Other:_____

Religious affiliation:_____Patient's level of Education:_____

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

Address Information:

Street Address:_____

City:_____ State:_____ Zip Code:_____

E-mail:_____ Phone (home):_____

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

OK to leave message at: ❍ Home ❍ Work ❍ Cell

Patient Employment Information:

Employment status: ❍ Full Time ❍ Retired ❍ Disabled ❍ Student
❍ Part Time ❍ Unemployed ❍ Homemaker ❍ Leave of Absence

Patient's Current Employer:_____ Years Employed:_____

Patient's Employer's address:_____

Patient's Present or Former Occupation:_____

Disabled? ❍ Yes ❍ No If Yes, specify the year and cause: Year:_____ Cause:_____

you walk unassisted? ❍ Yes ❍ No How far before needing rest?_____ (Approximate # of feet)

If you need assistance walking, what device(s) do you use? ❍ Cane ❍ Walker ❍ Crutches ❍ Other:_____

Are you wheelchair bound and unable to stand at all? ❍ Yes ❍ No How long in wheelchair?_____ (Month/year)

Do you have a Medical Surrogate, Power of Attorney or anyone who makes your medical decisions?

❍ **YES** ❍ **NO** If yes, who?_____Relationship to you?_____

Spouse Information:

Spouse's Name:_____ Spouse's Date of Birth:_____

Spouse's Employment Status: ❍ **Full Time** ❍ **Retired** ❍ **Disabled** ❍ **Student**
❍ **Part Time** ❍ **Unemployed** ❍ **Homemaker** ❍ **Leave of Absence**

Spouse's Occupation:_____ Spouse's SSN:_____

Spouse's Employer:_____ Years Employed:_____

Spouse's Employer's address:_____ Spouse's Cell Phone:_____

Insurance Information:

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 Bluegrass Bariatrics to discuss my process, diagnostic test results and any scheduled appointments with the following named person(s)":

Name:_____ Relation to you:_____

Name:_____ Relation to you:_____

Patient Signature:_____ Date:_____

Primary/Referring Physician:

First Name:_____ Last Name:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____ Phone:_____

How did you hear about us? ☐ Radio ☐ TV ☐ Newspaper ☐ Family/Friend ☐ Internet ☐ Social Media
☐ Other (Please List):_____

Please list all Specialist Providers:

Provider Name	Telephone Number	Specialty

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 ☐ Other:_____

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

How many pregnancies have you had:_____ Date of Last Pap Smear?_____

How many miscarriages or abortions have you had:_____ 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") ☐ Seen a Psychiatrist or Counselor

☐ Alcoholism / Substance Abuse ☐ Been hospitalized for psychiatric problems

☐ Been in a chemical dependency program ☐ Attempted suicide

☐ Currently taking medications for psychiatric problems or for depression ☐ Victim of Mental/Emotional/Sexual/Physical Abuse

☐ Attention Deficit Disorder ☐ 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

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

Weight Loss Surgery: Type:_____ Surgeon:_____

❍ Laparoscopic ❍ Open Year:_____

Anesthesia Problems: Please tell us about any problems that you have had with anesthesia: ❍ **NONE**

❍ Nausea	❍ Heart Stopped	❍ Woke up during procedure
❍ Vomiting	❍ Stopped Breathing	❍ Other:_____
❍ Difficulty Waking Up	❍ Difficulty Urinating	

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?_____
For how many years do/did you drink alcohol?	_____Years	
Is anyone concerned about the amount you drink?	❍ Yes ❍ No	If you have quit, how many years since?_____
Do you use street drugs now?	❍ 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							

Thank you for taking the time to fill out our Patient Profile Packet.

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 & back of your insurance card
- ❑ Signed the Blood Consent

Mail completed Packet and Insurance Card to:

Bluegrass Bariatrics
Attn: Insurance Department
2716 Old Rosebud Road, St. 350
Lexington, Kentucky 40509
Phone: 859-543-1577
Fax: 859-543-1637

Date Completed: _____