500 W. Broadway, 5th Floor Broadway Bldg.
Missoula, Montana 59802
P: 406-329-5866
F: 406-329-5864

Patient _____
(Last Name) (First Name) (Middle Initial)

Address _____

City _____ State _____ Zip _____

Phone (Hm) _____ Cell _____ Email_____

DOB _____ Age _____ Sex _____ Social Security # _____

Occupation _____ Employer _____ Employer's Phone _____

Employer Address _____

Spouse _____ Spouse's Social Security # _____

Spouse's Occupation _____ Spouse's Employer _____

Spouse's Employer Address _____ Phone # _____

Primary Care Provider (PCP)_____ Phone# _____

Emergency Contact: _____ Phone #: _____Relationship:_____

INSURANCE INFORMATION (Please provide a copy of both sides of Insurance card)

**do not send photo of Insurance card if emailing application*

PRIMARY Insurance Company _____

Address _____ Phone # _____

Policy ID# _____ Group # _____

Subscriber/Policy Holder _____ DOB _____ Employer _____

SECONDARY Insurance Company _____

Address_____ Phone # _____

Policy # _____ Group # _____

Subscriber/Policy Holder _____ DOB _____ Employer _____

PLEASE READ AND SIGN THE FOLLOWING: Payment of Benefits: I hereby give lifetime authorization for payment of benefits to be made directly to Providence Medical Group St. Patrick Hospital. I understand that I am financially responsible for all charges not covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Patient's Signature _____ Date _____

BARIATRIC VIDEO QUESTION **(on-demand videos can be found on providence.org/healthyMT)**

In most cases, weight loss surgery works by reducing hunger. TRUE FALSE

REVIEW OF CO-MORBID CONDITION: *(Please complete in detail)*

Sleep Apnea

Snoring No ☐ Yes ☐ Night Choking No ☐ Yes ☐
Using C-Pap No ☐ Yes ☐ How often awake at night? _____
Diagnosed Sleep Apnea No ☐ Yes ☐ Sleep study No ☐ Yes ☐
If Yes, year _____

Pulmonary Disease

Asthma No ☐ Yes ☐ Age onset _____
Shortness of breath Hay-Fever/Allergies No ☐ Yes ☐
on exertion No ☐ Yes ☐ Steroid use in last year No ☐ Yes ☐
Emphysema/COPD No ☐ Yes ☐ # ER visits in last year _____
#Hospitalizations in last year _____

Hypertension

Highest B/P _____ Current B/P _____ Take Meds No ☐ Yes ☐

Diabetes

Physician _____
Age of onset _____ Control: Good ☐ Poor ☐ Year Diagnosed _____
Controlled with: Diet ☐ Oral ☐ Insulin ☐
Blood sugars taken _____ Times per day _____ Last reading _____
Gestational No ☐ Yes ☐ Neuropathy _____

Musculoskeletal

Pain in weight bearing joints: Back ☐ Hips ☐ Knees ☐ Feet ☐
Exercise limitations Mild ☐ Moderate ☐ Severe ☐
Arthritis No ☐ Yes ☐ Joint replacement No ☐ Yes ☐
Take pain and/or anti-inflammatory medication No ☐ Yes ☐ Times per day _____

Cardiovascular

Congestive Heart Failure No ☐ Yes ☐ Varicose Veins No ☐ Yes ☐
Heart Attack No ☐ Yes ☐ Swelling of ankles No ☐ Yes ☐
Heart Murmur No ☐ Yes ☐ Thrombophlebitis No ☐ Yes ☐
Chest Pain No ☐ Yes ☐ Pulmonary Embolism No ☐ Yes ☐
Coronary Artery Disease No ☐ Yes ☐ Stroke No ☐ Yes ☐
High Cholesterol No ☐ Yes ☐ High Triglycerides No ☐ Yes ☐

Gallbladder Disease No ☐ Yes ☐ Frequency of attacks _____ Year removed _____
Hiatal Hernia No ☐ Yes ☐ Nissen procedure No ☐ Yes ☐ Year _____
Heartburn No ☐ Yes ☐ How often? _____ Aspiration/Choking No ☐ Yes ☐
Upper GI Series No ☐ Yes ☐ If yes, year _____
Diagnosed GERD No ☐ Yes ☐ Endoscopy No ☐ Yes ☐

Genito-Urinary

Stress Incontinence No ☐ Yes ☐ How often? _____ Wear pad? No ☐ Yes ☐
Vaginal Infections No ☐ Yes ☐

REVIEW OF SYSTEMS

General

Fevers	No ☐ Yes ☐	Sweats	No ☐ Yes ☐
Loss of Appetite	No ☐ Yes ☐	Autoimmune	No ☐ Yes ☐
Persistent Cough	No ☐ Yes ☐	Blood Disorder	No ☐ Yes ☐

Skin

Rashes	No ☐ Yes ☐	Skin Cancer	No ☐ Yes ☐

Eyes and Ears

Visual Problems	No ☐ Yes ☐	Hearing Problems	No ☐ Yes ☐
Ear Ringing	No ☐ Yes ☐	Dizziness	No ☐ Yes ☐

Gastrointestinal

Colitis/Enteritis	No ☐ Yes ☐	Rectal Bleeding	No ☐ Yes ☐
Liver Disease	No ☐ Yes ☐	Ulcers/Gastritis	No ☐ Yes ☐
Kidney Stones	No ☐ Yes ☐	Hepatitis C	No ☐ Yes ☐
Pancreatitis	No ☐ Yes ☐	Prostate Infections	No ☐ Yes ☐
Blood in Urine	No ☐ Yes ☐		

Endocrine

Thyroid Disease	No ☐ Yes ☐	Osteoporosis	No ☐ Yes ☐

Neurologic

Headaches	No ☐ Yes ☐	Migraines	No ☐ Yes ☐
Seizures	No ☐ Yes ☐	Strokes	No ☐ Yes ☐
Memory Loss	No ☐ Yes ☐	Shaking	No ☐ Yes ☐
Numbness	No ☐ Yes ☐	Uncoordinated	No ☐ Yes ☐

Infections

Swollen Glands	No ☐ Yes ☐	TB Exposure	No ☐ Yes ☐
HIV	No ☐ Yes ☐		

OB/GYN

Last Menstrual Period _____ Current Contraceptive Method _____

Is it possible you are currently pregnant? No ☐ Yes ☐

Number of pregnancies _____ Number of live births _____

1st Pregnancy	2nd Pregnancy	3rd Pregnancy
Age _____ Wt. gain _____	Age _____ Wt. gain _____	Age _____ Wt. gain _____

Do you have any religious objection to the use of blood products? No ☐ Yes ☐

PHYSICAL LIMITATIONS/DISABILITIES (Please check ALL that apply)

☐ Climbing stairs	☐ Use of public seating
☐ Tying shoelaces	☐ Lifting objects from floor
☐ Playing with children	☐ Caring for personal needs
☐ Unusual fatigue	☐ Airline travel

CURRENT MEDICATIONS: (USE BACK OF SHEET IF NECESSARY)

	Drug	Dosage	Reason Prescribed
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Aspirin No ☐ Yes ☐ NSAIDS No ☐ Yes ☐ Coumadin No ☐ Yes ☐

DRUG ALLERGIES (CHECK HERE IF NONE _____)

Drug	Reaction
_____	_____
_____	_____

Are you allergic to latex? No ☐ Yes ☐

SURGERIES	Year
_____	_____
_____	_____
_____	_____
_____	_____

History of surgical complications

Bleeding	No ☐	Yes ☐
Anesthesia Problems	No ☐	Yes ☐
Blood Transfusion	No ☐	Yes ☐
Infections	No ☐	Yes ☐

PAST MEDICAL HISTORY

Rheumatic Fever	No ☐	Yes ☐	Diabetes	No ☐	Yes ☐
Cancer	No ☐	Yes ☐	Scarlet Fever	No ☐	Yes ☐
Hepatitis	No ☐	Yes ☐	Hx of bleeding	No ☐	Yes ☐
TB	No ☐	Yes ☐	AIDS/HIV	No ☐	Yes ☐

SOCIAL HISTORY

Alcoholic Beverages None _____ Light _____ Moderate _____ Heavy _____

Smoking/Chewing Tobacco History Never _____ Former Smoker _____ Year Quit _____

CURRENTLY Smoking? No ☐ Yes ☐ Packs Per Day _____

CURRENTLY Chewing? No ☐ Yes ☐

When do you plan to stop smoking or chewing permanently? _____

Recreational Drug Use No ☐ Yes ☐ Describe _____

Coffee/Caffeine Use None _____ or Cups Per Day _____

Carbonated Beverages None _____ or Sodas Per Day _____

Weight During These Periods of Your Life	Age	Height	Weight
Current	_____	_____	_____
High School	_____	_____	_____
Marriage	_____	_____	_____
Lowest in last 5 years	_____	_____	_____
Highest in last 5 years	_____	_____	_____
When obesity first became a problem	_____	_____	_____

WEIGHT LOSS ATTEMPTS

Please be as detailed as possible. The information is used in the letter of medical necessity for your insurance carrier. Please estimate as closely as possible.

PROGRAM	YEAR BEGAN	#MONTHS OF PROGRAM	NET WT LOSS
Fen-Phen	_____	_____	_____
Redux/Other Rx Meds	_____	_____	_____
Injections (Describe)	_____	_____	_____
Medi-Fast/Opti-Fast/HMR	_____	_____	_____
Diet Centers	_____	_____	_____
Weight Watchers	_____	_____	_____
Nutri-System	_____	_____	_____
Behavior Modification	_____	_____	_____
Exercise	_____	_____	_____
Overeaters Anonymous	_____	_____	_____
Hypnosis	_____	_____	_____
Acupuncture	_____	_____	_____
Nutritionist	_____	_____	_____
Psychiatrist/Therapist	_____	_____	_____
Previous Wt Loss Surgery	_____	_____	_____
Physician Supervised Diet Plan			
_____	_____	_____	_____
_____	_____	_____	_____
Self-Monitored Diets			
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY

Have any blood relatives had:

Cancer No ☐ Yes ☐ Describe _____

Diabetes No ☐ Yes ☐ Describe _____

Heart Attack Before Age 40 No ☐ Yes ☐ Describe _____

Morbid Obesity No ☐ Yes ☐ Describe _____

	Age	Ht	Wt	Medical Condition	Please Check if Family Member is Deceased
Mother	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____
Siblings					
Male/Female ___	_____	_____	_____	_____	_____
Male/Female ___	_____	_____	_____	_____	_____
Male/Female ___	_____	_____	_____	_____	_____
Male/Female ___	_____	_____	_____	_____	_____
Spouse	_____	_____	_____	_____	_____
Children					
Male/Female ___	_____	_____	_____	_____	_____
Male/Female ___	_____	_____	_____	_____	_____
Male/Female ___	_____	_____	_____	_____	_____
Male/Female ___	_____	_____	_____	_____	_____
Maternal GM	_____	_____	_____	_____	_____
Maternal GF	_____	_____	_____	_____	_____
Paternal GM	_____	_____	_____	_____	_____
Paternal GF	_____	_____	_____	_____	_____

PSYCHOSOCIAL STATUS

1. In general, are you satisfied with:
   a. The quality of your marriage or primary relationship? No ☐ Yes ☐ Does not apply ☐
   b. The quality of your other family relationships? No ☐ Yes ☐ Does not apply ☐
   c. The quality of your friendships and other relationships? No ☐ Yes ☐ Does not apply ☐
   d. The quality of your sex life? No ☐ Yes ☐ Does not apply ☐
   e. The quality of your work (or school) life? No ☐ Yes ☐ Does not apply ☐

1. Have you ever had any episodes of feeling significantly sad or depressed for days or weeks at a time? No ☐ Yes ☐
   If "yes" when was the most recent episode? _____
2. Have you ever thought about committing suicide? No ☐ Yes ☐
   Have you ever tried to commit suicide? No ☐ Yes ☐
3. Have you ever had episodes of extreme anxiety or panic attacks? No ☐ Yes ☐
4. Have you ever had problems with excessive alcohol or drug use? No ☐ Yes ☐
5. Have you ever been diagnosed with an eating disorder, had periods of binge eating, or tried to lose weight by vomiting, fasting, excessive exercise or laxative use? No ☐ Yes ☐
6. Have you ever been in treatment for a psychiatric condition? No ☐ Yes ☐
   Any psychiatric hospitalizations? No ☐ Yes ☐
7. Have you ever been physically abused or sexually abused? No ☐ Yes ☐

Who are the people in your life who will be available to assist you and support you after bariatric surgery?_____

Please list the medicines you are currently taking for emotional or psychiatric reasons (e.g. antidepressants, tranquilizers, ADD medications, etc.).

Drug Name	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list the psychiatrists, psychologists or other mental health workers who have been involved in your care.

Name	Phone no.
_____	_____
_____	_____
_____	_____
_____	_____

Instructions For The Food Intake And Activity Log

We would like you to complete the Food Intake and Activity Log for three days, starting when you wake up tomorrow. This log provides your doctors with very important information about the foods you typically eat, how much you are eating, and how active you tend to be. It is in your best interest not to modify your food or exercise patterns during the week you are filling out this log. Just try to provide the information that reflects your typical patterns.

At the top of each page, be sure to fill in the date and the day of the week you are providing the information. On the Food Log, complete the time of your meal or snack, everything you ate, and estimates of the amount(s), and anything you may have noticed about your eating patterns that might be helpful to make note of. Similarly, on the Activity Log, list the time that you engaged in any non-sedentary activity and a brief description of the nature of the activity. This can include walks to work or chores around the house, as well as any planned exercise such as going to the gym. Again, feel free to jot down any notes about your activity patterns that you think may be useful to report. If you happen to fill up a page and need more space for a given day, feel free to continue on the back of the page.

Some people find it easiest to carry the Food Intake and Activity Log with them; others keep it in one place (typically at the kitchen table) and fill it out at meal or snack time. Please do whatever is easiest for you but try to be thorough.

FOOD INTAKE AND ACTIVITY LOG

Day 1 Date _____ Day of the Week _____

Time Meal/Snack	Food/Drink Log (include estimate of amounts)	Notes

ACTIVITY LOG

Time	Activity

Day 2 **Date _____** **Day of the Week _____**

Time Meal/Snack	Food/Drink Log (include estimate of amounts)	Notes

ACTIVITY LOG

Time	Activity

Day 3 **Date _____** **Day of the Week _____**

Time Meal/Snack	Food/Drink Log (include estimate of amounts)	Notes

ACTIVITY LOG

Time	Activity