

ARCH BARIATRICS
KUMARAN CHINNAPPAN MD,FACS,FRCS,FASMBS.

Please Return Form To:
Arch Bariatrics
10007 Kennerly Rd, Ste. A
St. Louis, MO 63128
Ph.No:3146901527
FAX: (314) 776-7114
www.weighthlossurgerysfl.com

Patient Registration and Medical History form for Bariatric Surgery

Surgery Interest <input type="checkbox"/> Gastric Band <input type="checkbox"/> Gastric Bypass <input type="checkbox"/> Gastric Sleeve <input type="checkbox"/> Uncertain <input type="checkbox"/> Gastric Balloon					
PATIENT INFORMATION					
Patient's Last Name		First		Middle	Preferred Name to be Addressed
Social Security Number - - -		Age	Patient Birth Date - -	Current Height	Current Weight
Patient Former Name		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widow		
		Ethnicity <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Native American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Other			
Primary Phone ()		<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Other		Alternate Phone () <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Other	
Patient Mailing Address			City	State	Zip
Patient Email		Patient Occupation		Employer	
Email may be used for: (check all that apply) <input type="checkbox"/> Appointment Reminders <input type="checkbox"/> Personal Correspondence <input type="checkbox"/> Newsletter & Announcements <input type="checkbox"/> E-bill (when available)					
Emergency Contact Name		Emergency Contact Relationship		Emergency Contact Phone ()	
INSURANCE INFORMATION					
PRIMARY Insurance Company		Subscriber ID Number		Group Number	Patient Relationship to Subscriber: <input type="checkbox"/> Self (skip to Secondary Insurance) <input type="checkbox"/> Spouse* <input type="checkbox"/> Child* <input type="checkbox"/> Other*
*Subscriber Name		*Subscriber Birth Date - -	*Subscriber Social Security Number - -		*Subscriber Employer
SECONDARY Insurance Company		Subscriber ID Number		Group Number	Patient Relationship to Subscriber: <input type="checkbox"/> Self (skip to next section) <input type="checkbox"/> Spouse* <input type="checkbox"/> Child* <input type="checkbox"/> Other*
*Subscriber Name		*Subscriber Birth Date - -	*Subscriber Social Security Number - -		*Subscriber Employer
REFERRAL SOURCE					
How did you hear about our practice?	<input type="checkbox"/> Physician <input type="checkbox"/> Friend/Relative <input type="checkbox"/> Web <input type="checkbox"/> Social Media <input type="checkbox"/> Other				
	Please Specify:				
CONSENT TO RELEASE INFORMATION					

The above information is true and complete to the best of my knowledge. I authorize my insurance benefits to be paid directly to Kumaran Chinnappan, MD. I understand that I am financially responsible for any balance due or if the procedure or service is a denied benefit. I understand that I am responsible to make sure that a referral for office visits are obtained prior to each visit and that the proper copayment is made at the time of each visit. I also authorize Kumaran Chinnappan, MD in association with Arch Bariatrics LLC, or the insurance company to release any protected health information required to process payment, treatment, or other health care operations.

(patient signature)

(date)

ARCH BARIATRICS
Specialists in Surgical Weight Loss

Past Medical History

Check all that apply and list details/diagnoses

- Myocardial Infarction Diabetes High Blood Pressure Emphysema
 Irregular Heartbeat High Cholesterol Thyroid Problems Asthma
 Stroke Coagulation Disorder (you may take Plavix or Coumadin for) Heart Failure
 Sleep Apnea Cancer
 Other _____

Other Medical Problems and details:

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, aspirin or blood thinners:

Medication	Dose	Times per day

Medication	Dose	Times per day

SURGICAL HISTORY: Including Defibrillators, Pacemakers or Stents

Operation	Date

Operation	Date

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ALLERGIES or REACTIONS: None Latex

Medication	Reaction or Side Effect

FAMILY HISTORY:
Please check all that apply.

Medical Condition	Mom	Dad	Sister	Brother	Daughter	Son	Other
Anesthesia Problem							
Asthma							
Bleeding Problems							
Breast Cancer							
Colon Cancer							
Melanoma							
Thyroid Cancer							
Parathyroid Cancer							
Prostate Cancer							
Diabetes							
Heart Attack							
High Blood Pressure							
Kidney Disease							
Leukemia							
Lupus							
Lymphoma							
Stroke							
Vascular Disease							

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SOCIAL HISTORY

Tobacco Use

Cigarettes

Never Current Smoker: packs/day _____ # of years _____

Quit: Date _____ How many years did you smoke? _____

Other Tobacco:

Pipe Cigar Snuff Chew

Alcohol Use

No Yes: # drinks/week _____

PLEASE INDICATE BELOW IF YOU ARE CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS:

General, constitutional		
Does your job require heavy lifting	no	yes
Recent weight change	no	yes
Fever	no	yes
Fatigue	no	yes
Eyes and vision		
Eye disease or injury	no	yes
Wear glasses or contact lenses	no	yes
Blurred or double vision	no	yes
Glaucoma	no	yes
Ears, nose, throat		
Hearing loss	no	yes
ringing in the ears	no	yes
Earaches or drainage	no	yes
Sinus problems	no	yes
Nose bleeds	no	yes
Mouth sores	no	yes
Bleeding gums	no	yes
Bad breath or bad taste	no	yes
Sore throat or voice change	no	yes
Swollen glands in neck	no	yes

Musculoskeletal		
Joint Pain	no	yes
Joint stiffness or swelling	no	yes
Weakness of muscles/joints	no	yes
Muscle pain or cramps	no	yes
Back pain	no	yes
Cold extremities	no	yes
Difficulty in walking	no	yes
Skin and Breasts		
Rash or itching	no	yes
Change in skin color	no	yes
Change in hair or nails	no	yes
Varicose veins	no	yes
Breast pain	no	yes
Breast lump	no	yes
Breast discharge	no	yes
Neurological		
Frequent or recurrent headaches	no	yes
Light headed or dizzy	no	yes
Convulsions or seizures	no	yes
Numbness or tingling sensations	no	yes

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Heart and Cardiovascular		
Heart trouble	no	yes
Chest pains	no	yes
Swelling of feet, ankles, hands	no	yes
Respiratory		
Frequent coughing	no	yes
Spitting up blood	no	yes
Shortness of breath	no	yes
Asthma or wheezing	no	yes
Gastrointestinal		
Loss of appetite	no	yes
Change in bowel movements	no	yes
Nausea or vomiting	no	yes
Frequent diarrhea	no	yes
Painful bowel movements or constipation	no	yes
Genitourinary		
Frequent urination	no	yes
Burning or painful urination	no	yes
Blood in urine	no	yes
Change in force or strain with urination	no	yes
Incontinence or dribbling	no	yes
Kidney stones	no	yes
Sexual difficulty	no	yes
Painful periods	no	yes
Irregular periods	no	yes

Paralysis	no	yes
Stroke	no	yes
Head injury	no	yes
Psychiatric		
Nervousness	no	yes
Depression	no	yes
Sleep problems	no	yes
Endocrine		
Thyroid disease	no	yes
Diabetes	no	yes
Excessive thirst or urination	no	yes
Heat or cold intolerance	no	yes
Dry skin	no	yes
Change in hat or glove size	no	yes
Hematologic/Lymphatic		
Slow to heal after cuts	no	yes
Easily bruise or bleed	no	yes
Anemia	no	yes
Phlebitis	no	yes
Transfusion	no	yes
Swollen glands	no	yes

Patient Signature: _____

Date: _____