Please Return Form To:
Arch Bariatrics
10007 Kennerly Rd, Ste. A
St. Louis, MO 63128
FAX: (314) 776-7114

ARCH BARIATRICS

Specialists in Surgical Weight Loss...

Patient Registration and Medical History *for* Bariatric Surgery

Surgery Interest ☐Gastric Band ☐Gastric Bypass ☐Gastric Sleeve ☐Uncertain 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	Current BMI
– –		– –			

Patient Former Name	Sex ☐M ☐F	Marital Status ☐Single ☐Married ☐Divorced ☐Separated ☐Widow
	Ethnicity ☐Caucasian ☐African American ☐Native American ☐Hispanic ☐Asian ☐Other	

Primary Phone	Alternate Phone
( ) ☐Home ☐Cell ☐Work ☐Other	( ) ☐Home ☐Cell ☐Work ☐Other

Patient Mailing Address	City	State	Zip

Patient Email	Patient Occupation	Employer

Email may be used for: (check all that apply) ☐Appointment Reminders ☐Personal Correspondence ☐Newsletter & Announcements ☐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: ☐Self (*skip to Secondary Insurance*) ☐Spouse* ☐Child* ☐Other*
**Subscriber Name*	**Subscriber Birth Date* – –	**Subscriber Social Security Number* – –	**Subscriber Employer*

SECONDARY Insurance Company	Subscriber ID Number	Group Number	Patient Relationship to Subscriber: ☐Self (*skip to next section*) ☐Spouse* ☐Child* ☐Other*
**Subscriber Name*	**Subscriber Birth Date* – –	**Subscriber Social Security Number* – –	**Subscriber Employer*

REFERRAL SOURCE

How did you hear about our practice?	☐Physician ☐Friend/Relative ☐Web ☐Social Media ☐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)

PHYSICIAN INFORMATION (Please obtain full information of your Primary Care Physician)

Physician Last Name	First	M.I.	Degree	Physician Phone
			MD DO	( )

Physician Address	City	State	Zip	Physician Fax
				( )

How long has he/she provided your care?

Please list the name, phone, and specialty of other Health Care Professionals who treat you:

PRE-OPERATIVE WEIGHT HISTORY

Please provide a weight history (in pounds).

2010	2011	2012	2013	2014	2015
lbs.	lbs.	lbs.	lbs.	lbs.	lbs.

What was your highest weight ever?	What age was your highest weight?	How much did you weight at 14 years of age?	At 18?	How many years have you been overweight?
lbs.	yrs.	lbs.	lbs.	yrs.

What was your lowest weight since you were 18 or older?	What age was that lowest weight?	How many years have you tried to lose weight?	How long have you been considering weight loss surgery?
lbs.	yrs.	yrs.	

MEDICAL PROBLEMS RELATED TO OBESITY

CARDIOVASCULAR DISEASE	Current	Past	Never		Current	Past	Never
High Blood Pressure or Hypertension?	☐	☐	☐	Peripheral Vascular Disease or Stroke?	☐	☐	☐
Congestive Heart Failure?	☐	☐	☐	Lower Extremity Edema or Swelling?	☐	☐	☐
Ischemic Heart Disease or Heart Attack?	☐	☐	☐	Leg Blood Clot or Pulmonary Embolus?	☐	☐	☐
Anginal Chest Pain?	☐	☐	☐	Heart Stress Test or Heart Catheterization?	☐	☐	☐

METABOLIC DISEASE	Current	Past	Never		Current	Past	Never
Diabetes Mellitus Type 2 ?	☐	☐	☐	Insulin Resistance or High Blood Sugar?	☐	☐	☐
Diabetes Mellitus Type 1 ?	☐	☐	☐	Elevated Cholesterol or Lipids?	☐	☐	☐
Gout or Hyperuricemia?	☐	☐	☐	Thyroid Disorder?	☐	☐	☐

PULMONARY DISEASE	Current	Past	Never		Current	Past	Never
Sleep Apnea?	☐	☐	☐	Pulmonary Hypertension?	☐	☐	☐
C-Pap or Bi-Pap use?	☐	☐	☐	Asthma?	☐	☐	☐

GASTROINTESTINAL DISEASE	Current	Past	Never		Current	Past	Never
Heartburn, Reflux or GERD?	☐	☐	☐	Liver Disease or Abnormal Liver Tests?	☐	☐	☐
Barrett's Esophagitis?	☐	☐	☐	Gallstones or Gallbladder Removal?	☐	☐	☐
Crohn's Disease or Ulcerative Colitis?	☐	☐	☐	Lupus or Autoimmune Disorder?	☐	☐	☐

MUSCULOSKELETAL DISEASE	Current	Past	Never		Current	Past	Never
Back Pain?	☐	☐	☐	Back Pain requiring Medical Treatment?	☐	☐	☐
Hip, Knee, Joint, or Ankle Pain?	☐	☐	☐	Leg Pain requiring Medical Treatment?	☐	☐	☐
Fibromyalgia?	☐	☐	☐	Joint Replacement or Back Surgery?	☐	☐	☐

REPRODUCTIVE DISORDERS	Current	Past	Never		Current	Past	Never
Polycystic Ovarian Syndrome?	☐	☐	☐	Menstrual Irregularities?	☐	☐	☐
Infertility?	☐	☐	☐	Have you had a Hysterectomy?	☐	☐	☐

GENERAL	Current	Past	Never		Current	Past	Never
Urinary Stress Incontinence?	☐	☐	☐	Pseudotumor Cerebri?	☐	☐	☐
Excess Abdominal Skin or Pannus?	☐	☐	☐	Abdominal Hernia?	☐	☐	☐
Previous Weight Loss Surgery?	☐	☐	☐	Previous Ulcer or Reflux Surgery?	☐	☐	☐

PSYCHOSOCIAL INFORMATION – MARK ONLY ONE BOX FOR EACH QUESTION

Depression
- ☐ No symptoms of depression
- ☐ Mild and episodic, not requiring treatment
- ☐ Moderate, accompanied by some impairment, may require treatment or medications
- ☐ Moderate, with significant impairment, treatment indicated
- ☐ Severe, definitely requiring intensive treatment
- ☐ Severe, requiring hospitalization

Tobacco/E-cigarette Use
- ☐ Never
- ☐ Rare
- ☐ Occasional
- ☐ Frequent
- ☐ No longer use – Date Quit:_____

Confirmed Mental Health Diagnosis
- ☐ None
- ☐ Bipolar disorder
- ☐ Anxiety/panic disorder
- ☐ Personality Disorder
- ☐ Psychosis or schizophrenia

Functional Status (ability to walk)
- ☐ No impairment of functional status
- ☐ Able to walk 200ft with cane or crutch
- ☐ Cannot walk 200ft with cane or crutch
- ☐ Requires wheelchair
- ☐ Bedridden

Substance Abuse
- ☐ None
- ☐ Rare
- ☐ Occasional
- ☐ Frequent

Alcohol Use
- ☐ None
- ☐ Rare
- ☐ Occasional
- ☐ Frequent

MEDICAL HISTORY

List ANY OTHER medical problems (like cancer, diverticulitis, etc.) not found above.

FAMILY HISTORY OF MEDICAL PROBLEMS (parents, grandparents, siblings, aunts, uncles) – MARK ALL THAT APPLY

☐ High Blood Pressure ☐ Cancer ☐ Stroke ☐ Bleeding Disorder ☐ Unknown
☐ Heart Disease or Heart Attack ☐ Diabetes ☐ Obesity ☐ Clotting Disorder

PRESCRIPTION MEDICATIONS (attach separate list if necessary)

Name	Strength	Frequency	Purpose	When Started

NON-PRESCRIPTION MEDICATIONS AND VITAMINS CURRENTLY TAKING

Name	Strength	Frequency	Purpose	When Started

ALLERGIES TO MEDICATIONS, LATEX, OR OTHER SUBSTANCES

Allergic Substance Name	Reaction to Substance

LIST ANY SURGERY (Please write "Lap" if done Laparoscopically)

Surgery	Date	Reason