

PATIENT INFORMATION SHEET

PATIENT INFORMATION:

PATIENT NAME: _____ DATE OF BIRTH: _____

AGE: _____ SS# _____ MARITAL STATUS: M S D W SEX: M F

RACE: _____ PREFERRED LANGUAGE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: HOME _____ CELL: _____ WK: _____

EMAIL: _____ PLACE OF EMPLOYMENT: _____

HOW DID YOU HEAR ABOUT US: TV NEWSPAPER BILLBOARD INTERNET FRIEND/FAMILY: _____

OTHER: _____

EMERGENCY CONTACT: _____ PHONE: _____

RELATIONSHIP: _____

REFERRING / FAMILY PHYSICIAN INFORMATION:

REFERRING / FAMILY PHYSICIAN: _____ PHONE: _____

CITY: _____ STATE: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY: _____

ID #: _____ GROUP #: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S SS# _____

SUBSCRIBER'S DATE OF BIRTH: _____ SUBSCRIBER'S SEX: M F

RELATIONSHIP TO PATIENT: _____ ADDRESS: _____ CITY STATE ZIP

SECONDARY INSURANCE COMPANY: _____

ID #: _____ GROUP #: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S SS# _____

SUBSCRIBER'S DATE OF BIRTH: _____ SUBSCRIBER'S SEX: M F

RELATIONSHIP TO PATIENT: _____ ADDRESS: _____ CITY STATE ZIP

INSURANCE IS NOT GUARANTEED PAYMENT. BALANCE IS DUE WITHIN 90 DAYS OF THE INSURANCE CLAIM UNLESS ARRANGEMENTS HAVE BEEN MADE THROUGH OUR OFFICE.

FINANCIAL AGREEMENT

"THE INFORMATION STATED ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE. I, THE PERSON RESPONSIBLE FOR PAYMENT OF MEDICAL CARE FOR THE ABOVE PATIENT, AGREE TO PAY FOR THE OFFICE VISIT AND SERVICES THE DAY THE CARE IS PROVIDED. I AGREE TO PAY ANY BALANCE DUE ON OTHER CHARGES WITHIN 90 DAYS FROM THE DATE THAT SERVICE IS PROVIDED".

SIGNATURE: _____ **DATE:** _____

BARIATRIC MEDICAL QUESTIONNAIRE

DATE TODAY: _____

LAST NAME	FIRST NAME	MI	AGE	BIRTHDATE
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MARITAL STATUS: M S W D

OCCUPATION: _____

PRIMARY HEALTH CARE PROVIDER (PLEASE LIST THE LAST 5 YEARS)

OK FOR US TO NOTIFY
THE PHYSICIAN?

1. PHYSICIAN NAME: _____
ADDRESS: _____
PHONE NUMBER: _____
DATES OF TREATMENT: _____

YES NO

2. PHYSICIAN NAME: _____
ADDRESS: _____
PHONE NUMBER: _____
DATES OF TREATMENT: _____

YES NO

3. PHYSICIAN NAME: _____
ADDRESS: _____
PHONE NUMBER: _____
DATES OF TREATMENT: _____

YES NO

4. PHYSICIAN NAME: _____
ADDRESS: _____
PHONE NUMBER: _____
DATES OF TREATMENT: _____

YES NO

5. PHYSICIAN NAME: _____
ADDRESS: _____
PHONE NUMBER: _____
DATES OF TREATMENT: _____

YES NO

6. PHYSICIAN NAME: _____
ADDRESS: _____
PHONE NUMBER: _____
DATES OF TREATMENT: _____

YES NO

7. PHYSICIAN NAME: _____
ADDRESS: _____
PHONE NUMBER: _____
DATES OF TREATMENT: _____

YES NO

WEIGHT LOSS ATTEMPTS

	PROGRAM	PROGRAM DATES	WEIGHT LOSS	WEIGHT REGAINED	HOW LONG TO REGAIN	PHYSICIAN SUPERVISED? Y/N	DIETICIAN SUPERVISED? Y/N
1	Weight Watchers						
2	Jenny Craig						
3	Diet Center						
4	Nutri-System						
5	High Protien. Low Carb (Atkins, Southbeach)						
6	Sugar Buster						
7	Tops						
8	Over the Counter Diet Pills						
9	SlimFast or similar						
10	Phentermine (Adipex, Fastin, Etx)						
11	Fenfluramine/Phentermine (Fen/Phen)						
12	Meridia or Xenical						
13	Hypnosis, Jaw wiring, Acupuncture						
14	Others						

PERSONAL HISTORY

Please **Circle** all that apply

Measles	Scarlet Fever	Polio	Hepatitis C
German Measles	Scarletina	Gonorrhea	Tuberculosis
Mumps	Diphtheria	Hepatitis A	HIV positive
Chicken Pox	Small Pox	Hepatitis B	

FAMILY HISTORY

Please **SPECIFY** which family member has the below co-morbidities:
Include (Grandparents, Parents, Siblings, and Children)

Diabetes _____

High Blood Pressure _____

Heart Attack(s) _____

Stroke _____

Obesity _____

High Cholesterol _____

Depression _____

Bleeding Disorder _____

Psychiatric illness _____

Cancer – If so, what kind(s)? _____

I HAVE/HAVE NOT had previous WEIGHT LOSS SURGERY.
If yes, complete below:

Date of Previous Weight Loss Surgery: _____

Surgeon/Address: _____

Type of Procedure:

- | | | |
|--|------------------------------|------------------------------|
| Gastric Bypass (Roux-en-Y), Laparoscopic | Gastric Band, adjustable | Vertical Banded Gastroplasty |
| Gastric Bypass (Roux-en-Y), Open | Gastric Band, non-adjustable | Biliopancreatic Diversion |
| Gastric Bypass, banded | Sleeve Gastrectomy | Other _____ |
| | | _____ |
| | | _____ |

Original Weight _____ **Lowest Weight Achieved** _____

Were there any Complications: **YES** **NO**

If so, explain _____

SURGICAL HISTORY
 Please **CIRCLE** and **LIST** date

- | | |
|--------------------------------|---------------------------|
| _____ Appendectomy | _____ Knee |
| _____ Back | _____ Lung |
| _____ Breast Cancer | _____ Ovaries |
| _____ Cancer (any type) | _____ Prostate |
| _____ Colon/Intestinal Surgery | _____ Thyroid |
| _____ Gallbladder | _____ Tonsillectomy |
| _____ Hemorrhoids | _____ Tubal Ligation |
| _____ Heart | _____ Ulcers, Stomach |
| _____ Hernia (hiatal) | _____ Uterus Hysterectomy |
| _____ Hernia (umbilical) | _____ Colon Scope |
| _____ Hernia (inguinal) | _____ Stomach Scope |
| _____ Hernia (ventral) | _____ Other |

HEALTH HISTORY

Check Those that Apply

CARDIOVASCULAR DISEASE

Hypertension

- No history of hypertension
- Diagnosis of hypertension, no medication
- Treatment with single medication
- Treatment with multiple medications

Congestive Heart Failure (CHF)

- No history or symptoms of CHF
- Symptoms with more than ordinary activity
- Symptoms with ordinary activity
- Symptoms with minimal activity
- Symptoms at rest

Ischemic Heart Disease

- No history of ischemic heart disease
- Abnormal EKG, no active ischemia
- History of MI or anti-ischemic medication
- Stent placement, CABG
- Active ischemia

Angina Assessment

- No chest pain symptoms/angina
- Anginal chest pain only with extreme exertion
- Anginal chest pain with minimal exertion
Or at rest
- Previous heart attack by history or by
Current workup

Peripheral Vascular Disease

- No symptoms of peripheral vascular disease
- Claudication, anti-ischemic medication
- Transient ischemic attack, rest pain
- Procedure for peripheral vascular disease
- Stroke, loss of tissue secondary to ischemia

Lower Extremity Edema (Swelling)

- No symptoms of lower extremity edema
- Intermittent lower extremity edema,
Not requiring treatment
- Stasis ulcers
- Disability, decreased function, hospitalization

DVT/PE (Blood clot in legs or lungs)

- No history of DVT/PE
- History of DVT resolved with anticoagulation
- Recurrent DVT long term anticoagulation meds
- Previous PE
- Recurrent PE, decreased function, hospitalization
- Vena Caval filter

METABOLIC

Glucose Metabolism

- No symptoms of diabetes
- Elevated fasting glucose
- Diabetes, controlled with oral medication
- Diabetes, controlled with insulin
- Diabetes, controlled with insulin and oral
Medication
- Diabetes, with sever complications
(retinopathy, neuropathy, renal failure)

Lipids (Cholesterol or Triglyceride)

- Not present
- present, no treatment required
- Controlled with lifestyle change
- Controlled with single medication
- Controlled with multiple medication
- Not controlled

Gout

- No symptoms of gout
- Increase in Uric acid, medications
- Arthropathy
- Destructive joints
- Disability, unable to walk

PULMONARY

Obstructive Sleep Apnea Syndrome

- No symptoms or evidence of OSA
- Sleep apnea symptoms (Negative sleep study)
- Sleep apnea diagnosis by sleep study (no CPAP)
- Sleep apnea with significant hypoxia or Oxygen
- Sleep apnea requiring CPAP
- Sleep apnea with complications

Obesity Hypoventilation Syndrome

- No Symptoms of obesity hypoventilation
- Pulmonary Hypertension
- Right heart failure
- Right heart failure-Left ventricular dysfunction

Pulmonary Hypertension

- No symptoms or indication of pulmonary hypertension
- Confirmed PH diagnosis
- Well controlled on anticoagulants and/or
Calcium channel blockers
- Stronger medications and/or oxygen
- Patient needs or has had a lung transplant

Asthma

- No symptoms of asthma
- Intermittent mild symptoms, no medication
- Symptoms controlled with oral inhaler
- Well controlled with ongoing daily medication
- symptoms not well controlled, steroids
Or anticholinergics
- Hospitalized within last 2 years, history of intubation

GASTROINTESTINAL

GERD

- No history of GERD
- Intermittent or variable symptoms, no medication
- Medication as needed
- Meds everyday
- Meet criteria for anti-reflux surgery, or prior
Surgery for GERD

Cholelithiasis

- No history of gallstones
- Gallstones
- History of Cholecystectomy

Liver Disease

- No history of liver disease
- Modestly enlarged liver, Normal Liver function
- Modestly enlarged liver, Abnormal Liver function
- Cirrhosis, Hepatitis
- Liver failure, transplant indicated or done

MUSCULOSKELETALBack Pain

- No symptoms of back pain
- Intermittent symptoms not requiring treatment
- Symptoms requiring non-narcotic treatment
- Degenerative changes or positive objective findings
- Symptoms requiring narcotic treatment
- Surgical intervention done or recommended
- Pending weight loss
- Failed previous surgical intervention with Existing symptoms

Musculoskeletal Disease

- No symptoms of musculoskeletal disease
- Pain with community ambulation
- Non narcotic analgesia required
- Pain with household ambulation
- Surgical intervention required (ex: arthroscopy)
- Awaiting or past joint replacement or Other disability

Fibromyalgia

- No history of fibromyalgia
- Treatment with exercise
- Treatment with non-narcotic medications
- Treatment with narcotics
- Treatment with narcotics: Surgical intervention Done or recommended
- Disabling, treatment not effective

REPRODUCTIVEPolycystic Ovarian Syndrome (PCOS)

- No history of PCOS
- Symptoms of PCOS, no treatment
- Birth control
- Metformin
- Combination therapy
- Infertility

PSYCHOSOCIALConfirmed Mental health diagnosis

- None
- Bipolar Disorder
- Anxiety/panic Disorder
- Personality disorder
- Psychosis

Depression

- No symptoms of depression
- Mild and episodic not requiring treatment
- Moderate, accompanied by some impairment, May require treatment
- Moderate with significant impairment, Treatment indicated
- Moderate with significant impairment Treatment indicated
- Severe, definitely requiring intensive Treatment
- Severe requiring hospitalization

Alcohol Use

- None
- Rare
- Occasional
- Frequent

Substance Abuse (Prescription or Illegal Drugs)

- None
- Rare
- Occasional
- Frequent

Tobacco Use

- None
- Rare
- Occasional
- Frequent

_____pack per day times_____years

GENERALStress Urinary Incontinence

- No history of stress urinary incontinence
- Minimal and intermittent
- Frequent but not severe
- Daily occurrence, requires pad
- Disabling
- Operation ineffective

Abdominal Hernia

- No Hernia
- Asymptomatic hernia, no prior operation
- symptomatic hernia with or without incarceration
- Successful repair
- Recurrent hernia
- Multiple failed hernia repairs

Functional Status

- No impairment of functional status
- Able to walk 200 ft with assistance device
- Cannot walk 200 ft with assistance device
- Requires wheelchair
- Bedridden

Abdominal Skin/Pannus

- No symptoms
- Irritation/Rash in skin fold
- Pannus so large it interferes with ambulation
- Recurrent cellulites, ulceration
- Surgical treatment required

**IT HAS BEEN PROVEN THAT 1 IN EVERY 3
AMERICANS SUFFER FROM A SLEEP DISORDER**



Complete the following quiz and score yourself at the bottom.

- 1. I have been told that I snore
 - 2. I have been told that I stop breathing while I sleep
 - 3. I have gained weight
 - 4. I suffer from high blood pressure
 - 5. I feel fatigued during the day
 - 6. I suffer from morning headaches
 - 7. I have lost interest in sex
 - 8. I sweat excessively during the night
 - 9. I suddenly wake up unable to breathe
 - 10. My family and friends say that they have noticed a change in my personality
-
- 11. I have been told that I kick in my sleep
 - 12. I experience a "creepy, crawly" sensation in my legs
 - 13. I have excessive daytime drowsiness
 - 14. I have been told that I am a restless sleeper
 - 15. I awaken with sore or achy muscles
 - 16. I often have trouble staying asleep throughout the night
-
- 17. I have fallen asleep while driving
 - 18. I experience vivid nightmares soon after falling asleep
 - 19. No matter how hard I try to stay awake, I fall asleep
 - 20. I fall asleep throughout the day
 - 21. I feel paralyzed when I am waking up or falling asleep
 - 22. I feel like I am hallucinating when I fall asleep
-
- 23. I feel afraid to go to sleep
 - 24. I have trouble falling asleep
 - 25. Thoughts run through my mind, preventing me from going to sleep
 - 26. It often takes me an hour or more before I fall asleep
 - 27. I wake up in the middle of the night unable to return to sleep

SCORES

Sleep Apnea is a life threatening sleep disorder which frequently causes you to stop breathing. It can happen hundreds of times per night while you sleep and you may not even be aware it is happening.

Place the number checked from each of the following sections in the space provided below.

- _____ Questions 1-10
- _____ Questions 11-16
- _____ Questions 17-22
- _____ Questions 23-27

OWLO PATIENT EMAIL CONSENT

Patient Name: _____

Patient Address: _____

Email: _____

1. RISK OF USING EMAIL

Transmitting patient information by email has a number of risks that patients should consider before using email. These include, but are not limited to, the following:

- a) Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- b) Email senders can easily misaddress an email.
- c) Backup copies of email may exist even after the sender of the recipient has deleted his or her copy.
- d) Employers and on-line services have the right to inspect email transmitted through their systems.
- e) Email can be intercepted, altered, forwarded, or used without authorization or detection.
- f) Email can be used to introduce viruses into computer systems.
- g) Email can be used as evidence in court.
- h) Emails may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. CONDITIONS FOR THE USE OF MAIL

Providers cannot guarantee but will use reasonable means to maintain security and confidentiality of email information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Patients must acknowledge and consent to the following conditions:

- a) Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular Email will be read and responded to within any particular period of time.
- b) Email must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via email.
- c) All email will be printed and filed in the patient's medical record.
- d) Office staff may receive and read your messages.
- e) The patient should not use email for communication regarding sensitive medical information.

f) Provider is not liable for breaches of confidentiality caused by the patient or any third party.

g) It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. INSTRUCTIONS

To communicate by email, the patient shall:

- a) Avoid use of his/her employer's computer.
- b) Put the patient's name in the body in the body of the email.
- c) Key in the topic (e.g., medical question, billing question) in the subject line.
- d) Inform Provider of changes in his/her email address.
- e) Acknowledge any email received from the Provider.
- f) Take precautions to preserve the confidentiality of email.

4. PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the Providers and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Provider may impose to communicate with patients by email. If I have any questions I may inquire with my treating physician or the OWLO Office Manager.

Patient Signature: _____

Date: _____

Ronnie Keith D.O
HIPAA

**CONSENT FOR USE & DISCLOSURE OF HEALTH
INFORMATION**

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security Number: _____ Date of Birth: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: by signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our Privacy Practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office.

Telephone: (405) 360-7100 Fax: (405) 364-9112
Address: 3400 West Tecumseh Road Suite 205, Norman, Oklahoma 73071

Right to revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

My information may be released to the following organizations and/or individuals:

SIGNATURE SECTION – PLEASE PRINT

I, _____, have had full opportunity to read and consider the consents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____