



**NORMAN
REGIONAL**
Health System

**JOURNEY
CLINIC**

Thank you for your interest in our weight loss program! If you would like to view more information about our clinic and programs, we encourage you to visit us online at www.journeyclinic.com. Please feel free to contact us if you have any questions 405-515-2049.

You can use the following checklist to help get started:

- Complete our online Patient Form
- Complete attached Patient Packet and submit
- Submit legible copy of the front and back of your insurance card(s)
- Submit legible copy of Picture ID
- If you have a surgical interest, view our online seminar

Feel free to mail or drop off the completed information at our office location:

2821 36th Ave NW Ste 200
Norman, OK 73072

or Fax 405-307-5630

To find out more information, visit us online at www.journeyclinic.com
2821 36th Ave NW Ste 200 Norman, OK 73072 • 405-515-2049

Review of Systems

The following information is very important to your health.
Please take time to fully and completely fill out this important information.

Patient Name: _____ Date of Birth: _____

Primary Care Physician: _____ Referring Physician: _____

Reason for Visit Today: _____ Physician you are seeing: _____

Review of Systems: (please mark all that apply to you)

Systemic

- ___ Weakness
- ___ Tiredness
- ___ Weight Loss
- ___ Weight Gain
- ___ Trouble Sleeping
- ___ Fever

Eyes

- ___ Blurred Vision
- ___ Glasses/Contacts

Ears/Nose/Mouth

- ___ Difficulty Hearing
- ___ Ringing in Ears
- ___ Recurrent Infection
- ___ Sinus Problems
- ___ Nose Bleeds
- ___ Post Nasal Drip
- ___ Mouth Sores
- ___ Bleeding Gums
- ___ Sour Taste
- ___ Bad Breath

Throat

- ___ Lump in Throat
- ___ Hoarseness
- ___ Swollen Glands
- ___ Sore Throat
- ___ Difficulty Swallowing

Cardiac

- ___ Chest Pain
- ___ Chest Tightness
- ___ Heart Palpitations
- ___ Swollen Feet/Ankles

Respiratory

- ___ Cough
- ___ Snoring
- ___ Difficulty Breathing
- ___ With Walking
- ___ Climbing Stairs
- ___ Laying Flat

Gastrointestinal

- ___ Abdominal Pain
- ___ Bloating
- ___ Excessive Gas
- ___ Loss of Appetite
- ___ Nausea
- ___ Vomiting
- ___ Problems Swallowing
- ___ Heartburn
- ___ Blood in Stool
- ___ Constipation
- ___ Diarrhea
- ___ Mucous in Stool
- ___ Pain in Rectum
- ___ Jaundice
- ___ Change in Appetite

Skin/Breast

- ___ Cyst in Breast
- ___ Lump in Breast
- ___ Breast Pain
- ___ Rash
- ___ Hives
- ___ Lesion, Mole
- ___ Itching
- ___ Change in Skin Color
- ___ Change in Nails
- ___ Change in Hair

Hematologic

- ___ Slow Healing
- ___ Easy Bruising
- ___ Swollen Glands
- ___ Varicose Veins

Neurologic/Psych

- ___ Dizziness
- ___ Seizures
- ___ Numbness
- ___ Frequent Headaches
- ___ Depression
- ___ Anxiety

Endocrine

- ___ Excessive Thirst
- ___ Heat Intolerance
- ___ Cold Intolerance

Gynecologic-Women

- ___ Irregular Periods
- ___ Heavy Periods
- ___ Painful Periods
- ___ No Periods

Genitourinary

- ___ Frequent Urination
- ___ Painful Urination
- ___ Blood in Urine
- ___ Dark Urine
- ___ Urine Leakage
- ___ Nighttime Urination

Musculoskeletal

- ___ Pain in Joints
- ___ Back Pain
- ___ Difficulty Walking

Patient Name: _____

Date of Birth: _____

Surgical History: (Please mark if any applies to you)

- | | | |
|-----------------------------------------|---------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Abdominal | <input type="checkbox"/> Hernia | <input type="checkbox"/> Spine Surgery |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Abdominal | <input type="checkbox"/> Thyroid Surgery |
| <input type="checkbox"/> Breast Surgery | <input type="checkbox"/> Groin | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Colon Surgery | <input type="checkbox"/> Hiatal | <input type="checkbox"/> Tubal |
| <input type="checkbox"/> C-Section | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Weight Loss Surgery |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Joint Surgery | <input type="checkbox"/> Gastric Bypass |
| <input type="checkbox"/> Groin | <input type="checkbox"/> Lung Surgery | <input type="checkbox"/> Sleeve Gastrectomy |
| <input type="checkbox"/> Heart Bypass | <input type="checkbox"/> Open Heart Surgery | <input type="checkbox"/> Switch |
| <input type="checkbox"/> Heart Cath | <input type="checkbox"/> Prostate Surgery | <input type="checkbox"/> Adjustable Gastric Band |
| <input type="checkbox"/> Neck Surgery | Other: _____ | <input type="checkbox"/> Other |

Past Medical History: (Please mark all that apply to you)

- | | | |
|------------------------------------------------------|-------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Heart Valve Problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Cirrhosis of liver |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Fatty liver |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Leg Swelling or Ulcers | <input type="checkbox"/> Pulmonary Hypertension | <input type="checkbox"/> Depression |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Gastroesophageal Reflux |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Laryngopharyngeal Reflux |
| <input type="checkbox"/> Stroke/Mini-stroke | <input type="checkbox"/> Degenerative Disc Disease | <input type="checkbox"/> Peptic/Stomach ulcer |
| <input type="checkbox"/> High Cholesterol/Lipids | <input type="checkbox"/> Gout | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> High Triglycerides | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Pre-diabetes | <input type="checkbox"/> Enlarged Prostate | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Metabolic Syndrome | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Bipolar disorder |
| <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Kidney insufficiency/failure | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Vitamin Deficiency | <input type="checkbox"/> Pituitary Disorder | <input type="checkbox"/> _____ in legs |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Adrenal Disorder | <input type="checkbox"/> _____ in lungs |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Polycystic Ovaries | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Tuberculosis | Type: _____ |
| <input type="checkbox"/> Hiatal | | Type: _____ |
| <input type="checkbox"/> Abdominal | | Type: _____ |
| | | Type: _____ |

Patient Name: _____

Date of Birth: _____

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Social History : (please mark all that apply to you)

Marital Status: ___Single ___Married ___Divorced ___Widowed

Work History: ___Student ___Self-Employed ___Employed ___Unemployed ___Disabled ___Retired

Is this a result of a Work Injury ? ___No ___Yes If Yes: Adjustor Name/Address: _____
Phone: _____

Living Status: ___Live Alone ___Live with someone

Exercise: ___Daily ___Occasionally ___Rarely ___Never

Caffeine use: ___Coffee ___Tea ___Energy Drinks ___Soda ___Total cups (8oz) per day

Tobacco Use:

Do you use tobacco/nicotine? ___Never ___Currently ___Previously Date quit? _____

If currently, what type: ___Cigarettes ___Cigars ___Vapor ___Oral tobacco

If currently, how often is your use ? ___Everyday ___Some days, but not every day ___Socially

How many cigarettes/cigars do you smoke a day ? ___5 or less ___6-10 ___11-20 ___21-30 ___31 or more

After waking, when do you smoke your first cigarette?
___within 5 minutes ___6-30 minutes ___31-60 minutes ___after 60 minutes

Are you interested in quitting? ___Ready to quit ___Thinking about quitting ___Not ready to quit

Alcohol Use:

Did you have a drink containing alcohol in the past year ? ___Yes ___No

If yes, how often did you have a drink containing alcohol in the past year ?
___2 to 4 times a month ___2 to 3 times a week ___4 or more times a week

If yes, how many drinks did you have on a typical day when you were drinking in the past year ?
___1 to 2 drinks ___3 to 4 drinks ___5 to 6 drinks ___7 to 9 drinks ___10 or more

If yes, how often did you have 6 or more drinks on one occasion in the past year ?
___Never ___Less than monthly ___Monthly ___Weekly ___Daily or almost daily

Recreational Drug Use:

Have you used drugs for other than medical reasons in the past 12 months? ___Yes ___No If yes, type _____

Have you ever used street drugs ? ___Never ___Currently ___Within last 12 months ___IV use ___Oral use

Patient Name: _____

Date of Birth: _____

Family History: (complete to the best of your knowledge)

___ I am adopted and do not know my family medical history

<u>Father</u>	<u>Mother</u>	<u>Siblings</u>	<u>Children</u>
___ Living	___ Living	___ Living	___ Living
___ Deceased	___ Deceased	___ Deceased	___ Deceased
___ bleeding disorders	___ bleeding disorders	___ bleeding disorders	___ bleeding disorders
___ breast cancer	___ breast cancer	___ breast cancer	___ breast cancer
___ colon cancer	___ colon cancer	___ colon cancer	___ colon cancer
___ diabetes	___ diabetes	___ diabetes	___ diabetes
___ heart disease	___ heart disease	___ heart disease	___ heart disease
___ high blood pressure	___ high blood pressure	___ high blood pressure	___ high blood pressure
___ lung disease	___ lung disease	___ lung disease	___ lung disease
___ ovarian cancer	___ ovarian cancer	___ ovarian cancer	___ ovarian cancer
___ prostate cancer	___ prostate cancer	___ prostate cancer	___ prostate cancer
___ thyroid disorder	___ thyroid disorder	___ thyroid disorder	___ thyroid disorder

Previous Exams: (list most recent date obtained)

<u>Exam Type</u>	<u>Yes / Year</u>	<u>Facility</u>	<u>Never</u>
Complete Physical			
Bone Density Scan			
Stress Test			
Heart Catherterization			
Upper Endoscopy			
Colonoscopy			
Prostate Exam			
Pap Smear			
Mammogram			

Patient Name: _____

Date of Birth: _____

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Preferred Pharmacy you use: _____

Current medications: (Please include non-prescription medications, vitamins, supplements, creams, eye drops and inhalers)

Medication Name:

Dosage:

Times taken daily:

Medication allergies:

Reaction:

Food allergies:

Latex allergy: ___Yes ___No

Height: _____ Weight: _____

**The questions on this form have been accurately answered to the best of my knowledge.
I understand that providing incorrect information may be dangerous to my health.
It is my responsibility to inform the doctor's office of any changes in my medical status.**

Patient Signature _____ Date: _____

Relationship to Patient (circle one): Self Parent Guardian POA

FOR OFFICE USE ONLY:

Physician's statement: I have reviewed the information and made additions or corrections as necessary.

Physician Signature: _____ Date: _____



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Last Name: _____ First Name: _____ DOB: ___/___/___

HEALTH CARE PROVIDERS

Please list the most recent providers you routinely seek health care from

		MAY WE CONTACT?
PHYSICIAN NAME:		
ADDRESS:		YES NO
PHONE NUMBER:		
TYPE OF PROVIDER:		
PHYSICIAN NAME:		
ADDRESS:		YES NO
PHONE NUMBER:		
TYPE OF PROVIDER:		
PHYSICIAN NAME:		
ADDRESS:		YES NO
PHONE NUMBER:		
TYPE OF PROVIDER:		
PHYSICIAN NAME:		
ADDRESS:		YES NO
PHONE NUMBER:		
TYPE OF PROVIDER:		

WEIGHT LOSS ATTEMPTS

Have you tried any of the below weight loss methods in the past?

PROGRAM	CIRCLE YES OR NO	APPROX PROGRAM DATES	WEIGHT LOSS	WEIGHT REGAINED	HOW LONG TO REGAIN	PHYSICIAN SUPERVISED Y/N	DIETITIAN SUPERVISED Y/N
WEIGHT WATCHERS	Y / N						
JENNY CRAIG	Y / N						
HIGH PROTEIN/LOW CARB (ATKINS, SOUTHBEACH)	Y / N						
NUTRI-SYSTEM	Y / N						
OVER THE COUNTER DIET PILLS	Y / N						
PHENTERMIN (ADIPEX, FASTIN, ETX, OR QSYMIA)	Y / N						
FENFLURAMINE/PHENTER MINE FEN/PHEN	Y / N						
CONTRAVE	Y / N						
XENICAL	Y / N						
SLIMFAST OR SIMILAR	Y / N						
HYPNOSIS, ACUPUNCTURE, EAR STAPLING	Y / N						
SAXENDA	Y / N						
OTHERS (LIST)							

FUNCTIONAL STATUS

Circle your highest level of functioning.

Walk without assistance

Walk a block with assistance (cane/walker)

Walk around house with assistance (cane/walker)

Require wheelchair

Bedridden

SLEEP QUESTIONNAIRE

Check all that apply

___ I have been told that I snore

___ I have been told that I stop breathing while I sleep

___ I suddenly wake up unable to breathe

___ I frequently toss and turn during sleeping hours

___ I don't feel well rested when I wake up

___ I frequently take naps during the day

___ I feel fatigued/tired during the day

___ I have difficulty with long periods of concentration

___ I suffer from morning headaches

___ I have problems with memory loss

___ My family and friends say that they have noticed that I am more irritable

FACTORS THAT HAVE CONTRIBUTED TO NOT ACHIEVING WEIGHT LOSS

Check all that apply

___ Lack of Exercise

___ Eating Sweets

___ Binge Eating

___ Eating Large Quantities

___ Stress Eating

___ Food Addictions

___ Eating Carbohydrates

___ Eating Out

___ Snacking

___ Grazing

Name: _____

DOB: _____

Last Physician Recorded: Height _____ Weight: _____ BMI: _____

CIRCLE if you are currently being TREATED for:

High Blood Pressure	High Cholesterol
Diabetes	Arthritis of the weight bearing joints
Sleep Apnea	Degenerative Disc Disease

Which service would you like to pursue? (please circle one)

Weight Loss Surgery

Medical Weight Loss

Surgical Follow Up Care

___ Gastric Bypass

___ Revision

___ Sleeve Gastrectomy

___ Back on Track

___ Adjustable Gastric Band

___ Routine Follow Up Care

HAVE you been a part of a weight loss program in the past 2 years? YES NO

Name of Program: _____

HAVE you been a part of a surgical program in the past? YES NO

Name of Program: _____

HAVE you previously had weight loss surgery? YES NO

Type: _____

Date: _____

For Weight Loss Surgery Patients ONLY: I have watched the complete Weight Loss Surgery Seminar series on Journey Clinic's website. _____ (Initials)

Patient Signature: _____

Date: ____/____/____



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We Would Like To Know....

What factor(s) made you decide to pursue weight loss surgery? (Check all that apply)

- | | |
|-------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Improve Health Condition(s) | <input type="checkbox"/> Become More Active |
| <input type="checkbox"/> Lose Weight | <input type="checkbox"/> Physician Recommendation |
| <input type="checkbox"/> Friend/Family Recommendation | <input type="checkbox"/> Other: _____ |

**What factor(s) made you decide to pursue weight loss surgery with Journey Clinic?
(Check all that apply)**

- | | |
|---------------------------------------|-----------------------------------------------------------------------------------|
| <input type="checkbox"/> Procedure | <input type="checkbox"/> Surgeon/Staff |
| <input type="checkbox"/> Timeliness | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Facility | <input type="checkbox"/> Recommendation (friend/family/health care provider, etc) |
| <input type="checkbox"/> Other: _____ | |

How did you hear about Journey Clinic? (Check all that apply)

- | | |
|------------------------------------------------------------------|-------------------------------------------------------------------------|
| <input type="checkbox"/> Internet Search | <input type="checkbox"/> Referred by Friend |
| <input type="checkbox"/> Referred by Primary Care Physician | <input type="checkbox"/> Referred by Specialist |
| <input type="checkbox"/> Saw Clinic While at Another Appointment | <input type="checkbox"/> Saw / Heard Advertisement
(Describe): _____ |
| <input type="checkbox"/> Other: _____ | |

What websites do you use when researching Weight Loss Surgery? (Check all that apply)

- | | |
|-------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Google/Yahoo/Bing/Etc. | <input type="checkbox"/> obesityhelp.com |
| <input type="checkbox"/> lapband.com | <input type="checkbox"/> journeyclinic.com |
| <input type="checkbox"/> normanregional.com | <input type="checkbox"/> other: _____ |