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 405-735-2049.

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:

3400 W. Tecumseh Rd Ste 105
Norman, OK 73072

or Email: journeyclinic@nrh-ok.com

or Fax 405-307-5630

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

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

___Abdominal
___Appendectomy
___Breast Surgery
___Colon Surgery
___C-Section
___Gallbladder
___Groin
___Heart Bypass
___Heart Cath
___Neck Surgery
___Hernia
___Abdominal
___Groin
___Hiatal
___Hysterectomy
___Joint Surgery
___Lung Surgery
___Open Heart Surgery
___Prostate Surgery
Other: _____
___Spine Surgery
___Thyroid Surgery
___Tonsillectomy
___Tubal
___Weight Loss Surgery
___ Gastric Bypass
___ Sleeve Gastrectomy
___Switch
___Adjustable Gastric Band
___Other

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

___Heart Valve Problems
___Hypertension
___Congestive Heart Failure
___Coronary Heart Disease
___Peripheral Vascular Disease
___Leg Swelling or Ulcers
___HIV
___Glaucoma
___Stroke/Mini-stroke
___High Cholesterol/Lipids
___High Triglycerides
___Diabetes
___Pre-diabetes
___Metabolic Syndrome
___Chronic Sinusitis
___Allergies
___Vitamin Deficiency
___Anemia
___Hemophilia
___Hernia
___Hiatal
___Abdominal
___Asthma
___Emphysema
___Bronchitis
___Pneumonia
___Sleep Apnea
___Pulmonary Hypertension
___Osteoporosis
___Osteoarthritis
___Degenerative Disc Disease
___Gout
___Rheumatoid Arthritis
___Fibromyalgia
___Enlarged Prostate
___Kidney Stones
___Kidney insufficiency/failure
___Thyroid Disorder
___Pituitary Disorder
___Adrenal Disorder
___Polycystic Ovaries
___Tuberculosis
___Gallstones
___Cirrhosis of liver
___Hepatitis
___Fatty liver
___Anxiety
___Depression
___Gastroesophageal Reflux
___Laryngopharyngeal Reflux
___Peptic/Stomach ulcer
___Crohn's disease
___Colitis
___Pancreatitis
___Epilepsy
___Bipolar disorder
___Schizophrenia
___Blood Clots
___in legs
___in lungs
___Cancer
Type:_____
Type:_____
Type:_____
Type:_____

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

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

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

Father	**Mother**	**Siblings**	**Children**
___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)

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

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: _____

JOURNEY CLINIC

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/PHENTERMINE 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:**_____/_____/_____

We Would Like To Know....

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

[ ] Improve Health Condition(s)

[ ] Become More Active

[ ] Lose Weight

[ ] Physician Recommendation

[ ] Friend/Family Recommendation

[ ] Other: _____

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

[ ] Procedure

[ ] Surgeon/Staff

[ ] Timeliness

[ ] Insurance

[ ] Facility

[ ] Recommendation (friend/family/health care provider, etc)

[ ] Other: _____

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

[ ] Internet Search

[ ] Referred by Friend

[ ] Referred by Primary Care Physician

[ ] Referred by Specialist

[ ] Saw Clinic While at Another Appointment

[ ] Saw / Heard Advertisement (Describe): _____

[ ] Other: _____

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

[ ] Google/Yahoo/Bing/Etc.

[ ] obesityhelp.com

[ ] lapband.com

[ ] journeyclinic.com

[ ] normanregional.com

[ ] other:_____