Cuyuna Regional Medical Center - Clinic
New Patient Registration

MIMIS Intake Packet

Date of seminar: _____

Location: _____

PERSONAL INFORMATION

Name: _____Maiden Name_____
Date of Birth: _____ Gender: ____ Male ____Female
Marital Status: ____ Single ____ Married ____ Divorced ____ Widow
Height: ____Feet____ Inches Weight: _____Pounds BMI: ____ (use chart)
Referred by:_____ Procedure desired: _____

HOME ADDRESS

Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____
Cell Phone: _____
E-mail: _____

WORK ADDRESS

Company: _____
Position: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____
E-mail: _____

PRIMARY HEALTH CARE PROVIDER

Physicians Name: _____
Name of Clinic: _____
Address of Clinic: _____
Clinic Phone: _____ Clinic Fax: _____
How long has he/she provided medical care for you? _____

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Have you ever been a patient here at the clinic? _____ ***If so, under what name?*** _____

Who is your Primary Care Provider?_____

Patient Information

Name: _____ Date of Birth: _____

Sex: _____ SSN#: _____ Marital Status: _____

Primary Insurance

Insurance Name: _____

Phone: _____Address: _____

_____

Policy Holder Name: _____Relationship to Patient: _____

Date of Birth: _____

ID Number: _____Group Number: _____

Secondary Insurance

Insurance Name: _____

Phone: _____Address: _____

_____

Policy Holder Name: _____Relationship to Patient: _____

Date of Birth: _____

ID Number: _____Group Number: _____

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EMERGENCY CONTACTS

Relationship: _____
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____
E-mail: _____

FAMILY HISTORY

Relationship	Weight (pounds)	Diabetes	High Blood Pressure	Sleep Apnea	Arthritis	High Cholesterol
Mother						
Father						
Sibling						
Sibling						
Sibling						

Condition	Date	Comments

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ALLERGIES

Drug/Food	Date	Reaction	Notes

DIETARY HISTORY

Type	Length of Diet	Starting Weight	Lbs. Lost	Lbs. Gained Back
Jenny Craig				
Nutri-Systems				
Weight Watchers				
Opti/Medi Fast				
Fen/Phen/Redux				
Meridia				
T.O.P.S				
Calorie Reduction				
Slim Fast				
Other				

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DIETARY HISTORY CONTINUED

How long have you been overweight? _____

How old were you when you first went on your first diet?_____

Name stressors or triggers which may cause inappropriate eating.

_____, _____, _____

Do you eat a large volume at mealtimes?	____ Yes	____ No
Do you often snack between meals?	____ Yes	____ No
Do you react to stress by eating or snacking?	____ Yes	____ No
Do you routinely eat after 7 pm?	____ Yes	____ No
Do you feel like you lose control or have lost control over how you eat?	____ Yes	____ No

Name your top three favorite foods.

1._____ 2. _____ 3. _____

What beverages do you consume on a daily basis?

_____

FOOD PREFERENCES

Indicate which foods you enjoy the most Rank each section from 1 to 4, with **1= like very much 4= don't care for.**

_____candy	_____ice cream	_____cakes/pies	_____salad dressings
_____pizza	_____potatoes	_____fried foods	_____soda/soft drinks
_____pasta	_____chocolate	_____chips/snacks	
_____cookies	_____French fries	_____steaks/chops	

How many times per week do you eat out?_____

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MEDICATIONS

(Also include vitamins, herbal supplements and over-the-counter meds)

Medication Name	Date Started	Indication	Dosage	Notes

PREVIOUS SURGERIES

Type	Why?	Date	Facility/Hospital

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Please remember that insurance is considered a method of reimbursing that patient for fees paid to the physician and hospitals. It is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charges. It is your responsibility to pay any deductible, co-pay, or other balances not paid for by your insurance.

I authorize my physician and the hospital to release my insurance company or any other third party, any information including diagnosis and records of such treatments as necessary to determine my eligibility for any procedure, liability for payment, and to obtain reimbursement. I also authorize and request my insurance companies to pay directly to my physician and to the hospital the amount due in my pending claim for surgical and medical care. I understand that I am financially responsible for all charges regardless of the insurance status and am aware that all outstanding balances will be subject charges as listed separately.

Signed: _____ Date: _____

SPECIAL NOTE:

COPIES OF ALL INSURANCE INFORMATION, FRONT AND BACK, IS REQUIRED. THANK YOU

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INITIAL ASSESSMENT

PATIENT NAME: _____

DATE: _____

GENERAL

How is your health in general? ____ Good ____ Fair ____ Poor

CENTRAL NERVOUS SYSTEM / PSYCHIATRIC

Have you been depressed? ____ Yes ____ No
Hospitalized for depression? ____ Yes ____ No
Suicidal? ____ Yes ____ No
Are you taking medications for depression? ____ Yes ____ No
Do you have or have you had any other mental health problems? ____ Yes ____ No
Please describe: _____
_____

What is your average alcohol use? (Drinks per week)_____
(Drinks per month)_____
Do you have a history of substance or alcohol abuse? ____ Yes ____ No
Please describe: _____
_____

CARDIOVASCULAR

Do you have hypertension (high blood pressure)? ____ Yes ____ No
How many years?_____
Do you have heart disease? ____ Yes ____ No
Please describe: _____
_____
Have you taken phen-fen? ____ Yes ____ No
When? _____
For how many months? _____
How many pounds did you lose? _____
Have you ever had an Echocardiogram? ____ Yes ____ No
(If yes, we will need a copy)
Do you see a Cardiologist? ____ Yes ____ No
Doctor? _____
Where? _____
Last Visit? _____

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PULMONARY

Do you have lung problems? ____ Yes ____ No
Do you ever experience shortness of breath with physical activity? ____ Yes ____ No
Do you smoke? ____ Yes ____ No
Have you quit smoking? ____ Yes ____ No
When? _____
Do you have Asthma? ____ Yes ____ No
So you have sleep apnea? ____ Yes ____ No
Do you use a CPAP? ____ Yes ____ No
Does your family say you have loud and/or irregular snoring? ____ Yes ____ No

SLEEP APNEA SCREENING TOOL

Height: _____ Weight: _____ Age: _____ ☐ Male / Female ☐
Do you snore? ☐ Yes ☐ No ☐ Don't Know

If you snore:

Your snoring is:
_____ slightly louder then breathing
_____ As loud as talking
_____ Louder than talking
_____ Very Loud - can be heard in adjacent rooms

How often do you snore?
_____ nearly every day
_____ 3 - 4 times a week
_____ 1 - 2 times a week
_____ 1 - 2 times a month
_____ Never or nearly ever

Has your snoring ever bothered other people? ____ Yes ____ No ____ Don't Know

Has anyone noticed the you quit breathing during your sleep?
_____ nearly every day
_____ 3 - 4 times a week
_____ 1 - 2 times a week
_____ 1 - 2 times a month
_____ Never or nearly ever

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SLEEP APNEA CONTINUED

How often do you feel tired or fatigues after you sleep?

_____ nearly every day
_____ 3 - 4 times a week
_____ 1 - 2 times a week
_____ 1 - 2 times a month
_____ Never or nearly ever

During your waking time, do you feel tired, fatigues or not up to par?

_____ nearly every day
_____ 3 - 4 times a week
_____ 1 - 2 times a week
_____ 1 - 2 times a month
_____ Never or nearly ever

Have you ever nodded off or fallen asleep while driving a vehicle? ____ Yes ____ No

If yes:
How often does this occur?

_____ nearly every day
_____ 3 - 4 times a week
_____ 1 - 2 times a week
_____ 1 - 2 times a month
_____ Never or nearly ever

Do you have high blood pressure?

_____ nearly every day
_____ 3 - 4 times a week
_____ 1 - 2 times a week
_____ 1 - 2 times a month
_____ Never or nearly ever

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GASTROINTESTINAL (GI)

Do you have frequent heartburn? ____ Yes ____ No
Do you take antacids or other medications for heartburn? ____ Yes ____ No
For how many years? ____
Have you had an upper gastrointestinal endoscopy? ____ Yes ____ No
Where? _____
When? _____
Do you ever have any type of pain in the abdomen? ____ Yes ____ No
If yes, give details including location: _____
_____
_____
_____

Any changes in bowels? ____ Yes ____ No
Any history of hemorrhoids? ____ Yes ____ No

GENITOURINARY

Do you have kidney problems? ____ Yes ____ No
Do you sometimes lose your urine with coughing or sneezing?
____ Yes ____ No
Times per week? _____
Or Times per month? _____
Do you have urinary stress incontinence? ____ Yes ____ No
Are you infertile? ____ Yes ____ No
Have you ever been pregnant? ____ Yes ____ No
Any miscarriages? ____ Yes ____ No
Have you seen your doctor about this? ____ Yes ____ No
Is there a diagnosis? ____ Yes ____ No
Diagnosis: _____
_____
_____

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MUSCULOSKELETAL

Have you had bone, joint, or muscle problems? ____ Yes ____ No
Which joints?
☐ Spine ☐ Hip ☐ Knee ☐ Ankle _____ Other?
Is there a diagnosis?
Diagnosis: _____
_____
Have you had an x-ray to prove this diagnosis? ☐ Yes ☐ No
Have you had lower leg ulcers? ☐ Yes ☐ No
Do you have fibromyalgia? ☐ Yes ☐ No

HEMATOLOGY / ONCOLOGY

Do you have, or have had anemia (low hemoglobin)? ☐ Yes ☐ No
Do you have a history of abnormal bleeding or clotting? ☐ Yes ☐ No
Have you had a cancer or other tumor? ☐ Yes ☐ No
When? _____
Where? _____
Are you HIV positive? ____ Yes ____ No

METABOLIC

Do you have elevated cholesterol or lipids? ____ Yes ____ No
Do you have diabetes? ____ Yes ____ No
When diagnosed? _____
_____
Have you seen an Endocrinologist? ____ Yes ____ No
Doctor? _____
Where? _____
Last Visit? _____

Please tell us anything else that you would like us to know to help us provide you with the best possible care: _____
_____
_____
_____

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To Whom it May Concern,

I, _____, understand that to become an eligible patient in the MIMIS Bariatric Program I need to know the following information: there is an evaluation process that requires me to see specialists in Crosby and other facilities deemed appropriate. At any one of these visits, my process in this program may be terminated and that I may no longer be considered a candidate for the Laparoscopic Gastric Bypass Roux-en-y or Gastric Sleeve. It is also my responsibility to notify this facility if my insurance changes at any time.
I understand and wish to continue on.

_____
Signature

_____
Date

Thank you and welcome to our program.

MIMIS Bariatric Team

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