

(Please fill out in black ink)

YOUR NAME: _____ PRIMARY CARE DOCTOR: _____
REFERRING DOCTOR: _____
HOSPITAL WHERE YOU WERE SENT FROM: _____

Please describe briefly in your own words

1) what **symptoms** you experienced on what date and /or how often they occurred

2) and any **tests or x-rays** done

3) and **medications** prescribed for this illness:

Please list all surgeries/operations you have had:

<u>Date</u>	<u>Operation performed</u>	<u>Reason</u>	<u>Hospital/Doctor</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you **allergic** to any medications Y___ N___ List: _____

Please list all **medications** that you take:

<u>Medication</u>	<u>Used for?</u>	<u>Dosage</u>	<u>(# per day)</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you **smoke**? ___Yes ___No Yes (but quit in year_____)

How many packs per day do you smoke? _____ How many years? _____

Do you drink **alcohol**? ___Yes ___No Yes (previously but sober since ___)

Answer: beer ___#per day/week/weekend wine or liquor ___#per day/week/weekend

Glenn M. Ihde, MD, PA
Minimally Invasive Bariatrics, PA
(Please fill out in black ink)

Have you ever received a **BLOOD TRANSFUSION**? NO _____ YES _____

If YES, please describe: _____

please provide GYN history: #pregnancies __ #live births __ :(#vaginal __ and/or #C-section __)

Dates of live births _____

Last menstrual period _____ birth control: _____ tubal _____ pills _____ other _____

Year of menopause _____ year if hysterectomy (partial) or (total) _____

On hormone replacement therapy since _____

FAMILY HEALTH HISTORY: if known, please identify any of these illnesses in close family members such as:

<u>Circle disease below and check blank</u>	grandparents	parents	brothers	sisters	children
Cancer of (breast), (prostate) (testicle)	_____	_____	_____	_____	_____
Cancer of (colon), (stomach),(liver), (pancreas)	_____	_____	_____	_____	_____
Cancer of (vagina), (cervix), (uterus), (ovary)	_____	_____	_____	_____	_____
(Leukemia), (Lymphoma)	_____	_____	_____	_____	_____
(High blood pressure)	_____	_____	_____	_____	_____
(Diabetes)	_____	_____	_____	_____	_____
(Heart attack), (Stroke)	_____	_____	_____	_____	_____

OWN HEALTH HISTORY: Do you have or have you ever had any of the following (indicate dates):

<u>Circle illness</u>	<u>Diagnosed</u>	<u>Treated</u>	<u>Hospitalized</u>
Diabetes	_____	_____	_____
High blood pressure	_____	_____	_____
Angina/heart attack/heart murmur	_____	_____	_____
Heart failure/feet swelling	_____	_____	_____
Irregular heart beat/pacemaker	_____	_____	_____
Heart bypass or angioplasty	_____	_____	_____
Asthma/emphysema	_____	_____	_____
Tuberculosis/pneumonia	_____	_____	_____
Seizures/stroke/carotid artery surgery	_____	_____	_____
Migraine or severe headaches	_____	_____	_____
Hepatitis A B C/ cirrhosis/jaundice	_____	_____	_____
Bleeding tendency/hemophilia/sickle cell	_____	_____	_____
Breast cancer/biopsy/fibrocystic disease	_____	_____	_____
HIV infection/AIDS/immunosuppressant med	_____	_____	_____
Mental illness/suicidal thoughts	_____	_____	_____
Depression/anxiety disorder	_____	_____	_____
Kidney problems/failure/dialysis/kid stones	_____	_____	_____
Hypothyroid/thyroid surgery/parathyroid	_____	_____	_____
Endometriosis/pelvic infection/uterine fibroids	_____	_____	_____
Blindness/cataracts/glaucoma/eyeglasses	_____	_____	_____
Leg pain/foot ulcers/blood clots/poor circulation	_____	_____	_____
Arthritis/osteoporosis	_____	_____	_____
Back pain or injury/back surgery/herniated disc	_____	_____	_____
Prostate enlargement/testicle problems	_____	_____	_____
Stomach ulcers/vomiting blood	_____	_____	_____
Diverticulitis/irritable bowel/hemorrhoids	_____	_____	_____
Crohn's disease/ulcerative colitis	_____	_____	_____
Esophageal reflux/ulcer/varices/Barret's	_____	_____	_____
Recent unintentional weight gain/loss	_____	_____	_____

IF FURTHER INFORMATION IS NEEDED I GIVE MY CONSENT TO ASK THE RESPECTIVE HEALTH CARE PROVIDER OR AGENCY TO RELEASE ANY INFO. I WILL NOTIFY THE DOCTOR OF ANY CHANGES IN MEDICATIONS OR MY HEALTH

Signature: _____

Glenn M. Ihde, MD, PA
Minimally Invasive Bariatrics, PA
(Please fill out in black ink)

Please check any that apply:

Psychologic Evaluation

_____ Embarrassed about appearance _____ Avoid social activities
_____ Feeling blue _____ Crying Easily _____ Feeling worthless
_____ Suicidal thoughts _____ Shouting frequently _____ Throwing things
_____ Frequent arguments _____ Temper outbursts _____ Urges to break things
_____ Urges to harm or injure someone _____ Hearing voices that others do not
_____ Feelings that others can control your thoughts _____ Having thoughts that are not your
own

On a scale of zero to ten rate how you feel you appear to others

_____ 0 _____ 10
OK Not too good Unpleasant

Sleep Apnea

_____ Snore _____ Wake choking _____ Wake with headache
_____ Wake frequently _____ Fall asleep reading _____ Fall asleep driving
_____ Nap during the day _____ Partner notices you hold your breath while sleeping

Reflux (heartburn)

_____ Previous history of reflux Episodes: per week _____ per day _____ per night _____
_____ Asthma _____ Hoarseness _____ frequent dry cough
_____ Difficulty swallowing _____ Food gets stuck _____ vomit acid/bile at night
Previous medications for reflux/heartburn _____ How long _____

Infertility

Regular periods Y/N Heavy Period Y/N Difficulty conceiving >6 mos Y/N
Polycystic ovary disease Y/N Do you use birth control Y/N

Previous Weight Loss Program
(Please fill out in black ink)

How many years have you been at least 100 lbs overweight?

Primary Care Physician(PCP): _____ Date of first exam with PCP _____

Have you discussed your weight with your PCP? Y/N

How much weight have you lost since first seeing your PCP? _____

How much weight have you gained or regained since first seeing your PCP? _____

Any other physicians you have seen regarding you weight? _____

How many years overall have you been trying to lose weight? _____

In that time, how much total have you lost? _____

How much have you regained? _____

What other programs have you tried?

Jenny Craig	Weight Watchers	Doctors Clinic	Nutrisystem
LA weight loss	Optifast	TOPS	Pritikin
Atkins	Cabbage Diet	Grapefruit diet	Metabolife
Herbalife	Slim Fast	Medifast	Liquid diet

Others: _____

Medications taken for weight loss

Amphetamines	Phentermine (Adipex, Fastin, Pondimen)	Phen-Fen
Redux (Dexfenfluramine)	Xenical (Orlistat)	Meridia (Sibutramine)

Others: _____

Non-dietary therapies

Exercise/Health Club Membership	Hypnosis	Behavior Modifications	Acupuncture
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Patient Signature: _____ Date: _____

Minimally Invasive Bariatrics, PA
(Please fill out in Black Ink)

Weight Loss Expectations

<u>Expectation</u>	<u>Description</u>	<u>Weight Lost</u>
Dream weight	“A weight you would choose if you could weigh whatever you wanted.”	_____
Happy weight	“This weight is not as ideal as the first one. It is a weight, however, that you would be happy to achieve.”	_____
Acceptable weight	“A weight that you would not be particularly happy with, but one that you could accept, since it is less than your current weight.”	_____
Disappointed weight	“A weight that is less than your current weight, but one that you could not view as successful in any way. You would be disappointed if this were your final weight after the program.”	_____

How do you expect surgery to help you?

Please rank these statements: 1 being the most important and 8 being the least

- _____ Improved overall medical condition
- _____ Improved overall quality of life
- _____ Less pain
- _____ Increased mobility
- _____ Improved self esteem
- _____ Improved relationships
- _____ Improved work life
- _____ All the above

Glenn M. Ihde, MD, PA
Minimally Invasive Bariatrics, PA
(Please fill out in black ink)

DATE: _____ SOCIAL SECURITY #: _____
NAME: _____ DOB: _____
ADDRESS: _____ APT#: _____
CITY/STATE: _____ ZIP: _____
PHONE #: _____ AGE: _____ SEX: M F
EMAIL: _____ CELL: _____
YOUR EMPLOYER: _____
OCCUPATION: _____ PHONE: _____
MARRIED _____ SINGLE _____ DIVORCED _____ WIDOWED _____

SPOUSE: _____ SOCIAL SECURITY: _____
SPOUSE'S EMPLOYER: _____ DOB: _____
OCCUPATION: _____ PHONE: _____

EMERGENCY CONTACT NOT LIVING WITH YOU: _____
EMERGENCY CONTACT PHONE #: _____
REFERRED BY: _____ PHONE: _____
PCP: _____ PHONE: _____

HEALTH INSURANCE: _____
POLICY #: _____ GROUP#: _____
EMPLOYER: _____ PHONE: _____
SECONDARY INSURANCE: _____
POLICY #: _____ GROUP #: _____
EMPLOYER: _____ PHONE: _____

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite health insurance carrier payments. However, the patient will be responsible for all fees, regardless of insurance coverage. Disability forms will be completed for a fee of \$10.00.

INSURANCE AUTHORIZATION/ASSIGNMENT

I request that payment of authorized medical and other insurance benefits be paid to Glenn M. Ihde, M.D., P.A. and or Minimally Invasive Bariatrics, PA for any service furnished to me by that party who accepts assignment/physician. I authorize any holder of medical information about me to release to the SSA and HCFA or its intermediaries or carrier or any other insurance company any information needed for this or related Medicare/other insurance claim. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay a claim.

SIGNATURE: _____ DATE: _____

Glenn M. Ihde, MD, PA
Minimally Invasive Bariatrics, PA
Financial Responsibility Agreement
(Please fill out in black ink)

Patient Name: _____ Date of Birth: _____ Date of Visit: _____

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any Medical service or visit, preventative exam, or physical, lab testing, x-ray, EKG, and any other Screening service or diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the Physician or Clinic to know if my insurance will pay for my Medical service or visit, Preventative exam or physical, Lab testing, X-ray, EKG, or any other Screening service of Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out of network amount, usual and customary limit or any other type of benefit limitation for the service I receive, and I agree to make full payment.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree it is my responsibility to know if my PCP choice has been processed by my Insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

Signature: _____ **Date:** _____

Responsible Party Name: _____

Glenn M. Ihde, MD, PA
Minimally Invasive Bariatrics, PA
(Please fill out in black ink)

In our efforts to comply with the Health Information Privacy Act (HIPPA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

Please circle your response to the following:

May we leave messages concerning your appointments with a co-worker, receptionist or secretary that regularly answer your calls? Yes No N/A

May we leave messages on a voice mail at home &/or work? Yes No N/A

May we discuss your appointments/treatment with your spouse? Yes No N/A

If you are over the age of 18, still living at home, may we discuss your appointments/treatment with your parent(s) or guardian? Yes No N/A

If you are over the age of 18, may we discuss your appointments and /or treatment with your children? Yes No N/A

You must inform us, in writing, of any changes in your directives. This record takes effect April 14, 2003, and will be kept in your file along with your acknowledgement of receipt of our Notice of Privacy Practices.

Signature: _____

Date: _____

Printed Name: _____

Date of Birth: _____

Witness: _____

Date: _____

Glenn M. Ihde, MD, PA
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817-467-3000
817-467-3001 Fax

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(Please fill out in black ink)

PRIVACY PRACTICE ACT

In our efforts to comply with the Health Information Privacy Practice Act (HIPPA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

PLEASE ANSWER THE FOLLOWING QUESTIONS

Please list **one** person of your choice who we may speak with regarding your surgery *postoperatively*.

NAME: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____

PHONE #: _____ SS#: _____

DATE OF BIRTH: _____

Please list a password that only you and the person listed above would know. This password would need to be given to Dr. Ihde before any information will be released.

Thank you for your assistance in protecting your patient privacy

AGREEMENT AS TO RESOLUTION OF CONCERNS

“I”, “Patient/Guardian” shall be understood to mean _____.
“Physician” shall be understood to mean Dr. Glenn Ihde, Glenn M. Ihde, MD, PA,
Minimally Invasive Bariatrics, PA, Ihde Surgical Group, PA.

Further, I understand that I am entering into a contractual relationship with Dr. Glenn Ihde for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Dr. Glenn Ihde, I, the patient/guardian and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Dr. Glenn Ihde.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use American Board of Medical Specialties (“ABMS”) board-certified expert medical witness (es) in the same specialty as Dr. Glenn Ihde. Furthermore, I agree that these expert witnesses will adhere to the guidelines and / or code of conduct defined for expert witnesses by the American Board of Surgery.

In further consideration for this, Dr. Glenn Ihde agrees to the same stipulations.

Physician

Patient/Guardian

Effective from Date of Treatment:

Date of Signature

MUTUAL AGREEMENT TO MAINTAIN PRIVACY

Dr. Glenn Ihde and Glenn M. Ihde, MD, PA, Minimally Invasive Bariatrics, PA, Ihde Surgical Group, PA agree to maintain Privacy of _____ as outlined in the HIPAA form. Dr. Glenn Ihde takes pride in being able to extend a greater degree of privacy than is required by HIPAA, state confidentiality mandates, and common law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, HIPAA forbids physicians from receiving money for selling lists of patients or protected health information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Dr. Glenn Ihde believes this is improper and may not be in your best interest. Accordingly, Dr. Glenn Ihde agrees not to provide any list for marketing or be paid for selling patient lists or protected health information to any party for the purpose of marketing directly to patients. Regardless of legal privacy loopholes, Dr. Glenn Ihde will never attempt to leverage its relationship with you, the patient, by seeking your consent for marketing products for others.

In consideration for treatment and the above noted patient protection, you agree to refrain from directly or indirectly publishing or airing commentary upon Dr. Glenn Ihde and his practice, expertise and/or treatment unless explicitly mandated by law. Publishing is intended to include attribution by name, by pseudonym, or anonymously. Dr. Glenn Ihde has invested significant financial and marketing resources in developing his practice. In addition, you, the patient, (i) will not denigrate, defame, disparage, or cast aspersions upon Dr. Glenn Ihde; and (ii) will use all reasonable efforts to prevent any member of your immediate family or acquaintance from engaging in any such activity. Published comments on web pages, blogs, and/or mass correspondence, however well intended, could severely damage Dr. Glenn Ihde's practice.

Dr. Glenn Ihde feels strongly about your privacy as well as the practices' right to control its public image and privacy. Both Dr. Glenn Ihde and you, the patient, will work to prevent the publishing or airing of commentary about the other party from being accessed via Internet, blogs, or other electronic, print, or broadcast media without prior written consent. Finally, this Agreement shall be in force and enforceable for a period of five years from Dr. Glenn Ihde's last date of service to you, the patient. As a matter of office policy, Dr. Glenn Ihde is requiring all patients in his practice sign the Mutual Agreement to Maintain Privacy so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Dr. Glenn Ihde's patients. Further, this Agreement will survive for a minimum of three years beyond any termination of the Physician-Patient relationship.

You, the patient, and Dr. Glenn Ihde acknowledge that breach of this Agreement may result in serious, irreparable harm. In addition to compensation for consequential damages, you, the patient, and Dr. Glenn Ihde agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

You, the patient, have been given the opportunity to ask questions and receive satisfactory and adequate explanations.

SO AGREED THIS ___ DAY OF _____, 2008. _____

Signature of patient

SO AGREED THIS ___ DAY OF _____, 2008. _____

Dr. Glenn Ihde
Glenn M. Ihde, MD, PA
Minimally Invasive Bariatrics, PA
Ihde Surgical Group, PA