Ihde Surgical Group, PA

YOUR NAME: _____ PRIMARY CARE DOCTOR: _____
REFERRING DOCTOR: _____

Please describe briefly in your own words
1) what **symptoms** you experienced on what date and /or how often they occurred

_____

_____

2) T**ests or x-rays** done

_____

_____

3) list all surgeries/operations you have had:

Date	Operation performed	Reason	Hospital/Doctor

Are you **allergic** to any medications Y___ N ___

Medication _____
Location: skin, local, abdominal, systemic/anaphylactic
Reaction: rash – localized, rash – generalized, itchiness, patchy swelling, facial swelling, hives: red eyes, runny nose, cough, stomach pain/cramping, bloating/gas, vomiting, diarrhea, nausea; shortness of breath, wheezing, tongue swelling, difficulty speaking/swallowing, dizziness/lightheadedness, loss of consciousness, chest pain, irregular heartbeat, rapid heart rate, slow heart rate,
Severity: Very mild, mild, moderate severe

Medication _____
Location: skin, local, abdominal, systemic/anaphylactic
Reaction: rash – localized, rash – generalized, itchiness, patchy swelling, facial swelling, hives: red eyes, runny nose, cough, stomach pain/cramping, bloating/gas, vomiting, diarrhea, nausea; shortness of breath, wheezing, tongue swelling, difficulty speaking/swallowing, dizziness/lightheadedness, loss of consciousness, chest pain, irregular heartbeat, rapid heart rate, slow heart rate,
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Reaction: rash – localized, rash – generalized, itchiness, patchy swelling, facial swelling, hives: red eyes, runny nose, cough, stomach pain/cramping, bloating/gas, vomiting, diarrhea, nausea; shortness of breath, wheezing, tongue swelling, difficulty speaking/swallowing, dizziness/lightheadedness, loss of consciousness, chest pain, irregular heartbeat, rapid heart rate, slow heart rate,
Severity: Very mild, mild, moderate severe

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

Medication	Used for?	Dosage	(# per day)

Smoking/Tobacco History:
_____ 0 cigarettes per day (non-smoker or less than 100 in lifetime)
_____ 0 cigarettes per day (previous smoker)
_____ Few (1-3) cigarettes per day
_____ Up to 1 pack per day
_____ 1-2 packs per day
_____ 2 or more packs per day

_____ Cigar smoker
_____ Snuff or chewing tobacco

Alcohol History:
_____ No use of alcohol
_____ Number of servings of alcohol per Month, week, day

Have you ever received a **BLOOD TRANSFUSION**? NO _____ YES _____
If YES, please describe: _____

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OB/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:

Circle disease below and check blank	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):

Circle illness	Diagnosed	Treated	Hospitalized
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/immunosuppresant 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

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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

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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: _____
Preferred Pharmacy: Location_____
Phone _____

Do You Have An Advance Directive To Physcian? Please Provide Copy

Do You Have Someone Designated As Your Durable Power Of Attorney For Healthcare? Please Provide Copy

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 $25.00.

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: _____

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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: _____

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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: _____

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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 before any information will be released.

_____

Thank you for your assistance in protecting your patient privacy.