

Dear Patient:

Welcome to our practice! You are about to embark in one of the most important health related decisions in your life; one that should greatly improve your quality of life and well-being. The following medical packet must be completed to the best of your ability to determine if you meet the medical criteria for this life altering surgery as well as aiding to obtain approval from your insurance company.

If your insurance requires a referral by your primary care physician (PCP), prior to consultation, please obtain it and bring it with you at the time of your first appointment.

This is an incredible time in your life and one that is filled with numerous questions. Please at anytime, do not hesitate to call the office at the above number so that we may answer your questions and ease your mind. We greatly look forward to meeting you and thank you for your consideration.

Best Regards,

A handwritten signature in black ink, appearing to read "John D. Husted", with a horizontal line extending to the right.

John D. Husted, MD

John D. Husted, MD
877-JHUSTED (877-548-7833) • (606)-425-4699 (Fax)
ellen@johnhustedmd.com • www.johnhustedmd.com

Patient Demographics:

Name: _____
Address: _____

Phone: _____ Work Phone: _____
Height: _____ Cell Phone: _____
Marital Status: _____ Occupation: _____
Drivers License: _____ Employer: _____
Social Security: _____ **Latex Allergy? Yes • No**
DOB: _____ Current Weight: _____
Email: _____
Which Surgery are you *most* interested in? _____

Spouse/Parent Demographics:

Name: _____ Home Phone: _____
Address: _____ Work Phone: _____

Occupation: _____ Driver's License: _____
Employer: _____ Social Security: _____

Referred By: _____

How did you first hear about us? _____

Primary Care Physician/ Referring MD:

Name: _____ Phone: _____
Address: _____

Fax : _____

Primary Insurance Co: _____ **Secondary Insurance Co:** _____
ID#: _____ ID#: _____
Policy#: _____ Policy#: _____
Group#: _____ Group#: _____
Effective Date of Policy: _____ Effective Date of Policy: _____

Emergency Contact:

Name: _____ Phone: _____
Address: _____ Relationship: _____

I authorize this office to release any information obtained in the course of my evaluation and treatment to permit processing of claims for insurance reimbursement. I understand that I am responsible for payment for any outstanding account balance and any reasonable cost of collection fees. A photocopy of my signature is valid.

Signature of Patient: _____ Date: _____

Name: _____ Gender: M ___ F ___ Age: _____

Medical History

Please check if you have/had or do any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> AIDS/Positive HIV |
| <input type="checkbox"/> Blood Clot/Pulmonary Embolus | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Smoke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Heartburn/Reflux | <input type="checkbox"/> Epilepsy/Seizure |
| <input type="checkbox"/> Hernia, Abdominal | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Hernia, Incisional | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Hernia, Hiatal | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> ___ Ankles | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> ___ Hips | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> ___ Lower Back | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> ___ Shoulders | <input type="checkbox"/> Serious Injury |
| <input type="checkbox"/> Menstrual Irregularities | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Polycystic Ovary Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Transfusion/Blood |
| <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Gastrointestinal Problems |
| <input type="checkbox"/> Urinary Stress Incontinence | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Drink Alcohol |
| <input type="checkbox"/> Bladder/Kidney Problems | <input type="checkbox"/> Swollen Feet/ankles |
| <input type="checkbox"/> Chronic Constipation | <input type="checkbox"/> Steroid Therapy |
| <input type="checkbox"/> Abdominal Cramping | <input type="checkbox"/> Nausea/Vomiting |
| | <input type="checkbox"/> Food Intolerance |

What are your eating patterns?

Binging Grazing Bulimia Compulsive Overeating

Do you have any medical conditions not listed above? Please list: _____

Have you been diagnosed with a psychiatric/mental illness? Yes ___ No ___

What is that diagnosis? _____

Admission to inpatient psychiatric facility? Yes ___ No ___

Do you have a history of physical or sexual abuse? Yes ___ No ___

Will you accept blood or blood products? Yes ___ No ___

Do you have any allergies to medications? Yes ___ No ___

If yes, please list: _____

Name: _____

Medical History Continued

Please list all medications that you are currently taking:

Medication	Dosage	Reason

If you take any herbal supplements, please list: _____

Previous Surgery

Procedure:	Date:
_____	_____
_____	_____
_____	_____
_____	_____

Family History

Please indicate if an **immediate** family member has suffered or been diagnosed with any of the following:

	Relationship
Diabetes	_____
Heart Disease/Attack	_____
Gallbladder Disease	_____
High Blood Pressure	_____
Morbid Obesity	_____
Sleep Apnea	_____
Stroke/Vascular Disease	_____
Colon Cancer	_____

Name _____

Weight Loss History

What is your desired weight? _____ Height _____
 What age did you become obese? _____ Years you have been obese? _____
 What has been your highest weight? _____

Medically Supervised Weight Loss Programs:

	Date:	How Long?	lbs Lost	Physician	City/State
Xenical	_____	_____	_____	_____	_____
Opti-Fast	_____	_____	_____	_____	_____
Fen/Phen	_____	_____	_____	_____	_____
Redux	_____	_____	_____	_____	_____
Meridia	_____	_____	_____	_____	_____
Medifast	_____	_____	_____	_____	_____
Prozac	_____	_____	_____	_____	_____
Synthroid	_____	_____	_____	_____	_____
Hypnosis	_____	_____	_____	_____	_____
Acupuncture	_____	_____	_____	_____	_____
Inpatient	_____	_____	_____	_____	_____
Behavior Mod.	_____	_____	_____	_____	_____
Dietary Council	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

Supervised Weight Loss Programs:

	Date:	How Long?	lbs Lost	Physician	City/State
Weight Watchers	_____	_____	_____	_____	_____
Jenny Craig	_____	_____	_____	_____	_____
Nutra Systems	_____	_____	_____	_____	_____
LA Wt Loss	_____	_____	_____	_____	_____
Nutritionist	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

Name: _____

Weight Loss History Continued

Independent Weight Loss Attempts:

Date	Length of time	Wt Lost/Wt Gained
Slim Fast	_____	_____
Atkins	_____	_____
Metabolife	_____	_____
Herbalife	_____	_____
Hydroxycut	_____	_____
Sugar Busters	_____	_____
Other Diets	_____	_____
Xenedrine	_____	_____
Grapefruit	_____	_____
Mayo Clinic	_____	_____

Sleep Apnea Screening

- | | | |
|------------|-----------|--|
| Yes | No | |
| • | • | Do you have sleep apnea? C-PAP or BiPAP? (please circle) |

If you answered no, please answer the following questions:

- | | | |
|---|---|---|
| • | • | Do you snore? |
| • | • | Do others say that choking sounds interrupts your sleep? |
| • | • | Do others say that you stop breathing while you are asleep? |
| • | • | Do you fall asleep during the day? |
| • | • | Have you ever fallen asleep while driving or at work? |
| • | • | Do you have trouble concentrating due to sleepiness? |
| • | • | Do you feel depressed due to lack of sleep or too much sleep? |
| • | • | Does your snoring awaken you? |

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Patient Agreement

If you are a candidate for surgery and you plan to have surgery, we request that you make a commitment to your health and your aftercare. The following questions are important for your desired weight loss, your overall general health and your aftercare. If you are willing to make the following commitments, please sign and date below.

- Are you willing to make all of your scheduled appointments?
- Are you willing to take all of the supplements recommended?
- Are you willing to never use tobacco products?
- Are you willing to adhere to the diet recommended to you?
- Are you willing to have no alcohol for two months after surgery?

I agree to the above and will adhere to the program recommended to me by Dr. Husted.

Patient Signature: _____ Date: _____

Please include an enlarged copy (if possible) of your insurance card with your fax.