Patient Guide to Insurance Verification

At OhioHealth Medical Weight Management, we strive to assist you throughout your journey. Your active participation in the program is vital to your success, and your assistance in the verification of your insurance benefits is a very important step in the process. The following guide will aid you in your conversation with your insurance.

Questions to ask your insurance representative:

- Name of the representative: _____
- Is Weight Management a covered benefit for me? YES or NO
- Is Medical Nutrition Therapy covered (CPT 97802/97803)? YES or NO
    - How many visits per a year are allowed? _____
- Is OhioHealth Physician Group In-Network? YES or NO
- Is OhioHealth In-Network for mental health? YES or NO
- Do you cover the following:
    - Diagnosis codes E66.0 / E66.9 / E66.3? YES or NO
    - Psychologist appointments for weight loss? YES or NO
- Have I met my deductible? YES or NO

Frequently Requested CPT Codes:

SERVICES	CODE	PROFESSIONAL FEES	CODE
EKG	93000	Provider	
Comprehensive Metabolic Panel	80053	New (1 hour)	99204 or 99205
Lipid Panel	80061	Established (30 minutes)	99213 or 99214
Magnesium	83735	Dietitian	
TSH	84443	New (1 hour)	97802
CBC	85027	Follow-Up (30 minutes)	97803
Uric Acid	84550	Psychologist	
Urinalysis	81001	New (1 hour)	96150
Glucose	82962/82947		
T4, Free	84439		
Vitamin D	82306		

OhioHealth
BELIEVE IN WE™

OhioHealth Weight Management Consent Form

I, _____, authorize OhioHealth Weight Management to help me in my weight loss efforts. I understand that this clinic uses a multidisciplinary approach; clinical staff includes medical providers, dietitians, psychologists, and exercise physiologists. My plan will include dietary change, regular exercise, and behavior modification techniques. My care plan may also involve the use of medication; this is an option my provider and I may choose through shared decision making, but it is not guaranteed. I understand that the OhioHealth Weight Management clinic does not participate in prescribing medications from compound pharmacies. I understand that by participating in the OhioHealth Weight Management clinic, I cannot participate in other health spas and online clinics to be prescribed weight loss medications.

I understand that any medical treatment may involve risks as well as the proposed benefits. I understand that there are certain health risks associated with remaining overweight or obese. These may include but are not limited to high blood pressure, high cholesterol, blood clots, diabetes, heart disease, arthritis, sleep apnea, infections, and even sudden death.

I understand that much of my success of this clinic will depend on my efforts and that weight loss is not guaranteed. I also understand that obesity is a chronic disease that will require long-term changes in eating habits and behavior to be treated successfully.

I have read and fully understand this consent form. All items on this form were explained to me in detail. I have voluntarily signed after/as my questions have been answered to my complete satisfaction.
If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your doctor before signing this consent form.

Printed Name: _____

Signature: _____

Date and Time: _____

OhioHealth Weight Management

No Show Policy

Our goal is to provide quality care to all of our patients in a timely manner. It is essential to your care, that you attend scheduled appointments. We have implemented a “no show” and cancellation policy, which enables us to better utilize available appointments for our patients. Please review the following information.

Please be courteous and call if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand and your early cancellation will give another person the possibility to have access to timely medical care.

No Show Policy: A “no-show” is when someone misses an appointment without cancelling or cancels an appointment less than 24 hours prior to their appointment time. Please note that if you call the office the same day as your appointment to cancel this will also result in a “no show.”

- First missed appointment: courtesy reschedule, documented occurrence.
- Second missed appointment: courtesy reschedule, documented occurrence with warning letter.
- Third missed appointment: You will no longer be able to reschedule your appointment or schedule any future appointments with our clinic.

Late Arrival: We ask that you arrive 15 minutes prior to the start of your scheduled appointment to complete registration and check in. If you arrive after the start of your appointment time, you will be asked to reschedule your appointment. Failure to be present at the time of a scheduled appointment will be recorded in your medical record as a “no-show.”

Patient Signature: _____ Date: _____

OhioHealth

Ref: OPG.POL.OPGE-1510.005 Effective Date: 3.8.22

INFORMED CONSENT FOR PSYCHOLOGICAL SERVICES

Throughout your participation in the OhioHealth Weight Management Program, you may receive psychological services. This form serves to provide an overview of psychological services offered through OhioHealth's Weight Management Program. Your signature constitutes consent for the services reviewed in this form.

Individual Behavioral Health Appointments

The purpose and nature of the relationship between this psychologist and you, the patient, is to provide brief short-term interventions for the duration of your time with the OhioHealth's Weight Management Program. Program psychologists can provide education, guidance, counseling, and support to develop a personalized plan for you to successfully meet your weight loss goals. Referral to outside mental health providers will be offered as needed or requested. The program psychologists are here as a support to you; however, the provision of long-term mental health care falls outside the scope of services offered.

Informed Consent: Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you hope to address. There are many different methods your therapist may use to deal with those problems. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But, there are no guarantees as to what you will experience.

Records: Progress notes will be entered into your electronic medical record and may be accessible by other OhioHealth providers and those participating in OhioHealth's organized health care arrangement, as indicated in OhioHealth's Joint Notice of Privacy Practices.

Pre-Surgical Psychological Testing and Evaluation for Bariatric Surgery

The purpose and nature of the relationship between this psychologist and you, the patient, is to provide a comprehensive pre-surgical evaluation, and may also include brief short-term interventions for the duration of your time with the OhioHealth Surgical Weight Management Program. Program psychologists can provide education, guidance, counseling, and support to develop a personalized plan for you to successfully meet your weight loss goals. Referral to outside mental health providers will be offered as needed or requested. The program psychologists are here as a support to you; however, the provision of long-term mental health care falls outside the scope of services offered.

Informed Consent: I understand that this psychological evaluation is a requirement for the OhioHealth Surgical Weight Management Program. Further, I understand that all program requirements must be completed successfully prior to insurance pre-certification for surgery. The program requirements may differ from those of my insurance plan; I understand that I will need to complete the requirements of the program and those of my insurance plan. I am aware that this psychological evaluation involves the completion of a variety of psychological tests, a clinical interview and education about risks and benefits of bariatric surgery. The psychologist will also review available medical records for which they have access and permissions (as indicated in OhioHealth's Joint Notice of Privacy Practices) to do so including information provided through OhioHealth's organized health care arrangement with participating community providers, hospitals, and physician practices. The total time of the evaluation varies but can take up to 3-4 hours. If my insurance company requires pre-authorization for psychological testing, or if other circumstances warrant it, I understand that I may need to schedule a second appointment in which to complete the testing. I understand that I could experience emotional distress due to the

personal nature of some of the questions that will be asked of me during the evaluation. I am aware that I can interrupt or discontinue the interview or testing at any time.

I understand that a written report of this evaluation will be submitted directly to my insurance company. I have a right to and will be provided with the evaluation results through my secure MyChart account. I understand that in some cases, I may be required to review the evaluation results with the psychologist. Following the evaluation, the psychologist may determine additional requirements that must be fulfilled prior to approval. I understand it is my obligation to complete these requirements as specified. All communication, including any such requirements, are communicated via MyChart, which I am responsible for monitoring.

Further, I understand that the psychologist completing this evaluation will consult with other members of the OhioHealth Surgical Weight Management Team, including the surgeons and dietitians, regarding pre-surgical recommendations. I understand that as a result of these consultations, the Team may require me to be evaluated by a psychiatrist or initiate other behavioral services to improve the likelihood of being able to safely proceed with surgery.

Telepsychology

As a patient receiving psychological services with OhioHealth through telepsychology methods, I understand:

1. This service is provided via technology (including by not limited to video, phone, text, and email) and may not involve direct, face-to-face, communication. There are benefits and limitations to this service. I will need access to, and familiarity with, the appropriate technology to participate in the service provided. Exchange of information will not be direct and any paperwork exchanged will likely be exchanged through electronic means or through postal delivery.
2. The psychologist is licensed to practice only in the State of Ohio and I (as the patient receiving care) must be located within the state at the time of the appointment. Should my location change I agree to notify the psychologist and reschedule my appointment for a later date when I am back within Ohio.
3. I may decline any telepsychology services at any time without jeopardizing my access to future care, services, and benefits. I may request face-to-face service once the crisis has resolved and in-person psychological services have resumed.
4. These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over the internet that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. My psychologist and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of technology.
5. In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means:
    a. In emergency situations, I understand that I need to call 9-1-1 or go to the nearest emergency room. I can also call Netcare Access at (614) 276-2273 if my situation is urgent, but not life-threatening.
    b. Should video-telecommunication service be disrupted, we may need to communicate by other means, including telephone, email or MyChart regarding alternative arrangements or to reschedule my appointment, if this is warranted. The psychologist will be checking voice messages frequently.
    c. For communication via email, I understand that the messages I receive will be encrypted and require me to follow the guidance provided in the email to access the message. For communication via MyChart, I understand that I need to have an active account and the ability to use a phone app or computer to access messages.
    d. Text messaging will not be part of my telepsychology services.
6. My psychologist may utilize alternative means of communication in the following circumstances and the appointment may need to be rescheduled to a later date.
    a. The psychologist is unable to reach me by the means we establish.

b. If internet service is disrupted during my appointment (if applicable).

7. It is my responsibility to maintain privacy on the patient end of communication. I agree to be on time, alone, in a quiet room, with the door closed at the time of my appointment. The use of headphones is encouraged for added security. I will attempt to find/remain in a good quality internet zone for highest quality video and/or audio.
8. I agree to devote my time and attention to the session for the duration of the appointment to the best of my ability and for which my present circumstances will allow. I will do my best to minimize outside distractions by turning off other devices (e.g., TV, cell phone apps, or other computer programs), and refrain from engaging in unnecessary tasks (e.g., cooking, cleaning, or driving).
9. I will do my best to ensure that my communications are directed only to my psychologist or other individuals, as deemed appropriate.
10. My communications exchanged with my psychologist will be stored in the electronic medical record. Insurance companies, those authorized by the patient, and those permitted by law may also have access to my medical records or communications.
11. The laws and professional standards that apply to in-person psychological services also apply to telepsychology services. This document does not replace other agreements, contracts, or documentation of informed consent. The extent of confidentiality and the exceptions to confidentiality that are outlined below still apply in telepsychology. Please let me know if you have any questions about exceptions to confidentiality.

For All Psychological Services

Contacting Your Provider: In order to provide quality services to clients during sessions, your treatment provider will not be available immediately by phone or email in most circumstances. If you need to communicate with your treatment provider at times other than your regularly scheduled appointment, you may call the office at which you receive services and leave a message. The office specialists will forward your message to the treatment provider who will determine if they will call you back or wait to discuss the issue at your next regularly scheduled appointment. The office specialists can work with you to make appointments or direct you to other associates to address most of your needs. You may also message your therapist via MyChart. If you are unable to reach associates and feel that you cannot wait for a return phone call, contact your family physician, or contact 911.

Limits of Confidentiality: I understand that if I disclose information related to actual or suspected threats of physical harm to myself or others; indicate the occurrence of child, elder, or dependent adult abuse; or if the psychologist conducting counseling is commanded by court order, OhioHealth will be required to disclose this information to appropriate authorities or parties mandated by law. I understand that with the exception of these circumstances, the progress notes about the counseling session are confidential and can be released only with my written consent authorizing such release.

Payment: I understand that OhioHealth Physician's Group, the practice contracted to provide the psychologist's services, will bill charges for counseling sessions to any and all insurance providers with whom I have active coverage. I understand that I am responsible for any portion of the payment that is not covered by my insurance, including, but not limited to a co-pay.

My signature represents my understanding of the procedure and agreement to participate psychological counseling with the OhioHealth Weight Management Program. It certifies that I have read and understood the conditions under which I have given this consent. I understand that with written notice, I can revoke this consent at any time.

Patient Name: _____ Patient Signature: _____

Date: _____ Time: _____

Witness: _____

OhioHealth

OhioHealth Weight Management
Surgical & Medical Weight Loss

Name of person completing this form: _____

Relationship to the patient: ❒ Self ❒ Spouse ❒ Parent ❒ Other: _____

Do you need help with completing this form? ❒ No ❒ Yes

PATIENT DEMOGRAPHICS

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____/_____/_____

How did you hear about us? _____

What is your highest level of education completed?

❒ Did not graduate high school ❒ High school ❒ Some college classes ❒ College degree ❒ Graduate degree

What is your preferred language? _____

Do you have any difficulty with hearing?

❒ No ❒ Yes ❒ I use hearing aids

Do you have any visual impairments?

❒ No ❒ Yes ❒ I use glasses/contact lenses

On the scale to the right, please rate your overall health by circling the number that best fits you:

1 2 3 4 5 6 7 8 9 10

unhealthy/ill average very healthy

Mark the statement below that best describes your sense of control over your health, life, and happiness.

❒ I feel in control, and what happens in my life is largely a result of my actions.

❒ I feel in control of my life most of the time.

❒ I feel that my life is often determined by outside influences and circumstances beyond my control

❒ I feel that I have little or no control, and am unable to change things in my life.

Have you had bariatric surgery in the past?

❒ No

❒ Yes ➔ What bariatric surgical procedure did you have? _____

Date of surgery: _____

Location (city, state): _____

PROCEED TO THE NEXT PAGE IF NOT INTERESTED IN WEIGHT LOSS SURGERY

SURGICAL WEIGHT MANAGEMENT

(fill out only if interested in bariatric surgery)

Have you ever been enrolled in another bariatric surgery program?

❒ No

❒ Yes ➔ When? _____

Name of other program: _____

Location (city, state): _____

Please mark the procedure or care that you seek from OhioHealth Surgical Weight Management from the options below.

❒ Gastric Bypass

❒ Gastric Sleeve

❒ Revision surgery (had prior bariatric surgery)

❒ Follow-up care after prior bariatric surgery through another program

WEIGHT HISTORY

How tall are you? _____ft. _____in. How much do you weigh now? _____lbs.

At what periods of your life have you been overweight? (please check all that apply)

❒ Childhood (age 12 or under) ❒ Young adult (ages 19-29) ❒ Older adult (age 60 or greater)

❒ Adolescence (ages 13-18) ❒ Middle adult (ages 30-59)

Have specific events ever resulted in your becoming overweight?

❒ No ❒ Yes ➔ What were these? _____
(e.g., illness/injury, inability to lose weight after pregnancy)

Have you ever been 100 pounds or more overweight? ❒ No ❒ Yes ➔ For how long? _____years

Have you ever gone on a diet? ❒ No ❒ Yes ➔ At what age did you begin dieting? _____years old

Please check all weight loss methods you have previously tried from the list below.

❒ Atkins diet
❒ Cabbage soup diet
❒ Calorie counting/restriction
❒ Cleveland Clinic diet
❒ Curves
❒ Diabetic diet/ADA
❒ Dr. Oz diet
❒ Dr. Phil diet
❒ Grapefruit diet
❒ Heart Healthy/DASH
❒ Herbalife
❒ High protein/low carb
❒ Hypnosis
❒ Intermittent fasting
❒ Keto
❒ Low fat diet
❒ Mayo Clinic diet
❒ McConnell Heart Health Center
❒ Meal replacements (SlimFast, Optifast)
❒ Overeaters Anonymous
❒ Prepared food programs (Jenny Craig, Nutrisystem)
❒ Physicians Weight Loss Centers
❒ South Beach diet
❒ Weight Watchers
❒ The Zone diet
❒ Other(s): _____
_____
_____

Please check all over-the-counter or prescribed medications/supplements you have tried specifically for weight loss from the list below.

❒ Accutrim/Dexatrim
❒ Adipex(phentermine)
❒ Alli/Xenical (orlistat)
❒ Contrave
❒ Cortislim
❒ Dexedrine dextroamphetamine)
❒ Didrex(benzphetamine)
❒ Diuretics ("water pills")
❒ Ephedra/Ephedrine
❒ Fen-Phen
months: _____
❒ GLP-1 Injections(Ozempic, Monjourno, Saxenda, Wegovy, Zepbound,)
❒ Green coffee bean
❒ Green tea extract
❒ HCG
❒ Hoodia
❒ Hydroxycut
❒ Jardiance
❒ Laxatives
❒ Lipozene/Leptoprim
❒ Meridia(sibutramine)
❒ Metabolife
❒ Metformin
❒ Pondimin (fenfluramine)
❒ Prozac
❒ Redux (dexfenfluramine)
❒ Relacor
❒ Sensa
❒ SlimQuick
❒ Tenuate(diethylproprion)
❒ TrimSpa
❒ Vitamin B_{12} injections
❒ Wellbutrin
❒ Xenadrine
❒ Other(s):
_____
_____

Did any weight loss methods or medications/supplements help you be successful in losing weight?

❒ No

❒ Yes ➔ ❒ I lost less than 25% of the weight I wanted to lose.

❒ I lost between 25% - 50% of the weight I wanted to lose.

❒ I lost between 50% - 75% of the weight I wanted to lose.

❒ I lost more than 75% of the weight I wanted to lose.

If you had some success using a weight loss method or medications/supplements, how long did you keep that weight off?

❒ No success ❒ 3 to 6 months ❒ 1 to 5 years

❒ Less than 3 months ❒ 6 months to 1 year ❒ More than 5 years

How much weight did you lose with your most successful attempt? _____lbs.

What method(s) were involved in this success? _____

Which reasons below do you feel contribute to your weight problems? (check all that apply)

❒ Poor food/beverage choices
❒ I don't like the taste of healthy foods.
❒ Healthy foods cost too much.
❒ Lack of knowledge about healthy foods
❒ Lack of time to prepare healthy foods
❒ I don't like to exercise.
❒ Lack of time for physical activity
❒ My health status prevents physical activity.
❒ I don't know how to exercise safely.
❒ Exercise equipment/gym membership too costly
❒ It hasn't been a priority for me.
❒ Medications I am taking
❒ Hormonal (menopause, hysterectomy, thyroid, etc.)

NUTRITION AND ACTIVITY EVALUATION

Please mark your activity level below – answer only one.

- ❒ Inactive: no regular physical activity with a sit-down job
- ❒ Light activity: no organized physical activity during leisure time
- ❒ Moderate activity: occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling
- ❒ Heavy activity: consistent lifting, stair-climbing, heavy construction, etcetera; or regular participation in jogging, swimming, cycling or active sports at least three times per week
- ❒ Vigorous activity: participation in extreme physical exercise for at least 60 minutes per session, 4 times per week

If you exercise, please list the types and indicate the frequency below.

Type of exercise: _____

❒ 0-3 times per week ❒ 1-3 times per week ❒ 3-5 times per week ❒ 5-7 times per week

Food allergies: _____

Foods you dislike: _____

Is there any specific time of day or month you crave food?
❒ No ❒ Yes ➔ When? _____

Do you drink coffee or tea? ❒ No ❒ Yes ➔ How much daily? _____

Do you drink cola drinks? ❒ No ❒ Yes ➔ How much daily? _____

Do you use sugar substitutes? ❒ No ❒ Yes Butter? ❒ No ❒ Yes Margarine? ❒ No ❒ Yes

Do you awaken hungry during the night?
❒ No ❒ Yes ➔ What do you do? _____

What are your worst food habits? _____

Please fill in the following based on your snacking habits.

What: _____

How much: _____

When: _____

When you are under stressful situations, do you tend to eat more?
❒ No ❒ Yes ➔ Please explain: _____

Do you think you are currently undergoing a stressful situation or an emotional upset?
❒ No ❒ Yes ➔ Please explain: _____

BINGE EATING AND PURGING

Aside from holiday feasts, have you ever eaten a large amount of food rapidly and felt afterward that this eating incident was excessive and out of control?

2 ☐	0 ☐
Yes	No

If you answered "Yes" to the question above, how often have you engaged in this behavior during the last year?

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Less Than Once A Month	About Once A Month	A Few Times A Month	About Once A Week	About Three Times A Week	Daily

Have you ever purged (used laxatives or diuretics, or induced vomiting) to control your weight?

2 ☐	0 ☐
Yes	No

If you answered "Yes" to the question above, how often have you engaged in this behavior during the last year?

1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
Less Than Once A Month	About Once A Month	A Few Times A Month	About Once A Week	About Three Times A Week	Daily

Binge Eating and Purging - total score: _____

Excerpted from the Diet Readiness Test (Brownell, 1994)

SOCIAL HISTORY & BEHAVIORAL HEALTH

Smoking History

Check the box below that most accurately describes your tobacco/nicotine status.

❒ Never smoked/used

❒ Current smoker ➔ ❒ Cigarettes ➔# packs/day & # years: _____

❒ Cigars ➔ How often & # years: _____

❒ Pipe ➔ How often & # years: _____

❒ Vaping ➔ How often & # years: _____

❒ Marijuana ➔ How often & # years: _____

❒ Currently use smokeless tobacco (snuff/dip/chew) ➔ How often & # years: _____

❒ Quit tobacco/nicotine less than 1 year ago ➔ Product of choice & quit date: _____

❒ Quit tobacco/nicotine more than 1 year ago ➔ Product of choice & quit date: _____

Alcohol History

Check the box below that most accurately describes your use of alcohol.

❒ Do not drink alcohol at all

❒ Drink alcohol rarely (less than once per month)

❒ Drink alcohol at least once per month, but not every week

❒ Drink alcohol weekly

❒ Drink alcohol nearly every day

How many drinks each time?

❒ 1 or 2 ❒ 3 or 4

❒ 5 or 6 ❒ 7 to 9

❒ 10 or more

Did you drink alcohol in the past?

❒ No

❒ Yes ➔ # years: _____

Year quit: _____

times per week: _____

drinks each time: _____

If you drink alcohol now, is anyone in your life concerned about the amount you drink?

❒ No ❒ Yes ❒ I don't drink alcohol now.

Were you ever in treatment for alcohol abuse or dependence?

❒ No

❒ Yes ➔ ❒ Outpatient ❒ Inpatient ❒ Both outpatient & inpatient

Approximate date(s): _____

Was this treatment successful for you? ❑ No ❑ Yes

Comments: _____

_____

Recreational or "Street" Drug History

Do you use or have you ever used prescription drugs that have ***not*** been prescribed for you?

❒ No

❒ Yes ➔ What drugs? _____

How many years? _____

How often? _____

Do you use or have you ever used recreational or "street" drugs?

❒ No

❒ Yes ➔ What drugs? _____

How many years? _____

How often? _____

Were you ever in treatment for drug abuse or dependence?

❒ No

❒ Yes ➔ ❒ Outpatient ❒ Inpatient ❒ Both outpatient & inpatient

Approximate date(s): _____

Was this treatment successful for you? ☐ No ☐ Yes

Psychological History

Have you been diagnosed with any of the following?

❒ No

❒ Yes ➔ Which? ❒ ADHD – year: _____ ❒ Personality disorder – year: _____

❒ Anxiety – year: _____ ❒ PTSD – year: _____

❒ Binge eating disorder – year: _____ ❒ Schizophrenia – year: _____

❒ Bipolar disorder – year: _____ ❒ Substance dependence – year: _____

❒ Bulimia – year: _____ ❒ Other psychiatric diagnosis – year: _____

❒ Depression – year: _____ _____

Do you have a history of trauma or abuse? ❒ No ❒ Yes – childhood ❒ Yes – adult

Have you been prescribed medications for this diagnosis/diagnoses?

❒ No

❒ Yes ➔ Medication: _____ Month/Year first prescribed: _____

Medication: _____ Month/Year first prescribed: _____

Medication: _____ Month/Year first prescribed: _____

Are you currently taking these medications as prescribed?

❒ Not applicable (no medications prescribed for psychiatric diagnoses)

❒ Yes

❒ No ➔ Why not? _____

Have you ever gone through counseling or psychotherapy?

❒ No

❒ Yes ➔ ❒ Outpatient ❒ Inpatient ❒ Both outpatient & inpatient

Reason: _____

Approximate date(s): _____

Have you ever been hospitalized for psychiatric reasons?

❒ No

❒ Yes ➔ Year of hospitalization: _____ Location: _____

Year of hospitalization: _____ Location: _____

Year of hospitalization: _____ Location: _____

MEDICATIONS

Prescribed to You

Drug Name	Dose	Times per day	Reason for taking

Over-the-Counter Medications, Vitamins, & Supplements

Drug Name	Dose	Times per day	Reason for taking

Do you have any medication allergies or sensitivities?

❒ No

❒ Yes ➔ Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

MEDICAL HISTORY

Family

In the table below, health problems appear down the left-hand column and family members appear in columns to the right of each condition. For each condition, check the appropriate box to the right for each family member who has had that condition. See the example below.

Condition	Father	Mother	Sibling	Grandparent	Other
Heart disease (EXAMPLE)	✓			✓	
Angioplasty or stent	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Blood clots	☐	☐	☐	☐	☐
Cancer (type):					
Cancer (type):					
Diabetes (adult onset)	☐	☐	☐	☐	☐
GERD/Acid reflux	☐	☐	☐	☐	☐
Gout	☐	☐	☐	☐	☐
Heart bypass surgery	☐	☐	☐	☐	☐
Heart disease/attack	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐
Irregular heartbeats	☐	☐	☐	☐	☐
Lung disease or emphysema	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐	☐
Peripheral vascular disease (PVD)	☐	☐	☐	☐	☐
Psychiatric conditions	☐	☐	☐	☐	☐
Sleep apnea	☐	☐	☐	☐	☐
Stroke/TIA	☐	☐	☐	☐	☐
Other:					
Other:					

Self

Surgical Procedure(s) & Year:

❒ Appendectomy (open/alp): _____
❒ Anti-reflux procedure/Nissen fundoplication: _____
❒ Back (describe): _____
❒ Breast Biopsy: _____
❒ Breast Lumpectomy/mastectomy: _____
❒ Bowel Resection: _____
❒ Gallbladder (open/laparoscopic): _____
❒ Heart Surgery - CABG/other: _____
❒ Hernia (type): _____
❒ Hip (replacement or fixation): _____
❒ Hysterectomy: _____
❒ Knee (replacement or arthroscopy): _____
❒ Neck (describe): _____
❒ Ovaries Removed: _____
❒ Other Ovary Surgery/Tubal Ligation: _____
❒ Peripheral Vascular Procedure: _____
❒ Tonsillectomy: _____
❒ Upper GI Endoscopy: _____
❒ Vasectomy: _____
❒ Other: _____

Anesthesia Problems:

❒ None ❒ Nausea ❒ Vomiting ❒ Difficulty urinating ❒ Difficulty waking up
❒ Heart stopped ❒ Stopped breathing ❒ Woke up during procedure ❒ Other: _____

Review of Systems: (check all that apply)

❒ Anemia ➔ ❒ iron-deficient ❒ vitamin B12-deficient
❒ Asthma ➔ ❒ inhaler(s) ❒ oral medications ❒ not controlled ❒ multiple hospitalizations
❒ Atrial fibrillation/arrhythmia
❒ Back pain ➔ ❒ intermittent ❒ constant
❒ Barrett's esophagus
❒ Bile duct disease/blockage
❒ Cancer: (type/s) _____
❒ Chest pain ➔ ❒ with activity ❒ at rest
❒ Colon polyps ➔ date of colonoscopy (month/year): _____
❒ Congestive heart failure
❒ Constipation
❒ Chronic obstructive pulmonary disease (COPD)/emphysema
❒ Deep blood clot in leg/deep vein thrombosis (DVT) ➔ ❒ resolved with anticoagulation ❒ recurrent
❒ Diabetes ➔ ❒ oral medication only ❒ insulin only ❒ oral medication & insulin
❒ pre-diabetes ❒ gestational diabetes ❒ complications (neuropathy/organ)
❒ Diarrhea
❒ Elevated cholesterol/triglycerides ➔ ❒ diet modification ❒ single medication ❒ multiple medications
❒ Eyes/vision ➔ ❒ glaucoma/eye disease ❒ cataracts ❒ blindness
❒ Fatigue/tiredness
❒ Gallbladder problems/gallstones ➔ ❒ intermittent symptoms ❒ gallbladder removal
❒ Gum problems/bleeding
❒ Hair loss/alopecia
❒ Headaches
❒ Hearing aid
❒ Heart attack (prior)
❒ Heart catheterization
❒ Heart disease
❒ Heartburn/gastroesophageal reflux disease (GERD) ➔ ❒ no medication ❒ intermittent medication
❒ daily medication ❒ prior surgery
❒ Hernia ➔ ❒ hiatal ❒ abdominal/incisional ❒ umbilical
❒ High blood pressure ➔ ❒ borderline/no medication ❒ single medication ❒ multiple medications
❒ poorly controlled
❒ Insomnia
❒ Joint pain: _____
❒ Kidney failure/renal insufficiency ➔ ❒ dialysis
❒ Kidney stones ➔ ❒ no treatment ❒ medication ❒ prior surgical procedure/lithotripsy (ESWL)
❒ Liver – abnormal findings ➔ ❒ elevated enzymes ❒ enlarged liver ❒ liver failure
❒ nonalcoholic steatohepatitis (NASH)/fatty liver
❒ Menstrual irregularity ➔ ❒ no menses ❒ abnormal periods ❒ excessively heavy periods
❒ menstrual pain
❒ Palpitation
❒ Poor circulation in legs/peripheral vascular disease (PVD) ➔ ❒ medication ❒ surgery/revascularization
❒ Pulmonary embolism (PE)/blood clot in lungs ➔ ❒ resolved with anticoagulation ❒ recurrent
❒ vena cava (Greenfield) filter placed
❒ Shortness of breath ➔ ❒ at rest ❒ with exertion
❒ Skin problems ➔ ❒ ulcers ❒ frequent infections ❒ poor wound healing
❒ recurrent/chronic rashes/chafing under skin folds
❒ Sleep apnea (obstructive) ➔ ❒ use of CPAP/BiPAP ❒ diagnosed but no appliance
❒ symptoms, but negative or no formal sleep study
❒ Stroke (prior)/CVA
❒ Swelling/edema
❒ Thyroid – underactive/overactive
❒ Transient ischemic attack (TIA)
❒ Vertigo (room spinning)
❒ Wheezing

❒ Other – cardiovascular: _____
❒ Other – respiratory: _____ ❒ Other: _____

❒ NONE OF THE ABOVE