Patient Information Form

Patient Name: (Last)_____(First)_____(MI)_____

Name you prefer to be called: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Cellular: _____

Email address: _____ It is OK to contact me via email for

(circle all that apply): Appointment Scheduling Medical Information Office News & Updates

Birth date: _____ Age: _____ Sex: M F

Social Security: _____ Drivers License: _____

Country of Birth: _____ Country of Parents' Birth: _____

Education: Elementary | High School/Technical School | 2-yr College | 4-yr College | Graduate School

Employment Information:

Patient Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work phone No: _____ Ext. _____

In Case of Emergency:

Name: _____Relationship: _____ Phone: _____

Patient's Spouse: _____ Phone: _____

Where did you hear about WaistLines? (Please include names if applicable) _____

_____

*(Many of our patients come to us through word of mouth, and we like to show our appreciation by giving referral gifts. Please be aware we will **never** use your name to another patient, associate, or medical professional without your consent)*

Financial Policy:

Thank you for selecting WaistLines for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. We do *not* file insurance as most carriers do not reimburse for weight loss. We do, however, provide you the necessary diagnosis codes so that you may file claims for reimbursement if you so choose. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard, checks, as well as cash.

If using health spending accounts or flexible spending accounts (HSA/FSA), it is your responsibility to know the policies with your specific benefits plan. Also, your company may deny or revoke permission of the use of these accounts for our services, at which point they may charge you out-of-pocket to reimburse these accounts.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements and I have received a copy of the Notice of Privacy Practices of WaistLines (provided at your initial appointment).

_____ _____

Patient's Signature Date

Medical History Form: Please take your time, your answers are important!

Name: _____ Age:_____ Sex: M F

Family Physician: _____ Phone: _____

Present Status:

Are you in good health at the present time to the best of your knowledge? Yes No

Are you under a doctor's care at the present time? Yes No
If yes, for what? _____

Are you taking any medications at the present time? Yes No
What: _____ Dosages: _____

What:_____ Dosages: _____

Any allergies to any medications? Yes No
Names: _____

History of High Blood Pressure? Yes No

History of Diabetes? Yes No
At what age? _____

History of Heart Attack or Chest Pain? Yes No

History of Swelling Feet? Yes No

History of Frequent Headaches? Yes No

Migraines? Yes No Medications for Headaches: _____

History of Constipation (difficulty in bowel movements)? Yes No

History of Glaucoma? Yes No

Gynecologic History:
Pregnancies: Number: _____ Dates: _____

Natural Delivery or C-Section (specify): _____

Menstrual: Onset (age of first period): _____

Duration (days your period usually lasts): _____

Are they regular: Yes No

Pain associated: Yes No

Last menstrual period: _____

Hormone Replacement Therapy: Yes No

What: _____

Birth Control Pills: Yes No

Type: _____

Last Check Up: _____

Serious Injuries: Yes No

Specify: _____ Date: _____

Any Surgery: Yes No

Specify: _____ Date: _____

Specify: _____ Date: _____

Family History:

	Age	Health	Disease	Cause of Death	Overweight?
Father:					
Mother:					
Brothers:					
Sisters:					

Has any blood relative ever had any of the following?

Glaucoma:	Yes	No	Who: _____
Asthma:	Yes	No	Who: _____
Epilepsy:	Yes	No	Who: _____
High Blood Pressure:	Yes	No	Who: _____
Kidney Disease:	Yes	No	Who: _____
Diabetes:	Yes	No	Who: _____
Tuberculosis:	Yes	No	Who: _____
Psychiatric Disorder:	Yes	No	Who: _____
Heart Disease/Stroke:	Yes	No	Who: _____

Past Medical History: (check all that apply)

Polio	Measles	Tonsillitis
Jaundice	Mumps	Pleurisy
Kidneys	Scarlet Fever	Liver Disease
Lung Disease	Whooping Cough	Chicken Pox
Rheumatic Fever	Bleeding Disorder	Nervous Breakdown
Ulcers	Gout	Thyroid Disease
Anemia	Heart Valve Disorder	Heart Disease
Tuberculosis	Gallbladder Disorder	Psychiatric Illness
Drug Abuse	Eating Disorder	Alcohol Abuse
Pneumonia	Malaria	Typhoid Fever
Cholera	Cancer	Blood Transfusion
Arthritis	Osteoporosis	Other: _____

Nutrition Evaluation:

1. Present Weight: _____ Height (no shoes): _____ Desired Weight: _____

2. In what time frame would you like to be at your desired weight? _____

3. Birth Weight: _____ Weight at age 20: _____ Weight one year ago: _____

4. What is the main reason for your decision to lose weight? _____

_____

5. When did you begin gaining excess weight? (Give reasons, if known): _____

_____

6. What has been your maximum lifetime weight (non-pregnant) and when?_____

7. Previous diets you have followed: Give dates and results of your weight loss:

_____ _____

_____ _____

8. Appetite suppressants tried in the past: _____

Side effects? _____

9. Is your spouse, fiancée or partner overweight? Yes No If yes, by how much? _____

10. How often do you eat out? _____

11. What restaurants do you frequent?_____

12. How often do you eat "fast foods?"_____

13. Who plans meals? _____ Cooks? _____ Shops? _____

14. Do you use a shopping list? Yes No

15. What time of day and on what day do you shop for groceries? _____

16. Food allergies: _____

17. Food dislikes: _____

18. Food you crave: _____

19. Any specific time of the day or month do you crave food? _____

20. Do you drink coffee or tea? Yes No How much daily? _____

21. Do you drink cola drinks/soda? Yes No How much daily? _____

22. Do you drink alcohol? Yes No

What? _____ How much? _____ Weekly? _____

23. Do you use a sugar substitute? _____ Butter? _____ Margarine? _____

24. Do you awaken hungry during the night? Yes No

What do you do? _____

25. What are your worst food habits? _____

26. Snack Habits:

What? _____ How much? _____ When? _____

_____ _____ _____

27. When you are under a stressful situation at work or family related, do you tend to eat more? Explain:

_____

_____

28. Do you think you are currently undergoing a stressful situation or an emotional upset? Explain:

_____

_____

29. Smoking Habits: (answer only one)

You have never smoked cigarettes, cigars or a pipe.
You quit smoking _____ years ago and have not smoked since.
You have quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke.
You smoke 20 cigarettes per day (1 pack).
You smoke 30 cigarettes per day (1-1/2 packs).
You smoke 40 cigarettes per day (2 packs).

30.

Typical Breakfast	Typical Lunch	Typical Dinner
_____	_____	_____
_____	_____	_____
_____	_____	_____
Time eaten: _____	Time eaten: _____	Time eaten: _____
Where: _____	Where: _____	Where: _____
With whom: _____	With whom: _____	With whom: _____

31. Describe your usual energy level: _____

32. Activity Level: (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, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week.
    Vigorous activity—participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

33. Behavior style: (answer only one)
    You are always calm and easygoing.
    You are usually calm and easygoing.
    You are sometimes calm with frequent impatience.
    You are seldom calm and persistently driving for advancement.
    You are never calm and have overwhelming ambition.
    You are hard-driving and can never relax.

34. Please describe your general health goals and improvements you wish to make: _____

_____

_____

_____

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.

Patient Informed Consent for Appetite Suppressants

(Please be aware the use of these medications is completely elective and strictly managed by Dr. Lyon. She will discuss your eligibility for and the risks and benefits of these medications during your appointment, but we provide you this information to read in advance if you are interested in their use.)

I. Procedure and Alternatives:

1. I,_____ (patient or patient's guardian) authorize Dr. Lyon to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks.

2. I have read and understand my doctor's statements that follow:

> "Medications, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosages indicated in the labeling.
>
> "As a bariatric physician, I have found the appetite suppressants helpful for periods far in excess of 12 weeks. As a physician, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer term studies and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time.
>
> "Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted below).
>
> "As a bariatric physician, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time. However, you must decide if you are willing to accept the risks of side effects, even if they might be serious, for the possible help the appetite suppressants use in this manner may give."

3. I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.

4. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.

5. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an exchange eating program without the use of the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

II. Risks of Proposed Treatment:

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heart beat and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal. <u>These medications should not be taken with any decongestants or ADD medications. Notify your physician prior to having any surgical procedures.</u>

III. Risks Associated with Being Overweight or Obese:

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

IV. No Guarantees:

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue watching my weight all of my life if I am to be successful.

V. Patient's Consent:

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

WARNING
IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK YOUR DOCTOR <u>NOW BEFORE SIGNING THIS CONSENT FORM</u>.

PATIENT:_____WITNESS:_____
(or person with authority to consent for patient)

DATE: _____

VI. <u>PHYSICIAN DECLARATION</u>:

I have explained the contents of this document to the patient and have answered all the patient's related questions, and, to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies and the risks of continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving the appetite suppressants in the manner indicated above.

_____

Physician's Signature