PATIENT INFORMED CONSENT FOR APPETITE SUPPRESSANTS

I, _____ authorize Performance Weight Loss to assist me in my weight loss reduction efforts. I understand that my program consists of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications.

Other treatment options may include a very low calorie diet and/or protein meal replacements and other medical supplements. I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese.

Risks of the program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with the remaining overweight tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death.

I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.
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 obesity may be chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

Women Only:
I understand that Phentermine or any other weight loss medication should not be taken during pregnancy, due to the chance of damage to the fetus. This has been explained to me fully, and I am aware of the risks involved. To the best of my knowledge, I am not pregnant. I am aware of the precautions that should be taken to avoid pregnancy while I am on medication. If I become pregnant, I will advise both the clinic and my OB/GYN immediately.

I have read and fully understand this consent form and I realize I should not sign this form is all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.
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, as your doctor now before signing this consent form.

Date:_____ Time:_____

Patient:_____ Witness:_____

MEDICAL WEIGHT LOSS CONSUMER BILL OF RIGHTS

WARNING:

Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more that 1 ½ pounds to 2 pounds per week or weight loss of more that 1% of body weight per week after the second week of participation in a weight loss program. Consult your personal physician before starting any weight loss program that is not supervised by a physician specializing in medical weight loss management. Only permanent lifestyle changes, such as making healthy food choices and increasing physical activity promote long-term weight loss. Qualifications of this provider are available upon request. You have a right to ask questions about the potential health risks of this program and its nutritional content, psychological support, and educational components; receive an itemized statement of the actual and estimated price of the weight loss program, including extra products, services, supplements, examinations, and laboratory test; know the actual estimated duration of the program.

I HAVE READ THE ABOVE STATEMENT ABOVE:

Patient's Signature: ________Date: _____

Office Personnel / Witness _____Date: _____

AKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Patient Name: _____

Date: _____

By signing this form, you acknowledge that Performance Weight Loss office has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. If there are any individuals with whom we are permitted to share your medical information, please provide their names(s) here:

_____ _____

Patient's Signature: ________Date: _____

Witness _____Date: _____

NAME:_____DOB_____DATE_____

MEDICAL HISTORY

Please check all that apply:

_____High Blood Pressure
_____Chest Pain
_____Edema (Swelling of Legs)
_____Congestive Heart Failure
_____Previous Stroke or Heart Attack
_____Varicose veins or Venous Stasis
_____DVT or Pulmonary Embolus
_____Shortness of Breath
_____Snore
_____Daytime drowsiness
_____Sleep Apnea
_____Use CPAP or BIPAP
_____Asthma
_____Emphysema
_____COPD
_____Use of Home Oxygen
_____Diabetes –Juvenile
_____Diabetes –Adult Onset
_____Diabetes –Pregnancy
_____Always Thirsty
_____Cold Intolerance
_____Bipolar Disease
_____Anxiety or High Stress
_____Migraine Headaches
_____Binge Eating
_____Bulimia or Purging
_____Anorexia Nervosa
_____Restless Leg Syndrome
_____HighTriglycerides
_____High Cholesterol
_____Gallbladder diseases
_____Heart Burn/Reflux/GERD
_____Chronic Constipation
_____History of Ovary or Uterine Cancer
_____Irritable Bowel Syndrome
_____History of Colon Cancer
_____Hernias
_____Urinary Incontinence
_____Trouble Urination/ Male BPH
_____Frequent Urination
_____History of Prostate Cancer
_____Low Sex Drive
_____Chronic Fatigue
_____Eats Ice Frequently (PICA)
_____Excess Facial Hair (Female)
_____Abnormal Menstrual Cycle
_____Difficulty becoming pregnant
_____Polycystic Ovarian Syndrome
_____History of Breast Cancer
_____Underactive Thyroid
_____Hot Flashes/Night Sweats
_____Trouble Falling Asleep
_____Trouble Staying Asleep
_____Depression -New Onset
_____Depression –Chronic
_____Overactive Thyroid
_____Significant Hair Loss
_____Pituitary Gland Disease
_____Adrenal Gland Disease
_____Kidney Disease
_____Gout
_____Chronic Diarrhea
_____Arthritis/Osteoarthritis
_____Lower Back Pain
_____Need Assistance Walking
_____Numbness in Hands/Feet

Any other medical or psychiatric problems not listed:

_____

NAME:_____DOB_____DATE_____

List all of medications you currently take including vitamins, minerals and herbs, hormones, birth control pills.

MEDICATIONS

1._____6. _____
2._____7._____
3._____8._____
4._____9._____
5._____10._____

ALLERGIES

Do you have any medical or food allergies? _____
Do you have a primary physician or Internal Medicine doctor? Yes □No□
PERSONAL PHYSICIAN
Primary Care Doctor's Name _____
City Located_____
PAST SURGICAL HISTORY
Previous Surgeries:
1._____4._____2.____
_____5._____3._____
_____6._____
Do you still have periods? Yes □ No □

OB/GYN HISTORY

Have you had a Hysterectomy or tubal ligation? Yes □ No □
Do you have regular monthly menstrual periods? Yes □ No □
If no, explain: _____
Are your periods heavy? Yes □ No □
How many days do your periods last? _____
Are you past menopause? Yes□ No □
History of Miscarriages Yes □ No □
Ectopic Pregnancies Yes □ No □
Birth Control Yes □ No □ What type do you use? _____
Date of last gynecologic exam: _____
Name of Gynecologist: _____

NAME:_____DOB_____DATE_____

FAMILY HISTORY :

Does anyone in your family have any of the following:
□ Obesity
□ High Cholesterol
□ Diabetes
□ Lung Disease/asthma/emphysema
□ High blood pressure
□ Kidney disease
□ Heart Disease/stroke
□ Bleeding disorder
□ Cancer
□ Psychiatric (depression, eating disorder, alcoholism)

SOCIAL HISTORY

Married □ Single □ Divorced □ Widowed □

Number of children or grandchildren living with you? _____
Ages: _____
Have you ever smoked cigarettes? Yes □ No □ Amount:_____
If you have quit smoking, when did you stop? _____
History of drug abuse? Yes □ No □
Treatment? Yes □ No □
History of alcohol abuse? Yes □ No □
Treatment? Yes □ No □
How many hours do you typically sleep per night?_____
Occupation: _____
Working Hours:_____
Are you a student? Yes □ No □ If so, full time □ part time □
Typical time you wake up _____Typical time you go to bed: _____
Do you work overnight shift? Yes □ No □What time do you wake up & go to sleep when working overnight? _____

NAME:_____DOB_____DATE_____

WEIGHT HISTORY

Marriage Weight _____
Desired Weight_____
When did you begin gaining excessive weight?_____
What is your high school graduation weight (age 18) _____

DIET HISTORY

Do you eat 3 meals/day? Yes □ No □ If not, how many?_____
Which meals do you commonly miss?_____
Do you graze throughout the day? Yes □ No □
How many times/week do you eat out or pick something up to bring home?_____
Are you a nighttime eater? Yes □ No □ If so what do you normally eat?_____
Are you a binge eater? Yes □ No □
History of purging after you binge? Yes □ No □ If yes, are you purging through exercise, vomiting, laxatives, or diuretics? _____
Do you do the majority of the grocery shopping? Yes □ No □
Do you or other people think you eat too fast? Yes □ No □
Do you cook at home? Yes □ No □
Is your spouse, fiancée or partner overweight? Yes □ No □
Do you have any overweight children? Yes □ No □
If you are a vegetarian, what foods will you not eat?_____
Have you used weight loss medications in the past? Yes □ No □ If yes
Name:_____
If you have taken weight loss medication in the past, how long ago did you take it?_____
If you have taken weight loss medication did you experience side effects? Yes □ No □
If yes, please explain_____
If you have taken weight loss medication in the past, how much weight did you lose?_____

NAME:_____DOB_____DATE_____

DO YOU DRINK:

Sweet Tea with sugar? Yes □ No □ If yes, □ Daily □ Few per week □ rarely
Regular Fruit Juices? Yes □ No □ If yes, □ Daily □ Few per week □ rarely Soft Drinks? Yes □ No □ If yes, □ Daily □ Few per week □ rarely
Hawaiian Punch? Yes □ No □ If yes, □ Daily□ Few per week □ rarely
Kool Aid? Yes □ No □If yes, □ Daily□ Few per week □ rarely
Energy Drinks? Yes □ No □ If yes, □ Daily□ Few per week □ rarely Whole Milk? Yes □ No □ If yes, □ Daily□ Few per week □ rarely
Alcohol? Yes □ No □ If yes, □ Daily□ Few per week □ Special Occasions
If yes, what type of alcohol do you drink?_____

Your diet history will be discussed during your initial visit. All efforts are relevant, even those with minimal or no weight loss. Please list all significant diet efforts for the past 5 years.

Name of Diet	Year	Length of Effort	Weight Loss	Weight Regained

PATIENT REGISTRATION: All Information is Confidential

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

Name you prefer to be called: _____

Patient Physical Address: _____

City: _____State: _____Zip:_____

Home Phone: _____ Cellular Phone: _____

Social Security #_____ Email address:_____

Date of Birth: _____ Age:_____ Sex: M F

Employment Information:

Employer: _____Occupation: _____
Employer Address: _____
City: _____State:_____ Zip:_____
Work Number: _____ Ext._____

Emergency Contact

First & Last Name _____
Relationship to Insured _____Cell # _____

Financial Policy

Thank you for selecting Performance Weight Loss for your Medical Weight Loss Management. We are honored to be of service to you and your family. Please be advised that payment of all services is due at the time services are rendered. We do not bill insurance, nor do we provide any information to insurance companies for any medical weight loss services rendered at Performance Weight Loss. For your convenience, we accept Visa, MasterCard, Discover, cash. I have read and understand all of the above and have agreed to these statements.

HIPPA Policy

I understand the HIPPA policy is available in the office and on the clinic web site for all patients to review.
Signature (Patient _____Date_____