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: ________________
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
- High Triglycerides
- High Cholesterol
- Gallbladder diseases
- Heart Burn/Reflux/GERD
- Chronic Constipation
- History of Ovary or Uterine Cancer

Any other medical or psychiatric problems not listed:

_____________________________________

900 East County Line Road, Suite 230, Ridgeland, MS 39157 Phone (769) 251-1040
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?______________
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
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.

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<th>Name of Diet</th>
<th>Year</th>
<th>Length of Effort</th>
<th>Weight Loss</th>
<th>Weight Regained</th>
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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________________________

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