

## Medical Weight Management – Patient Information Form

Date: \_\_\_\_\_

### PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Sex: M / F Marital Status: M S D W

Social Security Number \_\_\_\_\_ Email Address \_\_\_\_\_

Home Address: Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

### Work Address

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Working Shift & Hours of Travel \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Phone \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_

### Personal Primary Physician

Name: \_\_\_\_\_

City: \_\_\_\_\_

Date of Last Visit: \_\_\_\_\_

Name \_\_\_\_\_

### Medical Weight Management History

#### A. Food Issues (please check each statement if true most of the time)

1. \_\_\_\_\_ I eat the wrong things.
2. \_\_\_\_\_ I eat for comfort when stressed.
3. \_\_\_\_\_ I am hungry most of the time.
4. \_\_\_\_\_ I do not eat an unusual amount.
5. \_\_\_\_\_ Other (please specify) \_\_\_\_\_

#### B. Exercise (Please check each statement if true)

1. \_\_\_\_\_ I have been athletic in the past, but am no longer.
2. \_\_\_\_\_ I have joint and/or pain problems that limit my exercise.
3. \_\_\_\_\_ I regularly exercise now.
4. \_\_\_\_\_ Realistically, I do not have time to exercise often.
5. \_\_\_\_\_ Other (please specify) \_\_\_\_\_

#### Please tell us about your current exercise program

**Exercise type**                      **Days per week**                      **Minutes per session**

Aerobic Exercise/type		
Free weights		
Resistance machines		
Aerobics classes		
Stretching		
Other: please specify below		

Name \_\_\_\_\_

**Please check the statements that are true:**

- I enjoy exercise \_\_\_\_\_ I exercise to improve my fitness \_\_\_\_\_  
I do not enjoy exercise \_\_\_\_\_ I exercise to improve my health \_\_\_\_\_  
I only exercise to maintain weight \_\_\_\_\_  
I have a defined goal that I am trying to achieve in my exercise program \_\_\_\_\_

**C. Psychological Concerns** (please check each statement if true most of the time)

1. \_\_\_\_\_ I over eat for stress relief and emotional comfort.
2. \_\_\_\_\_ I am depressed about my weight.
3. \_\_\_\_\_ I have been a victim of abuse, and this affects my weight.
4. \_\_\_\_\_ I feel discouraged and/or hopeless about my weight.
5. \_\_\_\_\_ Other (please specify) \_\_\_\_\_

**D. Past Medical History** (please check each condition you either have or have had)

- |                              |   |
|------------------------------|---|
| 1. _____ Heart trouble       | _____ 10. Headaches                         |
| 2. _____ Strokes             | _____ 11. Gall stones                       |
| 3. _____ High blood pressure | _____ 12. Severe depression                 |
| 4. _____ Diabetes            | _____ 13. Manic / bipolar                   |
| 5. _____ Seizures            | _____ 14. Obesity in family                 |
| 6. _____ Glaucoma            | _____ 15. Tired / fatigue                   |
| 7. _____ Stomach acid        | _____ 16. Sleep disorders/sleep apnea       |
| 8. _____ Thyroid issues      | _____ 17. PCOS(polycystic ovarian syndrome) |

Name \_\_\_\_\_

**E. Family History**

(please list any medical conditions including overweight/obesity)

**Age**

**Medical Conditions**

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Siblings: \_\_\_\_\_

Grandparents: \_\_\_\_\_

**F. Surgical History: Please list any past surgeries**

\_\_\_\_\_  
\_\_\_\_\_

**G. Current Medications: Please list all current medication or over the counter supplements including vitamins and herbal supplements**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**H. Allergies: Please list any allergies to medication**

\_\_\_\_\_  
\_\_\_\_\_

**I. Please list weight loss programs you have tried in the past and results**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name \_\_\_\_\_

**J. Female Patient History** (If you are a female, please complete sections I and II below.)

**I. Please initial, indicating you understand and agree with the following statements:**

1. \_\_\_ I am not pregnant. I understand that weight control and weight-reducing diets and medication must be stopped immediately at any sign of pregnancy.
2. \_\_\_ I will notify this office if I become pregnant.
3. \_\_\_ I understand breast and pelvic exams need to be done on a regular basis, but these exams are not part of my treatment at this office. I am responsible for obtaining these exams through my family physician or gynecologist.

**II. Please check all that apply:**

1. \_\_\_\_\_ Has a doctor diagnosed fibrocystic disease in your breast?
2. \_\_\_\_\_ Have you had a mammogram?
3. \_\_\_\_\_ Are you still menstruating?
4. \_\_\_\_\_ Are your periods at regular monthly intervals?
5. \_\_\_\_\_ Do your periods cause you to be puffy and retain fluid?
6. \_\_\_\_\_ Do you have painful menstrual cramps?
7. \_\_\_\_\_ Do you have PMS (Premenstrual Tension Syndrome)?
8. \_\_\_\_\_ Could you be pregnant now?
9. \_\_\_\_\_ Are you now on birth control pills?
10. \_\_\_\_\_ Do you use methods of birth control regularly?
11. \_\_\_\_\_ Do you experience hot flashes or night sweats?
12. \_\_\_\_\_ Do you experience mood swings or irritability?
13. \_\_\_\_\_ Do you have decreased sex drive?

Name \_\_\_\_\_

**K. Male Patient History** (If you are a male, please answer yes or no.)

<b>Question</b>	<b>Yes</b>	<b>No</b>
1. Do you have a decrease in sex drive	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have a lack of energy?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have a decrease in strength and/or endurance?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you lost height?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you noticed a decreased enjoyment of life?	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you sad and or/grumpy?	<input type="checkbox"/>	<input type="checkbox"/>
7. Are your erections less strong?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has it been more difficult to maintain your erection throughout sexual intercourse?	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you falling asleep after dinner?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has your work performance deteriorated recently?	<input type="checkbox"/>	<input type="checkbox"/>

**L. Sleep History: check all that apply**

How many hours per night do you sleep? \_\_\_\_\_

Do you have: \_\_\_ trouble falling asleep \_\_\_ wake up frequently during sleep

\_\_\_ I experience daytime sleepiness/fatigue:

\_\_\_ I wake up tired even after a full nights sleep?

**M. Medical symptoms: Please check symptoms that you have experienced**

\_\_\_ I seem to be cold when everyone else is not

\_\_\_ dry skin or brittle hair/hair loss      \_\_\_ decreased sex drive

\_\_\_ constipation      \_\_\_ sluggishness      \_\_\_ muscle aches or weakness

\_\_\_ fatigue      \_\_\_ foggy memory      \_\_\_ depression/irritability

**N. Current Diet Information: What do you typically eat for:**

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Name \_\_\_\_\_

**Please tell us about your consumption of the following foods:**

<b>Food</b>	<b>servings per day/week</b>
Sweet drinks/soda/sweet tea	
White bread/rice/pasta	
Alcohol	
Fast food	
Dairy products type and %fat	
Typical snack foods	
Fruits	
Vegetables	
Artificial sweeteners	
Coffee/tea	
Sweets – please list types	
Water intake	

**Please answer yes or no:**

- |  | Yes | No  |
|--|-----|-----|
| 1. I feel like I am hungry all the time                    | ___ | ___ |
| 2. I feel like I eat more than most people                 | ___ | ___ |
| 3. I feel like I have a stronger appetite than most people | ___ | ___ |
| 4. I eat faster than most people                           | ___ | ___ |
| 5. I continue to eat even after I am full                  | ___ | ___ |
| 6. I frequently do not feel like my hunger is satisfied    | ___ | ___ |
| 7. I often feel guilty about the foods that I eat          | ___ | ___ |
| 8. I crave certain foods                                   | ___ | ___ |

Please list foods that you crave

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## O. The Center for Health and Age Management Procedures

Please initial, indicating you understand and agree with the following statements. Then sign below. If under the age of twenty-one (21) a parent or guardian must also sign.

\_\_\_The number of patients we see each day is limited and by appointment only. Missed appointments cause additional expense and inconvenience to other patients. Please notify us twenty-four (24) hours in advance if you are unable to keep your appointment.

\_\_\_Most health insurance companies (Champus, Blue Cross, Medicare, and Medicaid) do not provide coverage for treatment of obesity. Therefore, we do not take any form of payment from third party companies and all services must be paid for at the time services are rendered by cash, check, or credit card.

\_\_\_I understand any treatments rendered are solely for the purpose of weight control. The diagnosis and treatment of other illnesses and disease are not the responsibility of this clinic. If I become ill, I should contact my personal physician or visit an urgent care facility. If I become ill, I will discontinue any diet or medication from this clinic until it is determined safe to resume the weight control program. (Please call if uncertain.)

\_\_\_If my treatment includes the prescription of appetite suppressant medication, I will carefully follow the instructions given, notify the doctor of any change in my medical history (especially heart or blood pressure problems) and not resell the medication nor will I share it with any friend or family member, ever. I will not visit other doctors for the purpose of obtaining additional or duplicate medication of the same type.

### Weight Loss Consumer Bill of Rights

Florida Statute 501.0575 outlines the rights of consumers seeking professional weight-loss services.

- A. Warning: rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1 ½ to 2 pounds per week or weight loss of more than 1% of body weight per week after the second week of participation in a weight loss program.
- B. Consult your personal physician before starting any weight-loss program.
- C. Only permanent lifestyle changes, such as making healthful food choices and increasing physical activity, promote long-term weight loss.
- D. Qualifications of this provider are available upon request.
- E. You have a right to:
  - 1. Ask questions about the potential health risks of this program and its nutritional content, psychological support and educational components.
  - 2. Receive an itemized statement of the actual or estimated price of the weight loss program, including extra products, services, supplements, examinations, and laboratory tests.
  - 3. Know the actual or estimated duration of the program.
  - 4. Know the name, address, and qualifications of the physical, dietician or nutritionist who has reviewed and approved the weight-loss program according to Section 468.505(1)(i) of the Florida Statutes.

This statute may be found on-line at <http://www.flsenate.gov/statutes/>.

Name \_\_\_\_\_

## Patient Informed Consent to Use Appetite Suppressants

Please carefully read the following statements.

**I. Procedures and Alternatives:** I acknowledge I have read and understand each of the following statements:

**A.** 1. All prescription medications, including appetite suppressants, have labeling approved by the Food and Drug Administration. This labeling contains suggestions of the use of the medication. The labeling found on most appetite suppressants is based upon medical studies of less than twelve weeks using the dosages indicated on the labels.  
2. Notwithstanding such labeling, I understand that my physician, based upon his experience, the experience of his colleagues, and other factors, may recommend the use of such medications for a period of time or at doses in excess of those recommended by the manufacturer's label. I further understand that such usage may not have been as systemically studied as that suggested by the labeling, and it is possible, as with many other medications, that serious side effects could occur.

3. After consulting my physician, I believe that the probability of such side effects is outweighed by the potential benefit of the appetite suppressants being prescribed and/or provided to me, notwithstanding the fact that the dosage and/or term may exceed those recommended by the manufacturer.

**B.** I understand that it is my responsibility to follow my physician's instructions carefully and to report any medical problems immediately, regardless of whether I think that they may be related to my weight control program. I further affirm that I am not now pregnant and will report any pregnancy to my physician immediately.

**C.** I understand that there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain any weight loss. In particular, a balanced diet combined with physical exercise is recommended, with or without the use of appetite suppressants. I understand that a program including a revised diet and physical exercise could prove successful without appetite suppressants if I followed it, even though I would probably be hungrier than if I used appetite suppressants. I further understand that without long term lifestyle changes it will be difficult to maintain weight loss.

## II. Risks of Proposed Treatment

**A.** understand that this authorization is given to me with the knowledge that the use of appetite suppressants poses various risks, including by not limited to, pulmonary hypertension, nervousness, sleeplessness, headaches, dry mouth, weakness, fatigue, psychological problems, medical allergies, high blood pressure, rapid heart beat, and heart irregularities. These and other possible risks could occasionally be serious or even fatal.

**B.** Risks Associated With Being Overweight or Obese I understand that remaining overweight or obese poses certain risks, among them being tendencies to high blood pressure, to diabetes, to heart attack and heart disease, to arthritis at the joints, hips, knees and feet, and to certain cancers. I understand that these risks may be modest if I am not very overweight, but that these risks increase significantly with any weight gain.

## III. No Guarantees

I understand that much of the success of this program will depend on my efforts. Notwithstanding my efforts, I understand 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 my life if I am to be successful.

## IV. Patient's Consent

I have read and fully understand this consent form, the attached Weight Loss Consumers Bill of Rights (see page 6 of this document), and I have had all concerns addressed by the physician. Moreover, I have been informed by my physician of the nature, risks, possible alternative treatments, possible consequences and possible complications involved in the use of appetite suppressants for the treatment of obesity and for weight loss. Nevertheless, I authorize my physician to administer such treatment to me.

Patient Name: \_\_\_\_\_ Date \_\_\_\_\_

Patient/Parent/Guardian Signature \_\_\_\_\_

**HIPAA ACKNOWLEDGEMENT AND PRIVACY PREFERENCES**

You may be contacted by our office to remind you of appointments, Healthcare Treatment Options or other Health Services that may be of interest to you. In order to Maintain your Privacy, please answer the following:

May we contact you at home? YES NO	Ok to leave Message? YES NO
May we contact you at work? YES NO	Ok to Leave Message? YES NO
May we contact you VIA Cell? YES NO	Ok to Leave Message? YES NO
If it is ok to leave a message, that includes.....	
Practice Name and Phone Number Only YES NO	
Detailed or Specific Message YES NO	

Would you like to authorize someone else to schedule, confirm, or change appointments?  
If so, please provide: Name \_\_\_\_\_ Phone: \_\_\_\_\_

Would you like to authorize someone else to receive medical information on your behalf?  
If so, please provide: Name \_\_\_\_\_

For the purpose of marketing, advertising, special events and offers, may we contact you via email and/or newsletter? YES NO

**HOW DID YOU HEAR ABOUT US?**

Website  
 The Yellow Pages / Telephone Book  
 A Friend or Family Member (name) \_\_\_\_\_ May we Contact Y N  
 Internet Search ( Google Yahoo Other \_\_\_\_\_ )  
 Newsletter or Mailer  
 An Article or Advertisement in \_\_\_\_\_

Michael P. Heim, DO has posted my rights as a patient under the HIPAA (Health Insurance Portability and Accountability) ACT on his website [www.tampahealthcenter.com](http://www.tampahealthcenter.com). I have had the opportunity to read and understand my rights. I understand I can request a written copy at any time. I have been provided the opportunity to ask questions regarding my rights and received answers to my satisfaction.

I understand that The Center for Health and Age Management is a fee for service practice and that I am financially responsible for all charges upon date of service.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/ Parent/ Guardian Signature