Patient Information Form

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

Name you prefer to be called: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Beeper/Cellular: _____

Birthdate: _____Age: _____Sex: M F

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: _____

Family Physician: _____ Phone: _____

Referred by: _____

Financial Policy:

Thank you for selecting Dr. _____ 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. 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 and checks.

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.

_____ _____

Patient's Signature Date

Patient Medical History Form

Name: _____ Age:_____ Sex: M F

Present Status:

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

Explain a "no" answer:

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

3. Are you taking any medications at the present time? Yes No

Prescription Drugs: List all
Drug: Dosage:

Over-the-Counter medications, vitamins, supplements: List all Yes No
Product Dosage

4. Any allergies to any medications? Yes No
   Please list

5. History of High Blood Pressure? Yes No

6. History of Diabetes? Yes No
   At what age: _____

7. History of Heart Attack or Chest Pain or other heart condition? Yes No

8. History of Swelling Feet Yes No

9. History of Frequent Headaches? Yes No
   Migraines? Yes No Medications for Headaches: _____

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

11. History of Glaucoma? Yes No

12. History of Sleep Apnea? Yes No

13. Gynecologic History:
    Pregnancies: Number: _____ Dates: _____
    Natural Delivery or C-Section (specify): _____
    Menstrual: Onset: _____
    Duration: _____
    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: _____

14. Serious Injuries: Yes No
    Specify (list all) Date

15. Any Surgery: Yes No

Specify: (List all) Date

16. 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: _____

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. Weight at 20 years of age: _____ 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. Is your spouse, fiancee or partner overweight? Yes No

9. By how much is he or she overweight? _____

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 usually shop for groceries? _____

16. Food allergies: _____

17. Food dislikes: _____

18. Food(s) 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? Yes No How much daily? _____

22. Do you drink alcohol? Yes No

What? _____ How much daily? _____ 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 thing you are currently undergoing a stressful situation or an emotional upset? Explain:

_____

_____

29. Smoking Habits: **(answer only one)**

Smoker Non Smoker

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.

Weight Loss Program Consent Form

I _____ authorize Dr. Ghobraiel _____ and whomever they designate as their assistants, to help me in my weight reduction efforts. I understand that my program may consist 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, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

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 this 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.

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 a

chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form
If you have any questions regarding the risks of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask the Doctor

Date: _____ **Patient:** _____

Patient Informed Consent for Appetite Suppressants

I. Procedure And Alternatives:

1. I,_____ (patient or patient's guardian) authorize Dr.____Ghobraiel_____ 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 and when indicated in higher doses than the dose indicated in the appetite suppressant labeling.

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, and at times in larger doses than those suggested in the labeling. 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 and at times, in increased doses.

"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 and when indicated in increased doses. 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. **I will notify the physician if I am taking any anti-depressant medications.**

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 and in higher doses than the dose indicated in the labeling 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.

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.

DATE:_____

PATIENT:_____

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

<u>Pregnancy</u>

Warning: Medications used to help weight loss is absolutely contraindicated during pregnancy and it may cause fetal malformation so, if you are in childbearing period you should use means of contraception while taking the medications and you should stop the medications immediately if it happens and you get pregnant while taking the medication.

I have read and agree on the above;

_____ _____

Patient's Signature Date

Bariatric Physical Exam

Name: _____ Age: _____ Date: _____

Vital Signs: BP (sitting) _____ Pulse _____

Height (w/o shoes) _____in. Weight (w/o shoes) _____lbs.

BMI _____ Waist Circumference _____ Hip Circumference _____

W/H Ratio _____ Neck Circumference _____

Reviewed Patient History

PHYSICAL EXAM: ☒ WNL Other / Describe / Notes:

General	Well developed, well nourished, well groomed & in NAD	
Body Habitus	Endomorphic Obese Thin	
HEENT	Conjunctiva, lids clear to inspection	
	Ears without scars, lesions, drainage, avg. hearing	
	TM intact, no fluid levels, retraction or bulging	
	Nasal skin, mucosa, turbinates, septum WNL	
	Teeth intact, gums, palate, oral mucosa pink, no lesions	
	Posterior pharynx, tonsils without lesion, exudates	
	No jugular vein distention, no thyromegaly	
Respiratory	Respiratory effort unlabored, Lungs CTA bilat.	
	Chest tympanic to percussion, no tactile fremitus	
Cardio-Vascular	RRR, PMI @ 4th-5th IC space, small amplitude	
	No thrills, lifts, S3, S4 to palpation or auscultation	
	Carotids normal amplitude, without bruits or delay	
	Abd. Aorta not enlarged, without bruits	
	Femoral arteries with normal pulse, without bruits	
	Extremities without edema, varicosities	
Abdomen	No masses, tenderness, HSM or CVA tenderness	
	No lymphadenopathy of neck, axillae, groin	
Musculo-skeletal	Spine straight, no kyphosis, no scoliosis	
	Gait normal, stable, strong, appears capable of exercise	
	Full ROM of spine, extremities, no pain or crepitation	
Skin	No lesions, scars, rashes, café-au-lait spots, ulcers	
	No induration, nodules	
Extremities	Digits, nails without cyanosis, clubbing, infection	
Neuro	CN II-XII Grossly Intact	
	DTRs brisk at knees, ankles, elbows, wrists	
	Sensation intact, examined by light touch	
	Gait stable, upper extremity strength intact bilat	
Psych	Oriented x3, mood and affect appropriate	
	Recent & Remote memory intact	

Notes:

_____

_____

_____

_____

_____

Diagnostics: [X] Laboratory Results Reviewed

	Normal	Abnormal	
Urinalysis	[ ]	[ ]	_____
CBC	[ ]	[ ]	_____
Chemistry Profile	[ ]	[ ]	_____
Lipid Profile	[ ]	[ ]	_____

Thyroid Screen	[ ]	[ ]	_____
Glucose	[ ]	[ ]	_____
Liver Function Tests	[ ]	[ ]	_____
Vitamin D	[ ]	[ ]	_____
Amylase, Lipase	[ ]	[ ]	_____
H. Pylori	[ ]	[ ]	_____
Arthritis Panel	[ ]	[ ]	_____
Sed Rate	[ ]	[ ]	_____
PSA	[ ]	[ ]	_____
Urine Culture	[ ]	[ ]	_____
CXR	[ ]	[ ]	_____
EKG	[ ]	[ ]	_____
Treadmill	[ ]	[ ]	_____
Echocardiogram	[ ]	[ ]	_____
Sleep Study	[ ]	[ ]	_____
Other:_____	[ ]	[ ]	_____

Body Composition Analysis Completed and Reviewed [ ] _____% fat _____% lean
Diagnosis:

Overweight Class I Obesity Class II Obesity Class III Obesity

Diabetes Type _____ COPD PCOS/ Metabolic Syndrome

Sleep Apnea Arthritis Hypertension Hyperlipidemia CAD

Other _____

Plan:

[ ] Diet Discussed _____

_____

Recommended Diet: Low Calorie Modified Low Calorie Ketogenic Diet

1000 Calorie Other: _____

[ ] Exercise Prescription Discussed _____

_____

[ ] Counselor/Therapist Refer To: _____

[ ] Behavior Lifestyle Discussed _____

_____

[ ] Medications _____

[ ] Side Effects Discussed _____

Return in _____weeks for follow-up visit

Provider Signature