MDY Medical Weight Loss Center, LLC
Patient Information Form

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

Name you prefer to be called: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Email: _____

Birthdate: _____Age: _____Sex: M F

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

Education: Elementary High School/Technical School 2-yr College 4-yr College Graduate School
(Circle the highest level achieved)

Employment Information:

Patient Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work phone No: _____Ext. _____

Social Security: _____Drivers License: _____

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 Swelling Feet Yes No

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

7. History of Glaucoma? Yes No

8. History of Sleep Apnea? Yes No

9. Birth Control Pills: Yes No
   Type: _____

Last Check Up: _____

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

11. Any Surgery: Yes No

Specify: (List all) Date

12. Family History:

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

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

7. How often do you eat out? _____

8. What restaurants do you frequent? _____

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

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

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

12. Food allergies: _____

13. Food dislikes: _____

14. Food(s) you crave: _____

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

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

17. Do you drink cola drinks? Yes No How much daily? _____

18. Do you drink alcohol? Yes No

What? _____ How much daily? _____ Weekly? _____

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

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

What do you do? _____

21. What are your worst food habits? _____

22. Snack Habits:

What? _____ How much? _____ When? _____

_____ _____ _____

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

_____

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

_____

25. Typical Breakfast

_____
_____
_____
_____

Time eaten: _____
Where: _____
With whom: _____

Typical Lunch

_____
_____
_____
_____

Time eaten: _____
Where: _____
With whom: _____

Typical Dinner

_____
_____
_____
_____

Time eaten: _____
Where: _____
With whom: _____

26. Describe your usual energy level: _____

27. 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.

Weight Loss Program Consent Form

(Sample form only; consult with your attorney to ensure that the form is valid in your state.)

I _____ authorize Dr. _____ 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 or even fatal. Risks associated with remaining overweight are 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 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 and I realize I should not sign this form if 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, ask your doctor now before signing this consent form.

Date: _____ **Time:** _____

Witness: _____ **Patient:** _____

(Or person with authority to consent for patient)

Patient Informed Consent for Appetite Suppressants

(Sample form only; consult with your attorney for validity in your state)

I. Procedure And Alternatives:

1. I,_____ (patient or patient's guardian) authorize Dr._____ 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. 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.

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 NOW BEFORE SIGNING THIS CONSENT FORM.

DATE:_____ **TIME:**_____

PATIENT:_____ **WITNESS:**_____

(or person with authority to consent for patient)

VI. PHYSICIAN DECLARATION:

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

4 Reasons

"Why I Want to Reach My Goal Weight"

Name: _____ **Date:** _____

Before writing your reasons down, give them some thought. It is important that these 12 reasons be true personal goals and desires. They should not be generalizations or what you think would please others because they will be used as your "personal motivator."

Take a few moments from time to time each day to thoughtfully read through this list. This is called mental programming. The original of your 4 reasons list is retained in your medical file. You will be given a copy to carry at all times. We suggest that you also transfer your list onto a 3 x 5 card which may be more convenient.

Make a promise to yourself now: "I will read the entire card whenever I am confronted with a difficult food situation." Reading the list will clearly reinforce your personal commitment to take control of your health and self-esteem.

1. _____ 2. _____

3. _____ 4. _____

Weight-Loss Consumer Bill of Rights

Margaret Yee

WARNING: Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1½ pounds to 2 pounds per week or weight loss of more than 1 percent 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. Only permanent lifestyle changes, such as making healthful 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 or estimated price of the weight-loss program, including extra products, services, supplements, examinations, and laboratory tests; know the actual or estimated duration of the program; know the name, address and qualifications of the dietitian or nutritionist who has reviewed and approved the weight-loss program according to s.468-505(1)(j), Florida Statutes.

Required to be posted by section 501.0575 of Florida Statutes

I have read the above:

_____ _____

Patient's Signature Date