

### PATIENT DEMOGRAPHICS

DATE OF BIRTH	AGE	GENDER		SOCIAL SECURITY #	
		<input type="checkbox"/> Male	<input type="checkbox"/> Female		
LAST NAME		FIRST NAME		MI	
STREET ADDRESS		CITY	STATE	ZIP	COUNTY
HOME PHONE		WORK PHONE			
<i>May we leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No</i>		<i>May we leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No</i>			
CELL PHONE		EMAIL ADDRESS			
<i>May we leave a message at this number? <input type="checkbox"/> Yes <input type="checkbox"/> No</i>		<i>May we send information to this email address? <input type="checkbox"/> Yes <input type="checkbox"/> No</i>			
OCCUPATION	EMPLOYER	MARITAL STATUS	SPOUSE NAME (if applicable)		
EMERGENCY CONTACT (Last, First)		RELATIONSHIP	PHONE NUMBER		
HOW DID YOU LEARN ABOUT OUR PROGRAM?					

### PATIENT WEIGHT HISTORY

HEIGHT	WEIGHT	GOAL WEIGHT
HOW LONG HAVE YOU BEEN TRYING TO LOSE WEIGHT?		
WHAT WAS YOUR HEAVIEST WEIGHT?	WHAT AGE AT THAT WEIGHT?	
WHEN DID YOU FIRST BECOME OVERWEIGHT?		
WHAT DO YOU THINK IS THE CAUSE OF YOUR WEIGHT PROBLEM?		
ARE ANY MEMBERS OF YOUR HOUSEHOLD OVERWEIGHT? (If yes, please list relation and detail)		
WHAT WAS YOUR MOTIVATION FOR JOINING OUR PROGRAM?		
HAVE YOU PARTICIPATED IN ANY OF THE FOLLOWING OTHER WEIGHT LOSS PROGRAMS? (circle all that apply)		
Weight Watchers	Jenny Craig	Slim Fast
South Beach	Nutri System	Transformations
		Atkins
		Other
DO YOU EXERCISE?	IF YES, HOW OFTEN?	
	NEVER RARELY DAILY 4-5 times/wk 2-3 times/wk	
WHAT TYPES OF EXERCISES DO YOU DO? (Circle one)		
Walking	Swimming	
Treadmill/jogging	Bicycling	
Stairmaster	Sports (basketball, tennis, etc.)	
	Aerobics	
	Elliptical	
	Weight training	
	Other	
DESCRIBE THE DURATION OF YOUR EXERCISE ROUTINE (time)		



**PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_, DOB \_\_\_\_\_, SSN \_\_\_\_\_,  
authorize The Orlando Institute of Weight Mangement and Metabolic Medicine and/or staff to release information to the following individuals regarding my appointment and account history, and hereby authorize these individuals to reschedule, verify, cancel, and make payments on my behalf.

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

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_, have received a copy of The Orlando Institute of Weight Mangement and Metabolic Medicine Notice of Privacy Practices.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**PHOTOGRAPHS CONSENT FORM**

I hereby authorize Allison Haughton-Green and/or staff to take my photograph during my initial consultation, during, and at the end of my weight loss program. I understand that these pictures are for office purposes only, and are kept in my chart at all times. I understand that I may obtain copies of these photos at any time.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

PATIENT MEDICAL HISTORY

MEDICATIONS (Please list the medications you are currently taking, and as needed)		
MEDICATION NAME	DOSAGE & FREQUENCY	THIS MEDICATION IS FOR (LIST DISEASE)

ALLERGIES (Please list any medications you are allergic to)

FAMILY HISTORY (If blood relative has suffered the following, please indicate relationship)			
Heart attack		Arthritis	
Cancer		Diabetes	
Hypertension		Obesity	
Stroke		Glaucoma	
Epilepsy		Other	

HAVE YOU EVER BEEN HOSPITALIZED? IF YES, WHEN AND WHY? PLEASE INCLUDE HOSPITALIZATION FOR CHILDREN	
Year	Illness or operation

Please indicate any personal history below:

<b>CONSTITUTIONAL SYMPTOMS</b> Good general health lately      No    Yes Recent weight change            No    Yes Fever                                    No    Yes Fatigue                                 No    Yes Headaches                            No    Yes	<b>RESPIRATORY</b> Chronic or frequent coughs      No    Yes Spitting up blood                    No    Yes Shortness of breath                 No    Yes Asthma or Wheezing                No    Yes Smoking/Cigarette use             No    Yes	<b>HEMATOLOGIC/LYMPHATIC</b> Slow to heal after cuts             No    Yes Bleeding or bruising tendency    No    Yes Anemia                                 No    Yes Phlebitis                                No    Yes Enlarged glands                     No    Yes
<b>CARDIOVASCULAR</b> Heart trouble                         No    Yes Arrhythmia or abnormal rhythm    No    Yes Chest pain or angina pectoris     No    Yes Palpitation                             No    Yes Shortness of breath                 No    Yes Swelling of feet, ankles or hands   No    Yes	<b>MUSCULOSKELETAL</b> Joint pain                                No    Yes Joint stiffness or swelling         No    Yes Weakness of muscles or joints     No    Yes Muscle pain or cramps              No    Yes Back Pain                                No    Yes Cold extremities                     No    Yes Difficulty in walking                No    Yes	<b>INTEGUMENTARY (skin, breast)</b> Rash/ itching/ Eczema                No    Yes Change in skin color                 No    Yes Change in hair or nails                No    Yes Varicose veins                         No    Yes Breast pain                              No    Yes Breast lump                             No    Yes Breast discharge                     No    Yes
<b>NEUROLOGICAL</b> Frequent or recurring headaches    No    Yes Light headed or dizzy                 No    Yes Convulsions or seizures             No    Yes Numbness or tingling sensations    No    Yes Tremors                                 No    Yes Paralysis                                No    Yes Stroke                                    No    Yes Head Injury                              No    Yes	<b>GASTROINTESTINAL</b> Loss of appetite                        No    Yes Change in bowel movements        No    Yes Nausea or vomiting                  No    Yes Frequent diarrhea                    No    Yes Irritable Bowel Syndrome            No    Yes Constipation                            No    Yes Rectal bleeding or blood in stool    No    Yes Abdominal pain                        No    Yes Peptic ulcer ( <i>stomach or duodenal</i> ) No    Yes	<b>GENITOURINARY</b> Frequent urination                    No    Yes Burning or painful urination        No    Yes Blood in urine                         No    Yes Change in force of strain when urinating    No    Yes Incontinence or dribbling            No    Yes Kidney stones                          No    Yes
<b>PSYCHIATRIC</b> Memory loss or confusion            No    Yes Nervousness                            No    Yes Depression                             No    Yes Insomnia                                 No    Yes Alcohol use                             No    Yes	<b>ENDOCRINE</b> Glandular or hormone problem     No    Yes Thyroid disease                        No    Yes Diabetes ( <i>insulin or non- insulin</i> )    No    Yes Excessive thirst or urination        No    Yes	<b>EARS/NOSE/MOUTH/THROAT</b> Hearing loss or ringing                No    Yes Earaches or drainage                 No    Yes Chronic sinus problem or rhinitis    No    Yes Nose bleeds                            No    Yes Mouth sores                            No    Yes Bleeding gums                         No    Yes
<b>EYES</b> Eye disease or injury                 No    Yes Wear glasses/contact lenses        No    Yes Blurred or double vision             No    Yes Glaucoma                                No    Yes	Heat or cold intolerance             No    Yes Skin becoming dryer                 No    Yes PCOS/Infertility                        No    Yes Acne/ excessive facial hair         No    Yes <b>OTHER</b>	Bad breath or bad taste                No    Yes Sore throat or voice change         No    Yes Swollen glands in neck                No    Yes Snoring/ Obstructive sleep apnea    No    Yes



## WEIGHT LOSS CONSENT & CANCELLATION POLICY

I hereby authorize The Orlando Institute of Weight Management and Metabolic Medicine and associates to assist me in weight reduction. I understand that my program may consist of a balanced calorie deficient diet, regular exercise, and lifestyle changes. I understand there are 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 or an exchange-eating program without the use of the appetite suppressants would likely prove successful if followed. The Orlando Institute of Weight Management & Metabolic Medicine and associates believe that this is the safest way to lose weight.

The Orlando Institute of Weight Management and Metabolic Medicine and associates believe in the use of a personalized nutritional plan coupled with nutritional supplements and injections to promote weight loss. There are those practicing Bariatric Medicine that do not hold to these beliefs regarding the effectiveness of nutritional supplements, injections, and medications. Many of these physicians believe that in order to lose weight you simply need to exercise or and eat fewer calories. The Orlando Institute of Weight Management and Metabolic Medicine and associates disagree with this simplistic thinking, and believe that the nutritional supplements and injections that are prescribed are effective and therapeutic. If you have any problems or questions, please inform one of our medical associates immediately.

I also understand that appetite suppressants, other medications, and injections may be used in my program for up to and possibly more than 12 consecutive weeks. Appetite suppressants labeling suggestions are based on short-term studies of 12 weeks. The experience of Bariatric physicians, as well as recent long-term studies of university-based investigators, has shown that appetite suppressants, supplements and injections are effective for longer than 12 weeks. In order to continue to receive appetite suppressants, other medications, and injections depends on continued weight loss. The use of appetite suppressants, other medications, and injections involves potential risks. Reported side effects include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, medication allergy, high blood pressure, rapid heartbeat, and heart irregularities. These and other risks could, on occasion, be serious. I understand that if I develop side effects from the diet or the medication, I will discontinue the diet and/or the medication and notify a member of your medical staff immediately. I also understand that if the problem is severe, I will go to the nearest Emergency room or see my primary care physician as soon as possible. Because of the potential side effects of prescription appetite suppressants, The Orlando Institute of Weight Management & Metabolic Medicine and associates believe that this is the safest way to lose weight is with the utilization of a balanced calorie counting or an exchange-eating program without the use of the appetite suppressants.

### Cancellation Policy

There is no guarantee that the program will work for me. By consenting to treatment I agree to pay in full for all visits and charges at the time of each visit. **I understand that your services are not reimbursed by insurance.** I understand that no refunds are ever given at any time for any reason. I also understand that the supplements, injections and medications dispensed to me are included for quality assurance and my convenience and cannot be returned for a refund for any reason. **INTIAL \_\_\_\_\_**

By signing below I certify that I have read and fully understand this consent form. **I should not sign this form if I have any questions or concerns that have not been answered to my complete satisfaction.** My signature further confirms that I do not have a history of alcohol abuse, drug abuse, schizophrenia, manic-depressive illness, or history of any eating disorder, since these conditions constitute a contraindication to the use of appetite suppressants. I agree not to take any other appetite suppressants, other medications, or injections other than those prescribed by The Orlando Institute of Weight Management and Metabolic Medicine or this office’s physician, or listed on my medical history form. I agree to inform a member of your medical staff of any changes in my medications. If a female, my signature confirms that I am not pregnant, do not plan to get pregnant, and I will take all necessary precautions to prevent pregnancy during the time I will be taking appetite suppressants. If I become pregnant, I will stop the medication immediately and notify your office.

I further understand that The Orlando Institute of Weight Management and Metabolic Medicine and all written materials describing your program or any of its parts, and all applicable trademarks, copyrights and other intellectual property in or to your program and related materials are and remain your absolute property. I acknowledge that I am purchasing a non-exclusive, non-transferable license to use your program and the related written materials for my own use, and that I have no right to duplicate or to sell, lend or otherwise transfer to any other person or to make any commercial use of our program or related written materials. I may not modify, publish, distribute, perform, participate in the transfer or sale, create derivative work of, or in any way exploit any of the content, in whole or in part. **My signature below indicates my consent of treatment.**

<b>Patient Signature</b>		<b>Date</b>	
<b>Witness</b>		<b>Date</b>	

**FOOD & DRINK DIARY – PLEASE COMPLETE**

**Please let us know what you typically eat and drink throughout the day.**

Meal	Foods	Drinks
Breakfast	_____	_____
Snack	_____	_____
Lunch	_____	_____
Snack	_____	_____
Dinner	_____	_____
Snack	_____	_____

Are you an emotional eater? Circle your answer: YES NO

Do you drink alcohol Circle your answer: YES NO If YES how much and how often? \_\_\_\_\_

What are some things that trigger your hunger?

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