The Orlando Institute of Weight Management & Metabolic Medicine

PATIENT DEMOGRAPHICS

DATE OF BIRTH	AGE	GENDER	SOCIAL SECURITY #
		☐ Male ☐ Female	

LAST NAME	FIRST NAME	MI

STREET ADDRESS	CITY	STATE	ZIP	COUNTY

HOME PHONE	WORK PHONE
May we leave a message at this number? ☐ Yes ☐ No	*May we leave a message at this number? ☐ Yes ☐ No*
CELL PHONE	**EMAIL ADDRESS**
May we leave a message at this number? ☐ Yes ☐ No	*May we send information to this email address? ☐ Yes ☐ No*

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	Atkins
South Beach	Nutri System	Transformations	Other

DO YOU EXERCISE?		IF YES, HOW OFTEN?	NEVER RARELY DAILY 4-5 times/wk 2-3 times/wk

WHAT TYPES OF EXCERCISES DO YOU DO? (Circle one)

Walking	Swimming	Dancing	Elliptical
Treadmill/jogging	Bicycling	Yoga/pilates	Weight training
Stairmaster	Sports (basketball, tennis, etc.)	Aerobics	Other

DESCRIBE THE DURATION OF YOUR EXERCISE ROUTINE (time)	

The Orlando Institute of Weight Management & Metabolic Medicine

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**

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

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

_____ _____

Witness Signature Date

The Orlando Institute of Weight Management & Metabolic Medicine

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 CHILDBRITH	
Year	**Illness or operation**

Please indicate any personal history below:

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

The Orlando Institute of Weight Management & Metabolic Medicine

WEIGHT LOSS CONSENT & CANCELLATION POLICY

I hereby authorize The Orlando Institute of Weight Mangement 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 Mangement 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 Mangement 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 Mangement 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.**

Patient Signature		**Date**	
Witness		**Date**	

The Orlando Institute of Weight Management & Metabolic Medicine

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?

_____

_____