PATIENT INFORMATION FORM- LA MEDICAL WEIGHT LOSS LLC

Patient Name: _____

Date of Birth: _____ Age: _____ Sex: M / F

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____(Cell)

Email address: _____

Can we email you? YES / NO

How did you hear about us? (PLEASE CIRCLE) TV RADIO WEBSITE/ONLINE SOCIAL MEDIA OTHER

FAMILY/FRIEND/CO-WORKER, IF SO, WHO REFERRED YOU? _____

ARE YOU CURRENTLY BEING TREATED FOR ANY ILLNESS OR DISEASE? _____

IF YES, PLEASE LIST_____

_____

LIST OTHER DIAGNOSIS/ILLNESS:

IS THERE A HISTORY OF ANY OF THE FOLLOWING IN YOUR IMMEDIATE FAMILY?

HEART DISEASE/ATTACK- YES NO

STROKE- YES NO

DIABETES- YES NO

HIGH CHOLESTEROL- YES NO

HIGH BLOOD PRESSURE- YES NO

OBESITY- YES NO

MEDULLARY THYROID CANCER- YES NO

MULTIPLE ENDOCRINE NEOPLASIA SYNDRYOME TYPE 2- YES NO

DO YOU STILL HAVE YOUR GALLBLADDER?- YES NO

DO YOU HAVE A HISTORY OF GALL STONES- YES NO

DO YOU HAVE A HISTORY OF PANCREATITIS? YES NO

Are you currently getting treatment for obesity from another Physician? Yes / No

Is the Physician using medication? Yes / No

List medication: _____

Have you taken appetite suppressants before? Yes / No How long ago? _____

Was it successful? Yes / No

Please list any side affects you experienced: _____

LIST ALL MEDICATIONS/VITAMINS/HERBAL REMEDIES & DOSES YOU ARE CURRENTLY TAKING:

_____

DO YOU HAVE ALLERGIES TO ANY DRUGS/MEDICATIONS? YES/NO AND LIST REACTIONS, PLEASE LIST:

_____

HAVE YOU EVER BEEN TREATED FOR DRUG ABUSE? YES/NO

DO YOU DRINK ALCOHOL? YES/NO IF YES, HOW MUCH AND HOW OFTEN DO YOU DRINK?

_____

DO YOU SMOKE? YES/NO

ARE YOU PREGNANT? YES/NO

ARE YOU NURSING? YES/NO

HIGH BLOOD PRESSURE-- YES NO

ASTHMA-- YES NO

HEART DISEASE/ATTACK-- YES NO

CANCER-- YES NO

DIABETES-- YES NO

SLEEP APNEA-- YES NO

THYROID DISEASE-- YES NO

DEPRESSION-- YES NO

GLAUCOMA-- YES NO

BULIMIA/ANOREXIA-- YES NO

MITRAL VALVE PROLAPSE-- YES NO

STROKE-- YES NO

SURGERIES WITHIN THE LAST YEAR-- YES NO

UPCOMING SURGERIES-- YES NO

PLEASE CIRCLE BELOW IF YOU ARE EXPERIENCING ANY OF THESE SYMPTOMS:

RESPIRATORY

Frequent coughing

Spitting up blood

Shortness of breath

Asthma or wheezing

Nausea or vomiting

HEART & CARDIOVASCULAR

Chest Pains

Sudden heartbeat changes

Swelling of feet, ankles, hands

GASTROINTESTINAL

Loss of appetite

Frequent diarrhea

Constipation

Blood in stool

Stomach pain

GENITOURINARY

Frequent urination

Burning or painful urination

Burning or painful urination

Kidney stones

Irregular periods (females)

Vaginal discharge (females)

EYES AND VISION

Eye disease

Blurry vision

Glaucoma

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts

Easily bruise or bleed

Anemia

Phlebitis

Transfusion

Swollen lymph glands

NEUROLOGICAL

Headaches

Light headed or dizzy

Convulsions or seizures

Numbness or tingling

Tremors

Paralysis

Stroke

Head injury

SKIN

Rash or itching

Change in skin color

Change in hair or nails

Varicose veins

MUSCULOSKELETAL

Joint pain

Joint swelling

Muscle pain or cramps

Difficulty in walking

EAR, NOSE, THROAT

Sinus problems

Nose bleeds

Swollen glands in neck

Hearing loss

ENDOCRINE

Gland or hormone problem

Thyroid disease

Diabetes

If ANY symptoms were circled, please list the estimated date and frequency of occurrence:

_____

_____

_____

_____

Patient Signature: _____

Parent/Guardian Signature (if under 18)_____

Physician Signature: _____

Date: _____

Date: _____

CONSENT FOR MEDICAL WEIGHT LOSS TREATMENT FORM

I, _____ do hereby authorize the physicians of the LAMEDICAL WEIGHT LOSS LLC to assist me in weight reduction. I fully understand that this program shall consist of a reduction in caloric intake, regular exercise and behavioral lifestyle changes and that my treatment may include the use of appetite suppressants and other supplements. I further understand that to continue to receive appetite suppressants, I must show continued weight loss. Regarding the use of appetite suppressants, I understand that there are potential risks involved. Reported side effects include nervousness, constipation, sleeplessness, headaches, dry mouth, weakness, tiredness, medication allergy, high blood pressure, rapid heartbeat and heart irregularities. I understand that these and other risks could, on occasion, be serious and possibly permanently disabling. _____initial

I understand that if I develop side effects from the medication, I will discontinue taking the medication and notify the LA MEDICAL WEIGHT LOSS staff, as well as my primary care physician, immediately and in the event the problem is severe, I will go to the nearest emergency room for immediate care. I do not have a history of alcohol abuse, drug abuse, schizophrenia, manic-depressive illness, or eating disorder, since these conditions constitute a contraindication to the use of appetite suppressants. _____initial

I agree not to take any other weight loss medications, other than those prescribed by the physicians of the LA MEDICAL WEIGHT LOSS LLC and further agree to inform the LA MEDICAL WEIGHT LOSS LLC staff of ANY changes in my medication or medical history. _____initial

I understand the risk associated with being overweight/obese, which include the possibility of death, high blood pressure, diabetes, heart attack and heart disease, stroke, arthritis of the joints, hips, knees and feet, and gallbladder disease. I also understand that rapid weight loss programs may increase the incidence of symptomatic gallbladder disease. _____initial

I understand that Bariatric Physicians have found appetite suppressants helpful for periods longer than those suggested in the medication labeling, and at times in larger doses than those suggested in the labeling. The physicians of the LA MEDICAL WEIGHT LOSS are not required to use the medications as the labeling suggests but do use it as a source of information along with their own experience, the experiences of their colleagues, recent studies and recommendations of investigators. Based on these, they may choose, when indicated, to use the appetite suppressants for longer periods of time and in increased doses. As a patient of LA MEDICAL WEIGHT LOSS, I understand that I may be prescribed medications as stated above. _____initial

There is no guarantee that this program will work for me. I understand that I must follow the program as directed, in order to achieve weight loss. By consenting to treatment, I agree to pay, in full, for all visits and charges incurred at each visit. I understand that these charges may or may not be covered by insurance and LA MEDICAL WEIGHT LOSS LLC does not provide or fill out claim forms for insurance purposes. I also understand that no refunds are given.

By signing below, I certify that I have read and fully understand this consent form and understand the risks associated with my treatment for weight loss.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if under 18): _____

HIPPAA PATIENT CONSENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996(HIPPA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct, plan, and direct my treatment and follow- up among the multiple healthcare providers who may be involved in that

treatment directly and indirectly.

• Obtain payment from third-party payers.

• Conduct normal healthcare operations such as quality assessments and physician certifications

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment,

payment, or healthcare operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have acted relying on this consent. I understand that my medical or personal information will never be conveyed to parties outside myself without consent.

Patient Signature: _____ Date: _____

Parent/Guardian(if under 18)_____

CANCELLATION POLICY

LA MEDICAL WEIGHT LOSS LLC implemented a cancellation policy which enables us to better utilize available appointments for patients, as well as decrease the waiting time. If you are unable to keep your appointment, we ask for you to notify us at least 24 hrs. in advance, or we will charge a non-cancellation fee of $15.00 for time reserved if you do not show or call to cancel/ reschedule 24 hrs. in advanced.

I am aware of the cancellation policy.
Patient Signature: _____

Parent/Guardian(if under 18)_____

LA MEDICAL WEIGHT LOSS LLC - LIFESTYLE QUESTIONAIRE

**PLEASE CIRCLE THE BEST ANSWER **

When did you first begin to have concerns about your weight?

3-6 MONTHS/1-2 YEARS/GREATER THAN 2 YEARS

What is the primary reason for your wanting to lose weight?
HEALTH/CONFIDENCE/FITNESS/APPEARANCE

If you are in a relationship/marriage – How would you rate your partner's eating habits?

(Poor) 1 2 3 4 5 (Ideal)

Select TWO reasons that you feel are most responsible for your weight:

Genetics/People Around You/ No Time to eat healthy and exercise/lack of Knowledge About Nutrition/Exercise / Environmental Events (stress, depression, etc.)/Age/ Social Obligations

Have you tried dieting in the past? ____ Yes ____ No

If yes, circle the type of diet below -

Low Carb, Liquid(Slim Fast), Low Fat, Vegan, Paleo, Keto, Intermittent Fasting, Other

Were these diets successful? YES NO

Favorite food _____

Favorite drink _____

Sweet or salty cravings? Sweet/salty/both

In a typical DAY - How many meals do you eat? _____None _____1 _____2 _____3 _____4 _____5