Arnold Medical Weight Loss

Patient Basic Information Form

(to be filled out by patient)

Last Name:	First Name:	Middle Initial:	Nickname:

Street Address:	Apt/Suite#:	City:	State:	Zip Code:

Home Phone:	( ) -			
Cell Phone:	( ) -	**Birth Date:**	/ /	**Gender:** M____ F____
SSN:	- -	**Email:**		

How Did You Hear About Us?

- ☐ Radio
- ☐ Mailing
- ☐ Internet search
- ☐ Sign/Billboard
- ☐ Television
- ☐ Newspaper
- ☐ Word of Mouth
- ☐ Other _____

Emergency Contacts (at least 2 other people & your **physician**)

Last Name:	First Name:	Relationship:	Phone:
			( ) -
			( ) -
		Physician	( ) -

Allergy Information

Are you allergic to any medications?

Yes ____ No____	**If Yes– what?**

Financial Policy

Thank you for selecting Arnold Medical Weight Loss for your health care. 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. For your convenience, we accept Cash, Visa, MasterCard, Discover, and checks.

I have read and understand all of the above and have agreed to these statements.

Patient (or Guardian) Signature **Date Signed** / /

Patient Medical History

Last Name:	First Name:	Age:	Gender:
			Male_____ Female_____

1.	Are you in good health at the present time, to the best of your knowledge?	**Yes___**	**No___**
	If "No", explain:		
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___**

List all Prescription Drugs:		Drug:	Dosage:
Drug:	Dosage:	Drug:	Dosage:
Drug:	Dosage:	Drug:	Dosage:

Any History of the Following:

4.	High blood pressure?	**Yes___**	**No___**
5.	Diabetes?	**Yes___**	**No___**
6.	Heart disease?	**Yes___**	**No___**
7.	Chest pain?	**Yes___**	**No___**
8.	Feet swelling?	**Yes___**	**No___**
9.	Headaches?	**Yes___**	**No___**
10.	Constipation?	**Yes___**	**No___**
11.	Glaucoma?	**Yes___**	**No___**
12.	Sleep apnea?	**Yes___**	**No___**
13.	Any surgery?	**Yes___**	**No___**

If "Yes", list type and date performed. Use back of page if needed.

Type:	Date: / /	Type:	Date: / /
Type:	Date: / /	Type:	Date: / /
Type:	Date: / /	Type:	Date: / /
Type:	Date: / /	Type:	Date: / /
Type:	Date: / /	Type:	Date: / /

Patient Medical History (cont)

Your Past Medical History (check all that apply)

	Gallbladder Disorder		Jaundice		Kidneys		Tonsillitis
	Nervous Breakdown		Pleurisy		Scarlet Fever		Ulcers
	Rheumatic Fever		Tuberculosis		Drug Abuse		Anemia
	Blood Transfusion		Pneumonia		Arthritis		Gout
	Whooping Cough		Eating Disorder		Typhoid Fever		Chicken Pox
	Bleeding Disorder		Osteoporosis		Liver Disease		Lung Disease
	Heart Valve Disorder		Thyroid Disease		Heart Disease		Alcohol Abuse
	Psychiatric Illness		Cancer		Measles		Other

Your Family Medical History (Tell us of your family's medical history to the best of your ability)

	Father	Mother	Brother(s)	Sister(s)	Close Relatives
Age if living?					
General Health?					
Diseases?					
Overweight?					
Cause of Death?					
High Blood Pressure?					
Kidney Disease?					
Heart Disease/Stroke?					

Nutritional Evaluation

1.	What is the main reason for your decision to lose weight?		
2.	Desired weight:		
3.	In how many months would you like to be at this weight:		
4.	Weight at 20 years of age? Weight 1 year ago?		
5.	When did you begin gaining excess weight? (give reason(s) if known)		
6.	What is the most you have weighed (non-pregnant)? When?		
7.	Is your spouse, fiancée or partner overweight?	**Yes___**	**No___**
	If "Yes", approximately how much overweight?		

Nutritional Evaluation (cont)

8.	How often per week do you eat out?		
9.	How often per week do you eat "fast food"?		
10.	Foods you are allergic to:		
11.	Foods you strongly dislike:		
12.	Foods you crave:		
13.	Time(s) of day or month you crave food?		
14.	Do you drink coffee or tea?	**Yes___**	**No___**
	If "Yes", how much daily?		
15.	Do you wake up hungry during the night?	**Yes___**	**No___**
	If "Yes", how often?		
16.	Previous diets you have followed. List name (description) and your results:		

Lifestyle Considerations

1.	Do you drink alcohol?	**Yes___**	**No___**
	If "Yes", complete: Daily? **Yes___** **No___** Weekly? **Yes___** **No___** Occasionally? **Yes___** **No___**		
2.	Tobacco smoking habits		
	☐ Have never smoked		
	☐ Quit smoking _____ years ago and have not smoked since		
3.	Activity level (choose only 1)		
	☐ 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, etc.		
	☐ Heavy activity: consistent lifting, stair climbing, etc. or regular jogging, swimming, etc. 3 times per week		
	☐ Vigorous activity: extensive physical exercise at least 60 minutes per session, 4 times per week		

Patient Informed Consent for Appetite Suppressants

Procedure and Alternatives:

1. I _____(patient or guardian) authorize Dr. J.W. Campbell _____ and whomever he designates as his assistants 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, I understand that my program may consist of a balanced deficit diet, a regular exercise program, instructions in behavior modification techniques, and may involve the use of appetite suppressant medications.

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 (see page 6 "Risks")."

"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.

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 suppressant.

(continued on next page and acceptance signature required)

Patient Informed Consent for Appetite Suppressants (cont)

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.

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.

No Guarantee:

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.

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.

Patient (or guardian) Signature: _____ Date:____/____/_____

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 THE CONSENT SIGNATURE FORM.

Physician's 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/Nurse Practitioner Signature: _____ Patient Initials_____

Patient Consent for Appetite Suppressants & Weight Loss Program

I have read and fully understand this consent form. 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.

Patient (or guardian) Signature: _____ Date:____/____/_____

Witness Signature: _____ Time:_____AM / PM

HIPAA Privacy Notice

I have received a copy of the HIPAA privacy notice.

Patient (or guardian) Signature: _____ Date:____/____/_____

Consent to Treatment

(Women Only)

I understand that Phentermine and other anorectic medications should not be taken during pregnancy, due to the change of damage to the fetus. The medications have been explained to me fully and I am aware of the risks involved.

To the best of my knowledge, I am not pregnant. I am aware of the precautions that should be taken to avoid pregnancy while I am on the medication. If I become pregnant, I will advise both this clinic, ***and*** my OB/GYN immediately.

Patient (or guardian) Signature: _____ Date:____/____/_____

Provider Signature: _____ Date:____/____/_____