Weight Loss Program
New Patient Pre-Registration

First Name _____ M.I. ____ Last Name _____ Marital Status _____

Address _____ Date of Birth _____
Month/Day/Year

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

E-Mail Address _____

How did you hear about us? (please be specific)

_____

_____

List any allergies to medication or foods (write none if none)	Current medications and dosages (write none if none)	Past surgeries (your procedure) (write none if none)

Weight in High School _____ Highest weight past 5 years _____ Current Weight _____ Height (inches) _____

Ideal (goal) weight _____ Previous medical weight loss program? **No** ☐ **Yes** ☐ _____

When did your weight first become a problem? _____ Type of gain Sudden ☐ Gradual ☐

Typical exercise regimen (if none, write none) _____

_____

Which of the following contribute to your problem? Check all that apply

- ☐ Emotional Eating
- ☐ Medications/Anti-Depressants
- ☐ Pregnancy/Tubal Ligation
- ☐ Menopause
- ☐ Hysterectomy/Hormones
- ☐ Abnormal Metabolism
- ☐ Too Much Alcohol
- ☐ Boredom/Stress Eating
- ☐ Skipping Meals Then Overeating
- ☐ Stopping Smoking
- ☐ Poor Food Choices
- ☐ Compulsive Eating/Binging
- ☐ Social Obligations
- ☐ Overeating Frequently
- ☐ Thyroid Problems
- ☐ None Of The Above

Your medical history (not your family) Check all that apply

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ High Triglycerides
- ☐ Heart Attack/Angina
- ☐ Diabetes/Gestational
- ☐ Cancer/Pre-Cancer
- ☐ Cancer Breasts/Ovaries
- ☐ Cancer Prostate/Testes
- ☐ Thyroid Disease
- ☐ Depression/Anxiety
- ☐ Fertility Problems
- ☐ Alcohol/Drug Problems
- ☐ Arthritis
- ☐ Abnormal Mammogram
- ☐ Psychiatric Disorder Requiring Hospitalization
- ☐ Reaction To Diet Pills
- ☐ HIV/Hepatitis
- ☐ Stroke
- ☐ Gallstones
- ☐ Fatty Liver Disease
- ☐ Blood Clots
- ☐ Glaucoma
- ☐ Sleep Apnea
- ☐ Bipolar Disorder
- ☐ Kidney Stones
- ☐ Polycystic Ovaries
- ☐ Seizures
- ☐ Panic Disorder
- ☐ Anorexia/Bulimia
- ☐ Exercise Restrictions
- ☐ None Of The Above

Current symptoms

- ☐ Fatigue
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Shortness Of Breath
- ☐ Swelling Of Extremities
- ☐ Joint Pain
- ☐ Snoring/Sleeping Problems
- ☐ Reflux/Heartburn
- ☐ Constipation
- ☐ Abnormal Periods
- ☐ Feel Hot Or Cold Often
- ☐ Muscle Cramps
- ☐ Excessive Facial Hair
- ☐ Skin Tags
- ☐ Cravings
- ☐ None Of The Above

Family History

Please indicate if any first degree relative (parents, siblings or children) have had problems with the following:

- ☐ High Blood Pressure
- ☐ Heart Disease / Attack
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Cushing's Syndrome
- ☐ Obesity
- ☐ Cancer
- ☐ Stroke
- ☐ Alcohol / Drug Problem
- ☐ Early Death (under age 40)
- ☐ None of the above

Social History

Have you ever smoked? Yes / No (circle one)

If yes how many packs/day? ____ For how many years? ____

Do you drink alcohol? Yes / No (circle one)

If yes, what do you drink? _____ Times per week ____

Do you drink sweet tea or regular soda? Yes / No (circle one)

If yes, how much per day? _____

For Women Only

Any chance you are pregnant? Yes / No (circle one)

Are you breast feeding? Yes / No (circle one)

Last period? ____/____/____ (date)

Number of pregnancies? _____

Number of living children? _____

Last mammogram date / results? _____

_____

By signing this form, you understand and agree to the following:

This form will be reviewed by our medical staff to determine if you are an acceptable candidate for the Program. I understand that weight loss programs are not a covered benefit of most insurance plans and that I am financially responsible for all charges presented to me at the time of service. Fees are listed in our program guide and are subject to change without notice. Also, please be aware that any nutritional products that are sold in connection with our services are carefully selected for taste and quality by our staff. As in any business enterprise, such items are typically offered on many products. There is never any obligation to purchase products at our facility. We do provide receipts at the time of the service and can provide a letter of medical necessity, if appropriate, upon request.

_____ _____

Signature indicating understanding and acceptance Date

PATIENT INFORMED CONSENT FOR MEDICAL TREATMENT

I. Procedure and Alternatives:

1. I _____ (patient or patient's guardian) authorize Dr. Scott Redrick 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. Treatment may also include the "off label" use of other FDA approved medications that have been found to be of benefit in treating various aspects of the disease of Obesity.

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 board certified physician involved in clinical drug research with diet medications, 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 would be serious side effects" (as noted in Section II).

   "As a board certified physician, I believe that 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 and 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 a desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependant 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 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. We do not give refunds for services provided. I also understand that I will have to continue to watch my weight all my life if I am to be successful.

V. Patient's Consent:

I have read and fully understand this consent form and I realize that I should not sign this form if all items have not been explained, or if 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 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.

I HEREBY REQUEST, CONSENT TO, AND AUTHORIZE DR. SCOTT REDRICK, SUPERVISED BY DR. SCOTT REDRICK, TO PROVIDE ME WITH DRUG AND/OR NUTRITIONAL THERAPY TO ASSIST WITH WEIGHT LOSS.

DATE: _____ **TIME:** _____

PATIENT: _____ **WITNESS:** _____
(Or person with authority to consent for patient)

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 had consented to therapy involving the appetite suppressants in the manner indicated above.

_____
Physician's Signature- Scott Redrick, M.D.