PHYSICIANS WEIGHT CLINIC

PATIENT INFORMATION FORM

Name:	
Preferred Pronoun(s):	
Today's Date:	
Date of Birth:	
Street Address:	
City, State, Zip:	
Phone Number:	
Email:	
Occupation:	
Referred By:	
How did you hear about us?	

PHYSICIANS WEIGHT CLINIC

TREATMENT INFORMATION

Please read and *initial* each item

_____ I understand to only take the prescribed dosage of oral medication that I am given and I will not give the medication to another person.

_____ I will notify this office of any and all changes of prescribed and over the counter medications I am taking, including strength and dose.

_____ I will update this office whenever I have a new diagnosis or new medical issue I am being treated for by all other medical offices I receive care from. This includes psychiatric or emotional disorders as well as any new medications prescribed elsewhere.

_____ I understand I will receive my weight management participation medical examination at Physicians Weight Clinic, for the sole purpose of the weight management program. All medical staff's directives and treatments should not be regarded as care from a primary care physician.

_____ I understand all injections have inherent risk which may include, but not be limited to: bruising, bleeding, infection, injection site reaction and allergic reaction.

_____ Federal regulations require packaging of medication in child-resistant containers to prevent accidental ingestion.

I have read, understood, agreed to and initialed all the items

Print Name _____ Signature _____

Date _____

PHYSICIANS WEIGHT CLINIC

POSSIBLE PROGRAM CONTRAINDICATIONS

Please answer and sign below:

Are you pregnant, breastfeeding or planning to get pregnant soon? (Appetite suppressant medication should not be taken while pregnant, breastfeeding, or attempting to conceive)	Yes	No
Are you currently on: Prozac, Paxil, Zoloft, Celexa, Effexor, Wellbutrin, Elavil , Cymbalta, Trazodone, Buspirone (Buspar), St. John's Wort, or any other type of anti-depressant?	Yes	No
Are you currently on any medication for migraines such as Axert, Amerge, Imitrex, Imigran, or Zomig?	Yes	No
Are you currently on Nardil, Parnate, Marplan, or Emsam (MAOI)	Yes	No
Have untreated or uncontrolled high blood pressure?	Yes	No
History of any heart problem: e.g. By-pass surgery, stent, valve problem?	Yes	No
Other Heart disease: Pacemaker, defibrillator, arrhythmia, WPW?	Yes	No
History of a Stroke - Cerebrovascular accident (CVA)?	Yes	No
History of peripheral arterial/vascular disease (PAD/PVD)?	Yes	No
Advanced kidney or liver disease? Yes No History of Thyroid disease?	Yes	No
Have ever or currently undergoing drug addiction treatment?	Yes	No
Are you allergic, or ever had a bad reaction to stimulant drugs?	Yes	No

If you answered YES to any of the above, please inform the office before scheduling your initial appointment.

Print Name _____ Signature _____

Date _____

PHYSICIANS WEIGHT CLINIC

MEDICAL HISTORY

This medical history is for Physicians Weight Clinic and in no way replaces the care and exams of your health care provider.

NAME _____ DOB _____ AGE _____

List ALL MEDICATIONS and DOSAGE, including prescription, herbal and over-the-counter medications:

_____

List ALL DRUG ALLERGIES, including prescription, herbal and over-the-counter medications:

_____

DO YOU HAVE or HAVE YOU EVER HAD:

Heart disease/problems (of any kind)	Y	N	Alcoholism and/or substance abuse	Y	N
Irregular heart beat/palpitations/chest pain	Y	N	Shortness of breath (without exertion)	Y	N
Heart murmur or mitral valve prolapse	Y	N	High cholesterol	Y	N
High blood pressure	Y	N	Stroke	Y	N
Depression, anxiety, or panic disorder	Y	N	Headaches or migraines	Y	N
Anorexia, bulimia, or other eating disorder	Y	N	Glaucoma	Y	N
Sensitivity to stimulant drugs	Y	N	Thyroid problems	Y	N
Diabetes: I, II or gestational	Y	N	Positive TB test / treatment for TB	Y	N
Seizures or epilepsy	Y	N	Liver disease, hepatitis, jaundice	Y	N
Lung disease: COPD, asthma, or emphysema	Y	N	Gallstones	Y	N
Peripheral arterial disease	Y	N	Scarlet fever or rheumatic fever	Y	N

Blood disease: anemia, blood clots, sickle cell, or bleeding problems Y N

Digestive Problems: IBS, chronic constipation, diarrhea, acid reflux, diverticulitis, or ulcers Y N

Are you breastfeeding, pregnant, or planning to get pregnant soon? Y N

Current form(s) of birth control: _____ Last menstrual period / menopause: _____

Do you have any family history of heart disease, high blood pressure, stroke, or diabetes? If yes, please list who and at what age they were diagnosed._____

Is there ant additional information regarding your medical history you would like us to know? Are you presently being treated for any other illness? Any other health conditions? If so, please explain.

_____

Patient signature _____ Date _____

I declare, to the best of my knowledge, this information is complete and true. I agree Physicians Weight Clinic providers believing it to be true and shall rely and act upon it in making medical decisions about my weight loss treatment.

Physicians Weight Clinic reviewer signature _____ Date _____

PHYSICIANS WEIGHT CLINIC

HIPAA NOTICE OF PRIVACY PRACTICES

How your health information may be used:

TO PROVIDE TREATMENT

We will use your Health Information within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physician assistant, nurse practitioner, nurse physician and business office staff. In addition, we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment.

TO CONDUCT HEALTH CARE OPERATIONS

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in the training progress for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

PATIENT REMINDERS

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care modern medicine can provide. They may include letters, telephone reminders, or voice mails regarding labs or future appointments. Please be sure the receptionist has your current contact information to insure accuracy and your privacy.

FOR LAW ENFORCEMENT

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than is stated above or where Federal, State of Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

I have read and understand the above information.

Signature: _____ Date: _____