Oakland Medical Weight Loss

simplifying **Weight Loss®**

6685 Hwy 64 Ste. 2
Oakland, TN 38060
901.465.0250

Patient Basic Information Form

(to be filled out by patient)

Your Name: Last _____ First _____ M.I. _____

Name you prefer to be called: _____

Your Address: Street _____ Apt/Suite #_____

City:_____ State: _____ Zip Code: _____

Home Phone (Including Area Code): _____ Cell:_____

Birth date: _____ Current Age: _____ Sex: M F

Your e-mail address: _____

Referred by: _____

How did you hear about us? (please check all that apply)

___Radio ___Mail-out ___Internet ___Saw a Sign

___Television ___Newspaper ___Word of Mouth

Allergy Information

Are you allergic to Sulfa type medications, or any other medications? Yes No

Emergency Contacts
(at least 2 other people)

Name: _____ Relationship _____ Phone _____

Name: _____ Relationship _____ Phone _____

Physician: _____ Phone _____

Financial Policy

Thank you for selecting Oakland 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 Visa, MasterCard and checks.

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

_____ _____

Patient's (or Guardian's) Signature Date

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Patient Medical History (1 of 2)

Full Name: _____ Age: _____ Sex: M F

Present Health Status:

1. Are you in good health at the present time, to the best of your knowledge? Yes No
   Explain a "no" answer:

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
   Prescription Drugs (List all)
   Drug: Dosage:

   Over the Counter medication, vitamins, supplements, etc. (List all)
   Product: Dosage:

4. Any allergies to any medications? Yes No
   Please List:

5. History of High Blood Pressure? Yes No
6. History of Diabetes? Yes No
   At what age:_____
7. History of Heart Attack or Chest Pain or other Heart condition? Yes No
8. History of Swelling Feet? Yes No
9. History of Frequent Headaches? Yes No
   Migraines? Yes No Medications for Headaches: _____
10. History of Constipation? (difficulty in bowel movements) Yes No
11. History of Glaucoma? Yes No
12. History of Sleep Apnea? Yes No
13. Any Surgery? Yes No
    Specify with date: (List all, use back of page if needed)

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Patient Medical History (2 of 2)

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

Family History:

Tell us of your family's medical history to the best of your ability including these items as they apply: Age | General Health | Diseases | Overweight | Cause of Death

Father: _____

Mother: _____

Brother(s): _____

Sister(s): _____

Has any blood relative ever had any of the following?

High Blood Pressure: Yes No Who: _____

Kidney Disease: Yes No Who: _____

Heart Disease/Stroke: Yes No Who: _____

At what age did they have their heart / stroke problems? _____

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Nutritional Evaluation (1 of 2)

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 old? _____ Weight one year ago? _____
5. When did you begin gaining excess weight? (give reasons, if known) _____

   _____

6. What is the most you have weighed (non-pregnant) and when? _____
7. Is your spouse, fiancée or partner overweight? (circle one) Yes No

   If yes, approximately how much overweight?_____
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. Times of day or month that you crave food? _____
14. Do you drink coffee or tea? Yes No How much daily?_____
15 Do you wake up hungry in during the night? Yes No How often? _____
16. Previous diets you have followed: list description (or name) and your results

_____

_____

_____

_____

_____

_____

_____

_____

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Nutritional Evaluation (2 of 2)

Lifestyle Considerations

This information will assist us in assessing your particular problem areas as it relates to weight and health, and establishing your medical management. Thank you for your time and patience in completing this form.

1. Do you drink alcohol? Yes No

   Daily? Yes No Weekly? Yes No Occasionally Yes No

2. Smoking Habits (choose only one)

   _____ You have never smoked cigarettes, cigars or a pipe

   _____ You have quit smoking ____ years ago and have not smoked since

   _____ You have quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke

   _____ You smoke 20 cigarettes per day (1 pack)

   _____ You smoke 30 cigarettes per day (1 ½ packs)

   _____ You smoke 40 cigarettes per day (2 packs) or more

3. Activity Level (choose only one)

   _____ 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, swimming or cycling.

   _____ Heavy activity: consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week.

   _____ Vigorous activity: participation in extensive physical exercise for at least 60 minutes per session for times per week.

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Patient Consent for Appetite Suppressants and Weight Loss Program (1 of 3)

I. Procedure And Alternatives

1. I _____ (patient or patient's guardian) authorize Dr. Jesse J. Cannon, M.D. 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 (as noted below).
   "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. (continued on next page)

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Patient Informed Consent for Appetite Suppressants (2 of 3)

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.

II. Risks of Proposed Treatment:

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than twelve 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 l am not very much overweight but that these risks can go up significantly the more overweight I am.

IV. 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.

V. 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.

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.

VI. 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's Signature / Nurse Practitioner's Signature

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Patient Consent for Appetite Suppressants and Weight Loss Program (3 of 3)

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: _____ Date:_____
(or person with authority to consent for patient)

Witness:_____ Time: _____

HIPAA Privacy Notice

I have received a copy of the HIPPA privacy notice.

Signature: _____

Date: _____

Consent to Treatment

(Women Only)

I understand that Phentermine and other anorectic medications should not be taken during pregnancy, due to the chance 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 Signature: _____ Date:_____

Provider Signature: _____ Date:_____