Genesis Medical Group

New Patient Weight Loss Medical History Form

Name: _____ Age:_____ Sex: M F

How did you hear about us? _____

Who is your Primary Care Physician? _____ Phone # (_____) _____

When were you last labs drawn? _____ When was your last EKG? _____

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. Medications taken at the present time: List all
   Drug & Dosage

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Over-the-Counter medications, vitamins, supplements: List all
Medication & 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. Gynecologic History: WOMEN ONLY

Pregnancies: Number: _____Ages of children: _____

Natural Delivery or C-Section (specify): _____

Menstrual Cycles: Onset: _____

Duration: _____

Are they regular: Yes No

Pain associated: Yes No

Last menstrual period: _____

Hormone Replacement Therapy: Yes No

What: _____

Birth Control Pills: Yes No

Type: _____

Last Check Up: _____

14. Serious Injuries: Yes No

Specify & Date

_____ _____

_____ _____

_____ _____

15.Any Surgery: Yes No

Specify & Date

_____ _____

_____ _____

_____ _____

_____ _____

16. Family History:

	Age	Health	Disease	Cause of Death	Overweight?
Father:					
Mother:					
Brothers:					
Sisters:					
Children:					

Medical Review: (check all that apply)

_____Depression	_____Anxiety	_____ Memory Loss	_____Joint Pain
_____ Jaundice	_____ Heart palpitations	_____ Fever	_____Fatigue
_____ Kidney disease	_____ Scarlet Fever	_____ Liver Disease	_____Cough
_____ Lung Disease	_____ Night Sweats	_____ Chicken Pox	_____Shortess of Breath
_____ Rheumatic Fever	_____ Bleeding Disorder	_____ Nervous Breakdown	_____Chest Pain
_____ Ulcers	_____ Gout	_____ Thyroid Disease	_____Swelling
_____ Anemia	_____ Heart Valve Disorder	_____ Heart Disease	_____Nausea
_____ Tuberculosis	_____ Gallbladder Disorder	_____ Psychiatric Illness	_____Vomiting
_____ Drug Abuse	_____ Eating Disorder	_____ Alcohol Abuse	_____Diarrhea
_____ Pneumonia	_____ Malaria	_____ Headaches	_____Constipation
_____Heart disease	_____ Cancer	_____ Blood Transfusion	_____Heartburn
_____ Arthritis	_____ Osteoporosis	_____ Leg pain with walking	Blood in Stool
_____Burning with urination	_____Urine Frequency	_____Erectile Dysfunction	_____Muscle Cramps
_____ Thirst	_____ Congestion	_____ Other: _____	

Nutrition Evaluation:

1. Present Weight: _____ Height (no shoes): _____ Desired Weight: _____

2. In what time frame would you like to be at your desired weight? _____

3. Birth Weight: _____ Weight at 20 years of age: _____ Weight one year ago: _____

4. What is the main reason for your decision to lose weight? _____

5. When did you begin gaining excess weight? (Give reasons, if known): _____

_____

6. What has been your maximum lifetime weight (non-pregnant) and when? _____

7. Previous diets you have followed: Give dates and results of your weight loss:

_____

_____

_____

Have you ever tried appetite suppressants?	Yes	No
Which one/s? _____		
If yes, would you use them again?	Yes	No
Have you ever used Nutritional Supplements as part of weight loss programs?	Yes	No
If yes, would you use them again?	Yes	No
Would you like information about the products we carry in our center?	Yes	No

8. Is your spouse, fiancé or partner overweight? Yes No

9.

9. By how much is he or she overweight? _____

Does he or she encourage your weight loss plan? Yes No

10. How often do you eat out? _____

11. What restaurants do you frequent? _____

12. How often do you eat "fast foods"? _____

13. Who plans meals? _____ Cooks? _____ Shops? _____

14. Do you use a shopping list? Yes No

15. What time of day and on what day do you usually shop for groceries? _____

16. Food allergies: _____

17. Food dislikes: _____

18. Food(s) you crave: _____

19. Any specific time of the day or month do you crave food? _____

20. Do you drink coffee or tea? Yes No How much daily? _____

21. Do you drink cola drinks? Yes No How much daily? _____

22. Do you drink alcohol? Yes No What? _____

How much daily? _____ Weekly? _____

23. Do you use a sugar substitute? _____ Butter? _____ Margarine? _____

24. Do you awaken hungry during the night? Yes No

What do you do? _____

25. What are your worst food habits? _____

26. Snack Habits:

What? _____ How much? _____ When? _____

27. When you are under a stressful situation at work or family related, do you tend to eat more? Explain:

_____

_____

28. Do you think you are currently undergoing a stressful situation or an emotional upset? Explain:

_____

Typical Daily Food Log (1 day – Minimum) Please include Meals, Snacks, Beverages, & Estimate Portion Sizes

Time	Food Eaten	Serving Size	Home or Restuarant

29. Smoking Habits: **(answer only one)**

____ You have never smoked cigarettes, cigars or a pipe.

____ You 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 (1-1/2 packs).

____ You smoke 40 cigarettes per day (2 packs).

30. Describe your usual energy level: _____

31. What is your occupation? _____

32. Activity Level: **(answer 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 4 times per week.

33. Behavior style: **(answer only one)**

____ You are always calm and easygoing.

____ You are usually calm and easygoing.

____ You are sometimes calm with frequent impatience.

____ You are seldom calm and persistently driving for advancement.

____ You are never calm and have overwhelming ambition.

____ You are hard-driving and can never relax.

34. Please describe your general health goals and improvements you wish to make: _____

_____

**This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Epworth Sleepiness Scale

Name: _____ Today's date: _____

Your age (Yrs): _____ Your sex (Male = M, Female = F): _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0 = would **never** doze
1 = **slight chance** of dozing
2 = **moderate chance** of dozing
3 = **high chance** of dozing

It is important that you answer each question as best you can.

Situation	**Chance of Dozing (0-3)**
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	

THANK YOU FOR YOUR COOPERATION

Genesis Medical Group

Weight Loss Program Consent Form

I, _____ hereby authorize Crystal Broussard, MD and whomever designated as her assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medication have been used safely and successfully in private medical practice as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack, and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

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 obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

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 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: ____/____/_____

Witness: _____ Date: ____/____/_____

Genesis Medical Group

Patient Informed Consent for Appetite Suppressants

I. Procedure And Alternatives:

1. I,_____ (patient or patient's guardian) authorize Crystal Broussard, M.D. 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.

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. 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 can 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. 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 THIS CONSENT FORM.

Patient: _____ **Date:** _____ **Time:** _____

(Or person with authority to consent for patient)

Witness: _____ **Date:** _____ **Time:** _____

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

_____

Crystal Broussard, M.D.