**Patient Medical History – Weight Loss Program**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **DOB: \_\_\_\_\_\_\_\_\_\_\_\_**

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Environmental/Other Allergies: ­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: Male \_\_ Female \_\_

Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pregnant: Yes No Breastfeeding: Yes No Last Menstrual Period: \_\_\_\_\_\_\_\_\_

Current Medications (prescription, over-the-counter, vitamins, supplements)

**Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dose/Strength | Medication | Dose/Strength |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Past Medical History (make an X next to conditions you currently have or have had in the past)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Condition | Current | Past | Condition | Current | Past |
| Heart Disease |  |  | High Blood Pressure |  |  |
| High Cholesterol |  |  | Liver Disease |  |  |
| Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | Anemia/Blood Disorder |  |  |
| Diabetes |  |  | Thyroid Disease |  |  |
| Stroke |  |  | Seizures |  |  |
| Headaches/Migraine |  |  | TB (Tuberculosis) |  |  |
| Mental Health Disorder |  |  | Nerve Impairment |  |  |
| Spinal Disorder |  |  | Sleep Apnea |  |  |
| Lung Disease (Asthma/COPD) |  |  | Chronic Skin Condition |  |  |
| GI Disorder (Reflux/Heartburn) |  |  | Kidney/Bladder Prostate |  |  |
| Other Conditions: |  |  |  |  |  |

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **DOB: \_\_\_\_\_\_\_\_\_\_\_\_**

Surgical History

|  |  |
| --- | --- |
| Surgery | Approximate Date |
|  |  |
|  |  |
|  |  |
|  |  |

Family History

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Condition | Mother | Father | Sister | Brother | Daughter | Son | Grand-mother | Grand-father |
| Heart Disease |  |  |  |  |  |  |  |  |
| High Cholesterol |  |  |  |  |  |  |  |  |
| Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |  |
| Headaches/Migraine |  |  |  |  |  |  |  |  |
| Mental Health Disorder |  |  |  |  |  |  |  |  |
| Spinal Disorder |  |  |  |  |  |  |  |  |
| Lung Disease (Asthma/COPD) |  |  |  |  |  |  |  |  |
| GI Disorder (Reflux/Heartburn) |  |  |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |  |  |
| Liver Disease |  |  |  |  |  |  |  |  |
| Anemia/Blood Disorder |  |  |  |  |  |  |  |  |
| Thyroid Disease |  |  |  |  |  |  |  |  |
| Seizures |  |  |  |  |  |  |  |  |
| TB (Tuberculosis) |  |  |  |  |  |  |  |  |
| Nerve Impairment |  |  |  |  |  |  |  |  |
| Sleep Apnea |  |  |  |  |  |  |  |  |
| Chronic Skin Condition |  |  |  |  |  |  |  |  |
| Kidney/Bladder Prostate |  |  |  |  |  |  |  |  |
| Deceased/Age at Death |  |  |  |  |  |  |  |  |
| Other Conditions: |  |  |  |  |  |  |  |  |

Social History

|  |  |  |  |
| --- | --- | --- | --- |
| Do you: | Current | Past | Never |
| Smoke Cigarettes |  |  |  |
| Chew Tobacco |  |  |  |
| Smoke Marijuana |  |  |  |
| Use Vaping Device |  |  |  |
| Drink Alcoholic Beverages |  |  |  |
| Drink Caffeine |  |  |  |

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **DOB: \_\_\_\_\_\_\_\_\_\_\_\_**

Weight Loss Program

Current weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weight one year ago \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ideal weight \_\_\_\_\_\_\_\_\_\_\_

Family/living Situation – who lives in your home?

Children with age:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse/partner:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise/Recreation – Frequency

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What health concerns are you most worried about? How much does this affect your daily life?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How have you dealt with these concerns in the past?

 Professional medical treatment

 

 Self-care

Has this treatment been successful? Explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **DOB: \_\_\_\_\_\_\_\_\_\_\_\_**

List your health practitioners:

|  |  |  |
| --- | --- | --- |
| Name | Specialty/reason for seeing | Phone Number |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

In general, describe your diet/eating habits at home:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Which of the following do you consumer regularly?

 Soda Diet Soda Fast Food

 

 

 

 

 Refined Sugar Alcohol Gluten(wheat/rye/barley)

 

 

 Dairy Coffee

 

 

Are you on a special diet? Explain:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What percentage of your meals are cooked at home?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had periods of eating junk food, binge eating or dieting? List any known diets (WW, Atkins, Keto etc) that you have been on for a significant amount of time:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is there anything else we should know about your current diet, history or relationship to food?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **DOB: \_\_\_\_\_\_\_\_\_\_\_\_**

Have you used or abused alcohol, drugs, meds, tobacco or caffeine? Are you currently? Explain:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How do you handle or deal with stress in your life?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you satisfied with your sleep?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours of sleep do you get on average?

 6 or less 6-8 more than 8

 

 

 

Do you doze off or nap during the day? Do you fall asleep in less than 30 minutes?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you think your family and friends will be supportive of you making health and lifestyle changes to improve your quality of life? If not, explain:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Who in your family or on your healthcare team will be the most supportive of you making dietary changes?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your health goals? Why do you want to achieve this?

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**Consent for Medical Weight Loss Treatment**

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (patient) do hereby authorize the providers, staff and Wellness Coordinator of Consiglio Wellness Center to assist me in weight reduction. In order to be successful, I fully understand that this program consists of behavioral lifestyle changes and that my treatment may include the use of appetite suppressants and other supplements. I further understand that in order to continue to receive appetite suppressants, I must show continued weight loss.

Regarding the use of appetite suppressants, I understand that there are potential risks involved. Reported side effects include nervousness, constipation, sleeplessness, headaches, dry mouth, weakness, tiredness, medication allergy, high blood pressure, rapid heartbeat and heart irregularities. I understand that these and other risks could, on occasion, be serious and possibly permanently disabling. \_\_\_\_\_\_\_\_initial

I understand that if I develop side effects from the medication, I will discontinue taking the medication and notify the staff at Consiglio Wellness Center, as well as my primary care physician, immediately and in the event the problem is severe, I will go to the nearest Emergency room for immediate care. I do not have a history of alcohol abuse, drug abuse, schizophrenia, manic-depressive illness, or eating disorder, as these conditions constitute a contraindication to the use of appetite suppressants.
\_\_\_\_\_\_\_\_\_initial

I agree not to take any other weight loss medications, other than those prescribed by the providers of the Consiglio Wellness Center and further agree to inform the Consiglio Wellness Center staff of ANY changes in my medication or medical history.
\_\_\_\_\_\_\_\_\_initial

Female patients – I am not pregnant, nor am I trying to get pregnant. If I become pregnant, I will stop taking the medication, notify the Consiglio Wellness Center and my OB/GYN immediately. I am not breastfeeding.
\_\_\_\_\_\_\_\_\_initial

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 appetite suppressants would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants. I understand the risk associated with being overweight/obese, which include the possibility of death, high blood pressure, diabetes, heart attack and heart disease, stroke, arthritis of the joints, hips, knees and feet, and gallbladder disease. I also understand that rapid weight loss programs may increase the incidence of symptomatic gallbladder disease.
\_\_\_\_\_\_\_\_initial

There is no guarantee that this program will work for me. I understand that I must follow the program as directed, in order to achieve weight loss. By consenting to treatment, I agree to pay, in full, for all visits and charges incurred at each visit. By signing below I certify that I have read and fully understand this consent form and understand the risks associated with my treatment for weight loss.

Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_