Weight... know more

MEDICAL WEIGHT LOSS CLINIC

Name _____ D.O.B. _____

Address _____

City _____ State _____ Zip _____

Phone _____ Age _____ Height _____

Employer _____ Employer Phone _____

Email _____

HOW DID YOU HEAR ABOUT US?

Newspaper _____ Radio _____ TV _____ Friend _____

If friend, name please: _____

Date:_____

Weight... know more
MEDICAL WEIGHT LOSS CLINIC

Comprehensive Obesity Management Program

Patient History Form

Patient Name:_____ ☐Male ☐Female

DOB: _____**Age:**_____ **Marital Status:**☐S ☐M ☐W ☐D ☐SEP

Occupation:_____

Emergency Contact Name_____ **Phone#**_____

Height	Weight

Goal Weight: _____ **Age when you were last at goal weight:**_____

Do you have any spiritual practices, of which you would like to make us aware, that would impact the medical care plan we would provide for you? Yes☐ No☐

<u>Your Family History:</u> Please check which of the following conditions that your blood related family members have experienced. Please indicate by circling which family member was affected.

Diabetes	Mother	Father	Other _____
Hypertension	Mother	Father	Other _____
Heart Disease	Mother	Father	Other _____
Obesity	Mother	Father	Other _____
Early Death	Mother	Father	Other _____
Lipid/Cholesterol Problems	Mother	Father	Other _____

<u>Your Medical History:</u>

When was your last physical exam with your primary care physician?_____

Name:_____DOB_____Date:_____

Medications: Any Other Condition not Listed

List all Medications (including over the-counter medications, vitamins, herbs & diet aids):

Drug Name	Dose	Times Per Day	Purpose

List all medications not tolerate: (describe reaction) _____

_____

_____

_____

Do you have a latex allergy or sensitivity? _____

Name_____ Date_____

Health History

PLEASE PRINT, COMPLETE, AND BRING THESE FORMS WITH YOU

You must be honest and complete in providing your medical history. Giving false, incomplete, or misleading information about your medical history, including past and present drug use, could have very serious consequences.

Past Medical History

Please check or circle all medical problems:

	Yes	No
Heart Disease		
Hypertension		
Stroke		
Gallbladder Disease		
Osteoarthritis		
Sleep Apnea		
Respiratory Disease		
Thyroid Disorder		
Asthma		
Glaucoma		
Depression/anxiety		
Any Other Condition not Listed		

Hospitalizations

Please List all hospital stays, give dates and reasons, including all surgeries:

_____

_____

_____

_____

_____

_____

Name:_____DOB_____Date:_____

Are you currently at your highest weight? _____yes _____No

If no, what was your highest weight & when? _____

What is your expected weight loss after treatment?_____

Diet History:

Please list all diet attempts that you can remember starting with the most recent. It may be difficult to remember this information, but try to estimate the date (month, year) from start to finish and how many pounds were lost. For programs more than 5 years ago, just indicate the year.

Diet Programs: (Some examples are: Atkins, South Beach, Weight Watchers, Jenny Craig, Slimfast, Over the Counter Diet aids, Ephedra)

Diet	Starting Date: (Month/Year)	Ending Date: (Month/Year)	Pounds Lost

Prescription Diet Medications: (Please check the medications you have taken)

Medication	Starting Date: (Month/Year)	Ending Date: (Month/Year)	Pounds Lost
☐ Fen-Phen			
☐ Phenteramine(Fastin,Adipex)			
☐ Meridia (Sibutramine)			
☐ Xenical(orilstat)			
☐ Other:			

Eating Behaviors:

Are you currently following a diet? ☐Yes ☐ No If yes, which diet:_____

Are you currently taking vitamins?☐ Yes ☐No If yes, list them all:_____

Do you have any food allergies/intolerances? ☐ Yes ☐ No

If yes, Please list them:_____

Name:_____DOB:_____Date:_____

Social History:

Current Smoker: _____Yes_____ No Date Quit:_____

_____ Cigarettes, _____ Pipe, _____ Cigar, _____Packs per day x_____ years

Alcohol: ☐ Never ☐ Rare (Holidays) ☐occasionally (weekends) ☐ frequently

_____#of drinks per day _____# times per week

Other Substance:

Type & Use_____

Have you undergone any previous gastric surgery, stomach stapling? _____yes, _____No

Do you have any other health concerns?_____

_____

_____

_____

Name:_____DOB:_____DATE:_____

Please check the following behaviors that contribute to your weight problems:

- ☐ Skip meals/inconsistent meal patter — Specify: _____
- ☐ Frequent snacking-day, night or both — Specify: _____
- ☐ Portion Control — Specify: _____
- ☐ Eating too fast — Specify: _____
- ☐ Sweets (sugar, candy, cookies, ice cream) — Specify: _____
- ☐ Starches (breads, pastas, potatoes) — Specify: _____
- ☐ Fats (fried foods, butter, margarine) — Specify: _____
- ☐ Fast Food — Specify: _____
- ☐ Emotional Eating-stress, boredom, depression, anger **(Circle one)**
- ☐ Binge eating (eating unusually large amounts of food with lack of self-control)
  If checked off, when was your last binge and what food did you binge on?
  _____
- ☐ Purging/vomiting/laxatives to lose weight
  If checked off, please describe when, how long, and were you professionally treated?

_____

_____

Please answer the following:

How many meals per day do you eat? _____How many snacks do you eat per day?_____

Who cooks your meals?_____

Do you eat breakfast regularly? ☐Yes ☐No

List the beverages you drink mostly? _____

Do you drink water ☐Yes ☐No If yes, how much per day?_____

What are you worst food habits?_____

Which food do you crave the most?_____

How often do you eat at fast food restaurants?_____

If you east fast food, which restaurants do you eat at most frequent?_____

Typical Eating Pattern: (the food you eat daily)

Breakfast	
Lunch	
Dinner	
Snacks	

Name:_____DOB:_____Date:_____

Weight Loss Readiness:

Choose the reason(s) which best describes why you are pursuing weight loss at this time?

- ☐ To avoid medical disability in the future
- ☐ To better manage current medical problems
- ☐ To avoid or reduce social criticism from others
- ☐ To feel better about myself
- ☐ Other (specify)_____

Compared to previous attempts, how motivated are you to lose weight at the time?

- ☐ Not motivated
- ☐ Slightly motivated
- ☐ Somewhat motivated
- ☐ Quite motivated
- ☐ Extremely motivated

How Certain are you that you will stay committed to a weight reduction program for the time it will take to reach your goal weight?

- ☐ Not certain
- ☐ Slightly certain
- ☐ Somewhat certain
- ☐ Quite certain
- ☐ Extremely certain

To what extent will you be committed to this program considering all outside factors at this time in your life (work, family, obligations, etc.)?

- ☐ Not committed
- ☐ Slightly committed
- ☐ Uncertain
- ☐ Somewhat committed
- ☐ Very committed

0.

Name:_____ Date_____

Physical Activities History

(Check one answer on each line)

Does this accurately describe you?

	Yes	No
I rarely or never do any physical activities		
I do some **light** or **moderate** physical activities, but not every week(walk, bending, kneeling, or stooping)		
I do some **light** physical activity every week (vacuuming, bowling, lifting objects, or carrying groceries)		
I do **moderate** physical activities every week, but less than 30 minutes a day or 5 days a week (walking a mile)		
I do **vigorous** physical activities every week, but less than 20 minutes a day or 3 days a week (running, sports)		
I do 30 minutes or more a day of **moderate** physical activities, 5 or more days a week (walk quickly, mowing)		
I do 20 minutes or more a day of **vigorous** physical activites, 3 or more days a week (climbing stairs, aerobics)		
I do activities to increase muscle **strength**, such as lifting weights or calisthenics, once a week or more		
I do activities to improve **flexibility**, such as stretching or yoga, once a week or more		

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/____

Witness:_____ Date: ___/____/_____

Weight Know More

1205 Royal Ave
Monroe, LA 71201
P: 318-388-3534 F: 318-388-3989

1953 E. 70th St, Suite 7
Shreveport, LA 71105
P: 318-798-0323 F: 318-798-9402

Patient HIPPA Consent Form

Your health and health care information is both personal and private. *Weight Know More* is dedicated to protecting your health care information. This HIPPA Consent Form provides information about how *Weight Know More* may use and disclose your Protected Health Information. (PHI)

As part of your medical treatment, *Weight Know More* originates and maintains paper and/or electronic records which contain PHI such as: demographic information, personal and family histories, symptoms, examination, ; past, present and future plans for care and treatment; and information received from other health care providers. *Weight Know More* maintains Privacy Practices and Policies regarding the disclosure of PHI.

The Patient understands that:

- Protected Health Information may be disclosed or used for treatment, billing and payment.
- The patient has the right and the opportunity to review *Weight Know Mores'* Health's Privacy Practices and Policies;
- *Weight Know More* reserves the right to change its Privacy Practices and Policies at any time;
- The Patient has the right to request in writing, restricted disclosure of their PHI, however, *Weight Know More* is not bound by the restrictions unless an agreement regarding the requested restrictions has been reached;
- The Patient understands that they will be responsible for copying and mailing charges associated with sending their medical records;
- The Patient may revoke their consent, in writing, at any time regarding all future disclosures.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, or health care operations. You have the right to revoke this consent in writing, signed by you and delivered to our office. Revocation will apply to any future disclosures but not to any disclosure already made in reliance on your prior consent or as required by law. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). *Weight Know More* reserves the right to change its Privacy Practices and Policies at any time. A revised copy of the Privacy Practices and Policies may be requested by contacting the office.

Patient Name: _____

Patient Signature: _____

Weight... know more
MEDICAL WEIGHT LOSS CLINIC

CONSENT FOR WEIGHT KNOW MORE MEDICAL WEIGHT LOSS CLINIC

AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

State law requires us to obtain your consent before receiving any medications being used on this program. What you are being asked to sign is confirmation that we have discussed the nature and purpose of the medications and the program and have also answered all of your questions in satisfactory manner.

Please read the form carefully. If you do not understand something, please ask.

1. I _____hereby authorize and direct Weight Know More to the following medical weight loss program.

2. In general terms, the nature and purpose of the medication provided to you on this program (with the doctor's discretion) and indicated in the management of obesity in a regimen of weight reduction based primarily upon caloric restriction and physical exercise.

3. Some risks know to be associated with the medications used are:
   ADVERSE REACTIONS: Headaches, dry mouth, difficulty sleeping, diarrhea, blurred vision, constipation, dizziness or lightheadedness, irritability, nausea, increased heart rate, stomach cramps, unpleasant taste, increased urination.
   BAD, RARE SIDE EFFECTS: Erratic heart rhythm, elevated blood pressure, primary pulmonary hypertension.

   I hereby state that I have read and understand this consent. All questions about the procedure or procedures have been answered in a satisfactory manner. This consent is valid until revoked by me in writing.

CONSENT FORM

Date: _____

TIME: _____**AM/PM**

Signature of patient: _____

Doctor's use only

I certify that al blanks in this form were filled in prior to my signature and I explained them to the patient.

SIGNATURE OF DOCTOR: _____

WEIGHT...KNOW MORE
MEDICAL WEIGHT LOSS CLINIC
SHREVEPORT, LA 318.798.0323
MONROE, LA 318.388.3534

STATEMENT OF INFORMED CONSENT FOR USE OF SEMAGLUTIDE

1. I have sought the medical services of Weight Know More Medical Weight Loss Clinic due to my excess weight or obesity. I have discussed the limited success I have had in losing weight by diet and exercise alone. I understand I will be prescribed medications. These medications may include semaglutide.

2. I understand I will need to change my diet, exercise frequency and behaviors to aid in my long-term weight reduction efforts. I understand that the management of my weight will require a lifelong effort, no matter what method of weight reduction I choose. I understand that no drug can provide a quick fix for the problem of weight reduction and management.

3. Prior to my treatment, I have fully disclosed any medical conditions or diseases such as pregnancy, trying to get pregnant, breastfeeding, history of gallbladder disease, diabetes, autoimmune diseases, HIV, heart disease, liver disease, kidney disease, uncontrolled high blood pressure, seizure disorders, blood disorders, anemia, thalassemia, hemophilia, etc), emphysema or asthma, any history of stroke or cancer, multiple endocrine neoplasia Type II, or medullary thyroid carcinoma. These contraindications have been fully discussed with me. If I fail to disclose any medical condition that I have, I release the physician and facility from any liability associated with this treatment.

4. I understand that one who is overweight or obese has a heightened risk of suffering from high blood pressure, heart disease, diabetes, heart attack, stroke and arthritis (particularly involving the hips, knees and feet) Depression is more common in obese persons than in others. I understand that the risks of incurring these conditions tend to increase as one's obesity increases.

5. I understand that semaglutide is 94% similar to natural human glucagon-like peptide 1 (GLP-1) and therefore acts as a physiological regulator of appetite and thereby reducing food intake by reducing feelings of hunger and increasing feelings of fullness/satiety. For long term success the treatment needs to be combined with lifestyle changes including nutritional, exercise and behavioral habits.

6. I understand that my use of semaglutide may expose me to the risks of various conditions, including but not necessarily limited to low blood sugar (glucose ≤70 mg/dL), fast heart rate, sweating, shakiness, intense hunger, or confusion, nervousness, overstimulation, restlessness, dizziness, insomnia (inability to sleep), euphoria (sense of well-being), dysphoria (sense of unhappiness or depression), tremor, headache, dry mouth, diarrhea, constipation, other gastrointestinal disturbance, medication allergies, impotence, or changes in libido (sex drive). I further understand that my use of semaglutide may expose me to the less probable but more serious risk of potential pancreatitis, cholelithiasis and cholecystitis (gallstone and gallbladder disease), thyroid disease, heart rate, and dehydration. I am encouraged to ask questions concerns may arise. I should promptly bring any questions I have to the attention of a qualified provider.

→

7. I understand that if I begin to experience any unusual or unexpected symptoms at any time after I begin using semaglutide, I should immediately contact my doctor. Unusual symptoms may include, but are not limited to, shortness of breath, edema (swelling of hands, legs or feet, heart palpitations or tachycardia (rapid heartbeat), nervousness, restlessness, insomnia, tremor, rapid breathing or respiration, or inability to tolerate exercise or activity. I understand that I may seek help from another qualified physician or go to a hospital emergency room.

8. I understand that I should use semaglutide in the manner prescribed by the doctor and not provide this medication to any other person. I understand that I should not increase my dosage of semaglutide or use it with any other drug or substance without the recommendation of my doctor. Serious injury or death can result from improper use of medications and/or the illegal transfer of medications to another individual. I understand that I may decline to begin treatment using semaglutide. I also understand that I may stop using semaglutide at any time in the future but should notify my doctor before doing so.

9. I recognize that it is safer to diet alone. I am requesting medication to help control my appetite. I assume responsibility for taking my diet medication and waive Weight Know More Medical Weight Loss Clinic of any liability. My health has been good, and I will advise Weight Know More Medical Weight Loss Clinic should my health change.

10. I understand that I may stop this program at any time. While adverse side effects or complications are not expected, in the event an illness does occur, I understand that I need to contact Weight Know More Medical Weight Loss Clinic, inc. immediately. If I experience an emergency, I understand that I need to go to the emergency room. I understand the risks set forth above to my satisfaction. I have had an opportunity to ask questions I have concerning these and any other potential risks. I am encouraged to ask questions as concerns may arise. I should promptly bring any questions I have to the attention of a qualified physician.

I have read and understand this consent form. I have had the opportunity to ask questions concerning this consent form and the medications to be prescribed for me. Any questions I have asked have been answered to my satisfaction. I understand that I should not sign this consent form unless I understand its contents, as well as the risks and benefits associated with the treatment proposed by Weight Know More Medical Weight Loss Clinic. I agree to release the physician and facility from any liability associated with semaglutide treatment. In the event a dispute arises over the outcome of this treatment, I consent solely to arbitration as a legal means of settlement.

Patient Signature:_____ Date:_____

WEIGHT...KNOW MORE
MEDICAL WEIGHT LOSS CLINIC
SHREVEPORT, LA 318.798.0323
MONROE, LA 318.388.3534

STATEMENT OF INFORMED CONSENT FOR USE OF TIRZEPATIDE

1. I have sought the medical services of Weight Know More Medical Weight Loss Clinic due to my excess weight or obesity. I have discussed the limited success I have had in losing weight by diet and exercise alone. I understand I will be prescribed medications. These medications may include tirzepatide.

2. I understand I will need to change my diet, exercise frequency and behaviors to aid in my long-term weight reduction efforts. I understand that the management of my weight will require a lifelong effort, no matter what method of weight reduction I choose. I understand that no drug can provide a quick fix for the problem of weight reduction and management.

3. Prior to my treatment, I have fully disclosed any medical conditions or diseases such as pregnancy, trying to get pregnant, breastfeeding, history of gallbladder disease, diabetes, autoimmune diseases, HIV, heart disease, liver disease, kidney disease, uncontrolled high blood pressure, seizure disorders, blood disorders, anemia, thalassemia, hemophilia, etc), emphysema or asthma, any history of stroke or cancer, multiple endocrine neoplasia Type II, or medullary thyroid carcinoma. These contraindications have been fully discussed with me. If I fail to disclose any medical condition that I have, I release the physician and facility from any liability associated with this treatment.

4. I understand that one who is overweight or obese has a heightened risk of suffering from high blood pressure, heart disease, diabetes, heart attack, stroke and arthritis (particularly involving the hips, knees and feet) Depression is more common in obese persons than in others. I understand that the risks of incurring these conditions tend to increase as one's obesity increases.

5. I understand that tirzepatide is 94% similar to natural human glucagon-like peptide 1 (GLP-1) and therefore acts as a physiological regulator of appetite and thereby reducing food intake by reducing feelings of hunger and increasing feelings of fullness/satiety. For long term success the treatment needs to be combined with lifestyle changes including nutritional, exercise and behavioral habits.

6. I understand that my use of tirzepatide may expose me to the risks of various conditions, including but not necessarily limited to low blood sugar (glucose ≤70 mg/dL), fast heart rate, sweating, shakiness, intense hunger, or confusion, nervousness, overstimulation, restlessness, dizziness, insomnia (inability to sleep), euphoria (sense of well-being), dysphoria (sense of unhappiness or depression), tremor, headache, dry mouth, diarrhea, constipation, other gastrointestinal disturbance, medication allergies, impotence, or changes in libido (sex drive). I further understand that my use of tirzepatide may expose me to the less probable but more serious risk of potential intestinal blockage, pancreatitis, cholelithiasis and cholecystitis (gallstone and gallbladder disease), thyroid disease, heart rate, and dehydration. I am encouraged to ask questions concerns may arise. I should promptly bring any questions I have to the attention of a qualified provider.

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7. I understand that if I begin to experience any unusual or unexpected symptoms at any time after I begin using tirzepatide, I should immediately contact my doctor. Unusual symptoms may include, but are not limited to, shortness of breath, edema (swelling of hands, legs or feet, heart palpitations or tachycardia (rapid heartbeat), nervousness, restlessness, insomnia, tremor, rapid breathing or respiration, or inability to tolerate exercise or activity. I understand that I may seek help from another qualified physician or go to a hospital emergency room.

8. I understand that I should use tirzepatide in the manner prescribed by the doctor and not provide this medication to any other person. I understand that I should not increase my dosage of tirzepatide or use it with any other drug or substance without the recommendation of my doctor. Serious injury or death can result from improper use of medications and/or the illegal transfer of medications to another individual. I understand that I may decline to begin treatment using tirzepatide. I also understand that I may stop using tirzepatide at any time in the future but should notify my doctor before doing so.

9. I recognize that it is safer to diet alone. I am requesting medication to help control my appetite. I assume responsibility for taking my diet medication and waive Weight Know More Medical Weight Loss Clinic of any liability. My health has been good, and I will advise Weight Know More Medical Weight Loss Clinic should my health change.

10. I understand that I may stop this program at any time. While adverse side effects or complications are not expected, in the event an illness does occur, I understand that I need to contact Weight Know More Medical Weight Loss Clinic, inc. immediately. If I experience an emergency, I understand that I need to go to the emergency room. I understand the risks set forth above to my satisfaction. I have had an opportunity to ask questions I have concerning these and any other potential risks. I am encouraged to ask questions as concerns may arise. I should promptly bring any questions I have to the attention of a qualified physician.

I have read and understand this consent form. I have had the opportunity to ask questions concerning this consent form and the medications to be prescribed for me. Any questions I have asked have been answered to my satisfaction. I understand that I should not sign this consent form unless I understand its contents, as well as the risks and benefits associated with the treatment proposed by Weight Know More Medical Weight Loss Clinic. I agree to release the physician and facility from any liability associated with tirzepatide treatment. In the event a dispute arises over the outcome of this treatment, I consent solely to arbitration as a legal means of settlement.

Patient Signature:_____ Date:_____