Healthy Size Weight Loss Clinic Jennings Phone: (337)824-5200 Lake Charles Phone: (337)429-5060
Fax: (337)824-5292 Fax: (337)429-5316

Please return this first page to receptionist desk upon completion.
***Our program treats patients between the ages of 18 - 70 depending on Doctor's approval.**

MEDICAL HISTORY QUESTIONNAIRE

The information requested in this questionnaire is very important. To give you the best care we must have complete answers. Please be thorough. (Please Print)

_____ _____ _____ ____/____/____ _____ ____'____"
Last Name **First Name** **M.I.** **D.O.B.** **Age** **Height**

Email:_____ **Contact Phone Number** (_____)_____-_____
Providing email gives permission for us to send email messages
Mailing Address: _____ City _____ State _____ Zip _____
Physical Address (if different):_____ City _____ State _____ Zip _____
Employer: _____**Occupation:** _____

List All Medications Prescribed to you: (include over the counter, supplements and vitamins)
(We participate in the LA Board of Pharmacy Prescription Monitoring Program)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Yes □ No □ **Allergies to any medication, food or environmental?**
If Yes, List: _____

Do you have, or have you had any of the following illnesses or symptoms?

Yes □ No □ **Heart Attack** (M.I. myocardial infarction)
Yes □ No □ **Angina** (chest pain)
Yes □ No □ **Echocardiogram** (heart ultrasound) Date: _____
Yes □ No □ **High Blood Pressure**
Yes □ No □ **High Cholesterol**
Yes □ No □ **Stroke** –If Yes, Type: _____
Yes □ No □ **Gallbladder Disease**
Yes □ No □ **Glaucoma**-If Yes, Type: _____
Yes □ No □ **Palpitations**
Yes □ No □ **Open Heart Surgery** (CABG)
Yes □ No □ **Abnormal EKG**
Yes □ No □ **Heartburn/ Hiatus Hernia**
Yes □ No □ **Thyroid Disease**
Yes □ No □ **Diabetes**
Yes □ No □ **Gallbladder Removed**
Yes □ No □ **Alcohol or Drug** Addiction
Yes □ No □ Tested positive for **Hepatitis or HIV** (information requested for administering injections)
Yes □ No □ **Cancer** If Yes, Type: _____ Treatment: _____Remission: _____
Yes □ No □ **Anxiety, Depression, Psychiatric Illness** (If yes, please circle)
Yes □ No □ **Seizure Disorder** (History of Seizures)
Yes □ No □ **Sleep Disorder** If Yes, Type: _____
Yes □ No □ **Eating Disorder** If Yes, Type: _____
If female, Are you pregnant, nursing, or trying to get pregnant at this time? Yes □ No □

Please list below all serious illnesses and hospitalizations you have experienced in adulthood.
Major Illness / Date / Treatment (if any)
_____
_____
List Major Surgeries (if any)
_____Year_____ _____Year_____
_____Year_____ _____Year_____
Any weight loss operations? Yes □ No □ If yes, type _____
Date of Surgery: _____ Name of Surgeon: _____ #'s Lost _____
Please sign below – The above information is true to the best of my knowledge.

****Patient Signature: _____ Date: _____ Last 4 digits of SSN: _____**

Physician Signature: _____ Date: _____

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Please indicate if there is a **Family History** of:

□ Obesity □ Diabetes □ Kidney disease □ High blood pressure □ High blood cholesterol
□ Heart disease □ Breast cancer □ Bleeding tendency or blood disorder
□ Colon cancer □ Lung disease, asthma or emphysema

Additional Information:

Please list all the physicians whose care you are under.

	Physician Name	Physician Location (city/state)
Primary Care	_____	_____
Gynecologist	_____	_____
Orthopedist	_____	_____
Other	_____	_____

SOCIAL HISTORY

Marital Status: Single: ___ Married: ____ Divorced: ____ Widow: ____
Number of Pregnancies: _____ Number of Children: _____ Ages of Children: _____
Smoking History: Never □ Current □ Packs per day? _____ How many years? _____ □ Former Smoker □ Years Quit_____
Do you drink alcohol? Yes □ No □ Frequency of alcoholic beverages: Socially □ Moderately □ Heavy □

WEIGHT HISTORY (Please estimate as closely as possible for all that applies to you.)

Life Event	**Age**	**Weight**
High School Graduation	_____	_____
Lowest Weight in Past 5 Years	_____	_____
Highest Weight in Past 5 Years	_____	_____

Weight Loss Medications and/or Programs:

Have you tried to lose weight in the past? Yes □ No □
Have you ever taken prescription weight loss medication in the past? Yes □ No □

If yes, Medication Name	Dates Taken	Prescribing Physician
_____	_____	_____
_____	_____	_____

If yes, did you lose weight on the medication? Yes □ No □ Pounds Lost? _____
If yes, any problems taking medication? _____

Please circle all weight loss methods that apply:

Jenny Craig Weight Watchers Nutri-Systems Acupuncture
Opti/Medi Fast Overeaters Anonymous Nutritionist
List any other diets and/or weight loss attempts:
_____ _____ _____

Please list exercise level below: □ None □ Light □ Moderate □ Strenuous
Exercise limitation: Yes □ No □ If Yes, explain: _____
Type of exercise: How many times a week: How long at one time: (e.g. 30 min, 1 hr…)
_____ _____ _____
Are you currently a member of an exercise facility? Yes □ No □
Please list any other information you feel is important for your physician:

How did you hear about our weight loss program? _____

****Patient Signature: _____ Date: _____ Last 4 digits of SSN: _____**

Physician Signature: _____ Date: _____

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Patient Consent for Treatment:

The following information concerns the purpose of our weight loss program and the risks associated with the medications used for treatment. Please read this information carefully. Ask any questions you may have prior to signing the consent for the treatment. Additionally, we recommend that you consult your primary care physician regarding this weight loss program and its effect on medications you may already be taking.

The purpose of our program is weight management through the use of dietary counseling paired with appetite suppressant medications. The medications are meant to aid in compliance with the reduction in caloric intake necessary for optimal weight loss. These medications are controlled, prescription medications; they are not without risk and may be habit forming. Because of these reasons, patients who are unable to lose an average of one pound per month after three months of medical therapy will be taken off the medication until the benefit of medication can be re-evaluated.

The primary appetite medications used for this program are phentermine (Adipex-P 37.5 mg, Ionamin 30mg., and generic), phentermine HCI (Lomaira 8mg), diethylpropion (Tenuate 25mg and 75 mg), benzphetamine (Didrex 50mg.), phendimetrazine (Bontril 35 mg and 105mg), *Belviq (lorcaserin HCI) & Belviq XR, Contrave (naltrexone HCI/bupropion HCI) 8mg/90mg and Saxenda liragludide (rDNA origin) injection pen. These medications have the same basic side effect profile including, but not limited to potential for the following: Dry mouth, nervousness, insomnia, headache, irritability, impotence or decreased libido, increased heart rate/heart palpitations, transient hair loss, dizziness, fatigue, nausea, constipation, increased blood pressure and dehydration which could cause kidney problems. *Other side effects specific to Saxenda: possible thyroid tumors (including cancer), pancreatitis, gallbladder problems, and low blood sugar (hypoglycemia). *Other medications may be prescribed at Doctor's discretion.
**Detailed information for prescribed medication regarding possible side effects/adverse reactions may be provided upon request and/or provided by pharmacy filling prescription.
These medications are not recommended for individuals with uncontrolled hypertension, hyperthyroidism, glaucoma, cardiovascular diseases, or advanced arteriosclerosis.

Medication is prescribed strictly at the discretion of our physician. Our physician restricts the use of appetite suppressants for patients under 18 or over 70. Involvement in the program should not be construed as a guarantee of receiving medical therapy. Further, medications of a less restricted nature (i.e. phentermine and diethylpropion) will be used preferentially over more restricted medications (i.e. Didrex and phendimetrazine). Use of Didrex and phendimetrazine are restricted by state law to 12 weeks of therapy in a 12-month period.

I, _____, hereby acknowledge that I have read and understand the above information. I have been informed of the nature of this weight loss program and the potential side effects of the medications that may be prescribed to me. This consent shall remain in effect until revoked by me in writing.

Patient Consent for Injections:

Injections are offered as an option to our patients. They are pharmaceutical grade injections and have not been evaluated by the Food and Drug Administration. They will be given at the discretion of the physician and/or nurse. They include, but not limited to B12, Lipotropics, essential amino acids & supplemental injections.

The substances included in the injections occur naturally in the human body and diet. We have found these supplements to be helpful with energy and fat metabolism, but we make no guarantee of weight or fat loss with the injections. Further, we do not claim that they treat, prevent or cure any disease. We expect no adverse reactions. However, future research of injections could discover adverse side effects that are unknown at this time. Please discuss any concerns you may have about the injections with the nurse or physician.

The injections are generally not to be given if you have had heart attack (MI) or a hemorrhagic (bleeding) stroke, or if you are pregnant or nursing. <u>Please inform a Healthy Size staff member if you have had either of these conditions.</u>
The injections are given intramuscularly. Bruising is a normal potential side effect of intramuscular injections; it needs to be brought to the attention of the physician or nurse only if it occurs repeatedly. Swelling, infection, severe pain, and/or numbness and tingling are other potential side effects. These side effects should be brought to the attention of the physician or nurse immediately, should they occur.

I_____, hereby acknowledge that I have read and understand the above information and the potential side effects of these injections. This consent shall remain in effect until revoked by me in writing.

****Patient Signature: _____ Date: _____ Last 4 digits of SSN: _____**

Witness Signature: _____ Date: _____

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Healthy Size Clinic, LLC

1307 N. Cutting Ave.
Jennings, LA 70546
(337) 824-5200

4080 Nelson Rd. Ste. 200
Lake Charles, LA 70605
(337) 429-5060

Privacy Consent

I understand that as a condition to my receiving treatment at Healthy Size Clinic, Healthy Size Clinic may use or disclose my protected health information for purposes of 1) providing treatment and reporting progress periodically to primary and/or referring physician 2) obtaining payment for treatment, and 3) as necessary for the operations of Healthy Size Clinic. These uses and disclosures are explained more fully in the Notice of Privacy Practices, which has been provided to me and which I have had the opportunity to review.

I understand that the privacy practices described in the Notice of Privacy Practices may be revised in the future, and that I have a right to request from Healthy Size Clinic a copy of any revised Notice.

I understand that I have the right to request restrictions on certain uses and disclosures of my health information. I understand that requests for restrictions must be made in writing and addressed to the Privacy Officer at Healthy Size Weight Loss Clinic, located at 1307 N. Cutting Ave. Jennings, LA 70546, or 4080 Nelson Road Ste. 200 Lake Charles, LA 70605.

****Patient Signature: _____ Date: _____**

Notice of Doctor's Policy

Healthy Size Weight Loss Clinic is medically supervised by the physician on staff. In order to remain on appetite suppressants, I understand that I am required to see Healthy Size physician as needed for refills.

I, also, understand that the level or degree of treatment or services offered by Healthy Size Clinic, LLC may be limited, restricted, or denied pending approval by Healthy Size physician. Factors considered for determining approval for Healthy Size program would be my medical history, including but not limited to, current medical conditions or illness, or prescribed medications.

****Patient Signature: _____ Date: _____ Last 4 digits of SSN: _____**

Witness Signature: _____ Date: _____

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THE "WHY" BEHIND YOUR WEIGHT LOSS GOALS

2 Locations to Better Serve You

Lake Charles Office
4080 Nelson Road Ste. 200
Lake Charles, LA 70605
(337) 429-5060

Jennings Office
1307 N. Cutting Avenue
Jennings, LA 70546
(337) 824-5200

QUALIFYING AFFIRMATIONS:

I want to lose weight and start the Ideal Protein or Right Path Plan to improve *myself!* _____ dieters initials

I'm committed to making a complete and lasting lifestyle change. _____ dieters initials

I'm done with my weight controlling me and I am determined to learn how to control it instead. _____ dieters initials

I'm prepared to change what I put in my shopping cart and pantry. _____ dieters initials

I'm eager to learn about and apply good food combinations to my daily diet. _____ dieters initials

I agree to keep a detailed food journal, when necessary to achieve my goal. _____ dieters initials

I'm ready to comply with giving up or limiting all alcohol, including beer, wine, and spirits. _____ dieters initials

QUESTIONS TO HELP DETERMINE YOUR "WHY":

areas of your life to consider are physical health, career, mental/emotional, health, spirtuality, and relationships

1. What are your top 3 reason for wanting to lose weight? _____

2. What are you hoping will transpire as a result of your weight loss? _____

3. How will your life be different when you reach your goal? _____

MY WHY STATEMENT: _____

Client Signature: _____ Date: _____

Counselor Signature: _____ Date: _____