Island Diet Center
Patient Information Form

Patient Name: (Last)_____(First)_____(MI)____

Name you prefer to be called: _____

Patient Address: _____

City:_____State:_____Zip:_____

Home Phone: _____Cellular:_____ Birth Date:_____Age:__

Email Address: _____

Sex: M F Country of Birth: _____Country of Parents' Birth: _____

Education: Elementary High School/Technical School 2-yr College 4-yr College Graduate School
(Circle the highest level achieved)

Employment Information:

Patient Employer:_____Occupation: _____

Employer Address: _____

City:_____State:_____Zip:_____

Work phone No:_____Ext. _____

In Case of Emergency:

Name:_____Relationship:_____Phone: _____

Patient's Spouse:_____Phone: _____

Family Physician:_____Phone: _____

Referred by: _____

Financial Policy:

Thank you for selecting Joseph F. Lang, MD for your health care needs. 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, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard, Discover, Cash and Checks.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

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

_____ _____

Patient's Signature Date

Island Diet Center
Weight Loss Program Consent Form

I _____ authorize Joseph F. Lang, MD and whomever they designate as their 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 medications have been used safely and successfully in private medical practices 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 over- weight, 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. 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 what so ever concerning the proposed treatment or other possible treatments, you may ask the physician.

Date:_____ **Patient Signature:** _____

(Or person with authority to consent for patient)

Island Diet Center
Patient Medical History Form

Name:_____ Age:_____ Sex: M F

Present 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 ☐ SEE LIST
Drug: Dosage:

_____
_____
_____

Over-the-Counter medications, vitamins, supplements: List all ☐ SEE LIST Yes No
Product Dosage

_____
_____
_____

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

5. History of High Blood Pressure? Yes No

6. History of Diabetes? At what age: _____ Yes No

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:
Pregnancies: Number:_____ Dates: _____
Natural Delivery or C-Section (specify): _____
Menstrual: 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: ☐ See List Yes No
Specify (list all) Date
_____
_____
_____

15. Any Surgery: ☐ See List Yes No
Specify: (List all) Date
_____
_____
_____

16. Family History:

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

Has any blood relative ever had any of the following:
Glaucoma: Yes No Who: _____
Asthma: Yes No Who: _____
Epilepsy: Yes No Who: _____
High Blood Pressure Yes No Who: _____
Kidney Disease: Yes No Who: _____
Diabetes: Yes No Who: _____
Psychiatric Disorder Yes No Who: _____
Heart Disease/Stroke Yes No Who: _____

Past Medical History: (check all that apply)

_____Polio	_____Measles	_____Tonsillitis
_____Jaundice	_____Mumps	_____Pleurisy
_____Kidneys	_____Scarlet Fever	_____Liver Disease
_____Lung Disease	_____Whooping Cough	_____Chicken Pox
_____Rheumatic Fever	_____Bleeding Disorder	_____Nervous Breakdown
_____Ulcers	_____Gout	_____Thyroid Disease
_____Anemia	_____Heart Valve Disorder	_____Heart Disease
_____Tuberculosis	_____Gallbladder Disorder	_____Psychiatric Illness
_____Drug Abuse	_____Eating Disorder	_____Alcohol Abuse
_____Pneumonia	_____Malaria	_____Typhoid Fever
_____Cholera	_____Cancer	_____Blood Transfusion
_____Arthritis	_____Osteoporosis	_____Other: _____

Nutrition on 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:

   _____
   _____
   _____
8. Is your spouse, fiancée or partner overweight? Yes No
9. By how much is he or she overweight? _____
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:

_____

_____

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. Typical Breakfast _____ Typical Lunch _____ Typical Dinner _____

Time eaten: _____ Time eaten: _____ Time eaten: _____
Where: _____ Where: _____ Where: _____
With whom: _____ With whom: _____ With whom: _____

31. Describe your usual energy level: _____

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.

Island Diet Center
Patient Informed Consent for Appetite Suppressants

I. Procedure and Alternatives:

1. I, _____ (patient or patient's guardian) authorize Joseph F. Lang, MD 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 heartbeat 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, YOU MAY ASK THE PHYSICIAN.

DATE: _____

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

VI. <u>PHYSICIAN DECLARATION</u>:

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

Island Diet Center
Weight-Loss Consumer Bill of Rights

WARNING: Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1½ pounds to 2 pounds per week or weight loss of more than 1 percent of body weight per week after the second week of participation in a weight-loss program. Consult your personal physician before starting any weight-loss program. Only permanent lifestyle changes, such as making healthful food choices and increasing physical activity, promote long-term weight loss. Qualifications of this provider are available upon request. You have a right to: ask questions about the potential health risks of this program and its nutritional content, psychological support, and educational components; receive an itemized statement of the actual or estimated price of the weight-loss program, including extra products, services, supplements, examinations, and labora- tory tests; know the actual or estimated duration of the program; know the name, address and quali- fications of the dietitian or nutritionist who has reviewed and approved the weight-loss program according to s.468-505(1)(j), Florida Statutes.

Required to be posted by section 501.0575 of Florida

Statutes I have read the above:

_____ _____

Patient Signature Date