

**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: \_\_\_\_\_

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 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 what so ever concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

**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?<br>Explain a "no" answer: | Yes | No |
| 2. Are you under a doctor's care at the present time?<br>If yes, for what?                             | Yes | No |
| 3. Are you taking any medications at the present time?                                                 | Yes | No |

Prescription Drugs: List all  SEE LIST

Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_

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

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- |                                                                                         |     |    |
|-----------------------------------------------------------------------------------------|-----|----|
| 4. Any allergies to any medications?<br>Please list:                                    | Yes | No |
| 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?<br>Migraines? Yes No Medications for Headaches: _____ | Yes | No |
| 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?
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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)

<input type="checkbox"/> Polio	<input type="checkbox"/> Measles	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Mumps	<input type="checkbox"/> Pleurisy
<input type="checkbox"/> Kidneys	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Nervous Breakdown
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Gout	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Valve Disorder	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Gallbladder Disorder	<input type="checkbox"/> Psychiatric Illness
<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Alcohol Abuse
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Malaria	<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Cholera	<input type="checkbox"/> Cancer	<input type="checkbox"/> Blood Transfusion
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> 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, ASK YOUR DOCTOR NOW BEFORE SIGNING THIS CONSENT FORM.

**DATE:** \_\_\_\_\_

**PATIENT SIGNATURE:** \_\_\_\_\_  
(or person with authority to consent for patient)

**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.

\_\_\_\_\_  
**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 laboratory tests; know the actual or estimated duration of the program; know the name, address and qualifications 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:

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Patient Signature

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Date