# Patient Health History Questionnaire

The information requested in this questionnaire is very important. To give you the best care, and to obtain your insurance approval, we must have complete answers. *Please be thorough*. Blue or black ink only, please.

Name: D.O.B Date:

Age: Gender: Male Female Occupation:

Address: City: State:

Home Phone: Cell Phone: Driver's License #/ State

Referral Source: Email Address:

## Weight History

What has been your heaviest weight? _____ Lbs

What is the least you have ever weighed as an adult? _____ lbs When? _____

In your own words, please describe what you hope to accomplish and how you believe your life will be changed by losing weight:

_____

_____

_____

## Dietary History

Approximate age when you first seriously dieted: _____

Actual Body Weight: _____

Height: _____

List the diets and diet programs you have tried:

| Program | Yes | No | Dates | Duration | M.D Supervised? | Max Loss |
|---|---|---|---|---|---|---|
| Jenny Craig | | | | | | 2 |
| Nutri-System | | | | | | 2 |
| Weight Watchers | | | | | | 2 |
| Optifast | | | | | | 3 |
| Medifast | | | | | | 4 |
| Fen/Phen | | | | | | 5 |
| Phentermine | | | | | | 6 |
| Meridia | | | | | | |
| Atkin's Diet | | | | | | 2 |
| O.A. | | | | | | 2 |
| Metabolife | | | | | | 2 |
| | | | | | | 3 |
| | | | | | | 4 |
| | | | | | | 5 |
| | | | | | | 6 |

| Name: | Date: |
|---|---|

List any physician-supervised and documented weight loss attempt:

_____

_____

List any other diets and/or weight loss methods you have tried:

_____

_____

## Dietary/ Eating Patterns:

How many meals do you eat per day? _____

How many meals do you eat **per week** outside of the home? _____

Do you tend to eat carbohydrates ( starches and sweets) more than other foods? _____

## Activity/ Exercise:

To what extent do you enjoy activity / exercise? ( circle one)

Not at all Slightly Moderately Greatly

Area/Methods Utilized: Health Club Home Outdoors Pool Walking Jogging Sports Aerobics /Endurance Training Resistance Training

Frequency per week: _____ Duration per day: _____

| Name: | Date: |
|---|---|

## Weight Related Illnesses

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

1) Hear disease? _____ Yes _____ No

If yes : year diagnosed _____
If yes : year diagnosed
Do you have ,or had:

_____ Angina
_____ CABG ( coronary artery bypass graft
_____ Stress test to rule out cardiac problems
_____ M.I. ( myocardial infarction)
_____ Abnormal EKG
_____ Palpitations

2) High Cholesterol? _____ Yes _____ No

If yes: Year diagnosed: _____

List Medications: _____

3) High Blood Pressure? _____ Yes _____ No

If yes : year diagnosed _____

List Medications: _____

4) Diabetes? _____ Yes _____ No

If yes : year diagnosed _____

Gestational? _____ Yes _____ No

Neuropathy? _____ Yes _____ No

List Medications: _____

5) Asthma? _____ Yes _____ No

If yes: Year diagnosed: _____

6) Shortness of Breath? _____ Yes _____ No

7) Trouble sleeping? _____ Yes _____ No

Snoring? _____ Yes _____ No

Observed Apneas? _____ Yes _____ No

Restless sleep? _____ Yes _____ No

| Name: | Date: |
|---|---|

8) Sleep Apnea? _____ Yes _____ No

If yes: Year diagnosed: _____

CPAP used? _____

9)Heartburn/ Esohagitis/ Hiatal hernia? _____ Yes _____ No

If yes: Year diagnosed: _____

List Medications: _____

10) Gallbladder Disease? _____ Yes _____ No

If yes: Year diagnosed: _____

11) Weight related injuries and trauma: _____

12) Venous Stasis Disease? _____ Yes _____ No

If yes:-Do you have edema? _____

Leg Ulcers? _____

13) Gout? _____ Yes _____ No

If yes: Year diagnosed: _____

List Medications: _____

14) Personal history of deep vein thrombosis (DVT) , blood clots or pulmonary embolus?

_____ Yes _____ No

Family History? _____ Yes _____ No

## Past medical History

*Please identify which of the following you have experienced:*

| | | |
|---|---|---|
| ___ Stroke | ___ Obesity | ___ Infertility |
| ___ Rheumatic Fever | ___ Heart Murmur | ___ Blood transfusion |
| ___ Fatigue | ___ Hepatitis | ___ Thyroid Problems |
| ___ Colitis | ___ Kidney disease | ___ Polycystic Ovarian syndrome |
| ___ AIDS/ HIV exposure | ___ Tonsillectomy | |
| | ___ Bleeding abnormality | |

## Female Patients

Number of pregnancies: _____ Number of live births: _____

Miscarriages/abortions? _____

Do you presently use birth control pills? _____

Estrogen? _____

***Please list below all serious illnesses, surgeries, and hospitalizations you have experienced in adulthood:***

| Incident: | Date: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Allergies:**

List any medication allergies: _____

Allergic to: Latex? _____ Yes _____ No

Surgical tape? _____ Yes _____ No

Iodine? _____ Yes _____ No

List other allergies: _____

Medications:

*Please list below all medications you currently use:*

| Medication | Dose and Frequency |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Do you use tobacco? ____ Yes ____ No Frequency _____

Do you use alcohol? ____ Yes ____ No Frequency _____

Have you been treated for narcotic dependency? ____ Yes ____ No

Do you currently utilize recreational drugs? ____ Yes ____ No

**Family History**

| Family Member | Living? | Age | If Deceased, age | Illness/ Cause of Death |
|---|---|---|---|---|
| Mother | | | | |
| Father | | | | |
| Maternal Grandmother | | | | |
| Maternal Grandfather | | | | |
| Paternal Grandmother | | | | |

| Family Member | Living? | Age | If Deceased, Age | Illness/Cause of Death |
|---|---|---|---|---|
| Paternal Grandfather | | | | |
| Sibling | | | | |
| Sibling | | | | |
| Sibling | | | | |

*Please indicate if there is a family history of:*

_____ Obesity
_____ Diabetes
_____ High Blood Pressure
_____ Heart Disease
_____ High Cholesterol
_____ Stroke
_____ Liver Disease
_____ Thyroid Disease
_____ Gallbladder Problems
_____ Polycystic Ovary Syndrome
_____ Lung Disease, Asthma or Emphysema
_____ Kidney Disease
_____ Breast Cancer
_____ Colon Cancer
_____ Bleeding Tendency or Blood Disorder (blood clot, DVT, or emboli)

## Personal Physicians

*Please list all of the physicians under whom you receive medical care:*

| | Name | Address | Phone Number | Fax Number |
|---|---|---|---|---|
| Primary Care Physician | | | | |
| Cardiologist | | | | |
| Pulmonologist | | | | |
| Other | | | | |

System Review

Please circle all symptoms you currently experience, or have experienced in the past. Feel free to add any additional problems or information.

1) Head, Eye, Ear, Nose & Throat : nasal discharge – hay fever—sinus trouble—earache—headache—blurry vision—double vision—haloes around lights—loss of night vision—ringing in ears—discharge from ear—loss of hearing—dizziness—vertigo—loss of balance—sore throat—lump in throat— trouble swallowing—pain with swallowing—hoarseness— None of the Above

2) Respiratory: cough—wheezing—shortness of breath—use of two pillows—coughing up blood—out of breath with exertion—wake up at night short of breath—wake up at night coughing or choking—asthma—emphysema—bronchitis—None of the Above

3) Cardiovascular: palpitations—pounding heart—skipping heartbeat—pains in chest—pains in neck—heart attack (history of MI) – heart murmur—abnormal electrocardiogram—high blood pressure—pain in legs while walking— cold

4) Gastrointestinal: heartburn—nausea—vomiting—choking on food—food sticking in chest—burning in stomach—diarrhea—constipation—pain with bowel movement—blood in stools—hemorrhoids—fissures—gassiness—irritable bowel syndrome—

5) Genitourinary: pain with urination—changes in urinary habits—small urine stream—blood in urine—kidney stones—bladder stones—kidney failure—nephritis—urinary tract infections—frequent urination—getting up at night to urinate—leakage of urine with cough or sneeze—None of the Above

6) Endocrine ( Glandular) : low thyroid—hyperthyroid—goiter—diabetes—adrenal glad tumor—frequent flushing—frequent heavy sweating—None of the Above

7) Musculoskeletal: pain in joints—swelling of joints—arthritis—broken bones—sprains—low back pain—hip pain—knee pain—ankle pain—foot pain—flat feet—herniated disk—sciatica—limited joint motion—None of the Above

8) Neurological: numbness—tingling—weakness of any muscles—twitching of muscles—fainting—convulsions—None of the Above

9) Psychological: nervousness—anxiety—depression—thoughts of suicide—suicide attempts—hospitalization for emotional problems—psychiatric treatment—psychological counseling—memory loss—mood changes—None of the Above

10) Reproductive (Females) : premenstrual mood swings—inability to conceive—hormone replacement therapy—history of ovarian cysts—menopause—regular pap smears—abnormal pap smears—abnormal mammogram—None of the Above

How would you describe your general mood and emotions?

_____

_____

_____

Present or past eating disorders?

_____ Anorexia ( fear of weight gain leading to malnutrition and usually excessive weight loss)

_____ Bulimia ( overeating followed by vomiting, laxative/diuretic abuse and/or excessive exercise)

_____ Binge Eating Disorder ( consuming a large quantity of food in a

_____ Night Eating Disorder ( eating very late at night / waking up in the middle of the night to eat)

*If you have answered YES to any of the above:*

_____ Yes _____ No Have you been in treatment for the disorder?

_____ Yes _____ No Do you believe you still have problems with the disorder?

What type of medication or treatment plans have you completed related to eating disorders?

_____

_____

_____

The above information is true and correct to the best of my belief. I understand that the accuracy of this information is important and may affect medical outcomes.

_____

Patient Name ( Printed)

_____

Patient Signature

_____

Date

# Vitamin B12 / LipoTrim Injection Consent Form

This injection is formulated to decrease the fat deposits in the liver or speed up the removal of fat from the liver. It consists of three all natural amino acids. In combination, these amino acids support the health of the liver, aid in the metabolism of fat, and participate in action of serotonin ( a neurotransmitter known to control mood and appetite). Designed to support more fat burning and losing more inches.

- Helps expedite the breakdown of fat during body metabolism therefore increases metabolism
- Reduces body fat
- More effective if taken consistently rather than occasionally
- Promotes liver health
- Recommended that these injections are administered once per week
- These are essential for the maintenance of a healthy liver as well as burning the exported fat for additional energy
- Ingredients consist of Vitamin B12 and Lipotropic: Choline, Inositol and Methionine

## Side Effects

Common reactions to any injections include pain /stinging / burning at injection site during or shortly after receiving, bruising, soreness several days after administration. Seek medical attention right away if any of the following severe side effects occur: ( rash, hives, itching, difficulty breathing, and tightness in the mouth , face or throat, lips or tongue.) If it is after hours or your allergic reactions are severe, please go to the emergency room for evaluation and treatment.

## Please Read and Sign Below:

I have read the above information and fully understand about the above information about B12/ LipoTrim injections. Prior to injections being administered, I have had ample opportunity for any and all questions regarding B12/ LipoTrim injections to be satisfactorily answered. I further acknowledge that I am taking this injection on my own accord. I acknowledge, that I have carefully read the “side effects” and fully understand the instructions should an allergic reaction occur.

Patient Signature Date

# Weight Loss Consent Form

This low calorie / or low carbohydrate plan will be medically supervised. Some of our plans are designed to promote rapid weight loss. Therefore the benefits, adverse effects, and risks are explained below:

## Health Benefits:

Weight loss improves obesity-related conditions such as diabetes, high blood pressure, high cholesterol, sleep apnea, arthritis, depression, etc.

## Potential Adverse Effects and Risks:

- Fatigue / Weakness
- Constipation
- Nausea
- Diarrhea
- Lightheadedness / Dizziness
- headache
- Increased Risk of Pregnancy  Current form of Birth Control: _____
- Menstrual Irregularities
- Acne
- Muscle Cramps
- Arrhythmias
- Electrolyte imbalances ( potassium, sodium, magnesium, etc.)
- Gout
- Pancreatitis
- Gallstones

By signing below, you understand , agree and desire to precede with one of our prescribed diet plans.

_____ _____

Patient Signature  Date

# Prescription Medication Consent Form

Adipex / Phentermine: 30 mg (capsule) and 37.5 mg (tablet)

Indicated for patients greater than 17 years of age for short term use in conjunction with exercise and diet with the initial body mass index of > 30 kg/m2, or > 27 kg/ m2.Works by decreasing appetite, some adverse reactions include but are not limited to dry mouth, diarrhea, shortness of breath, chest pain, restlessness, constipation, dizziness, unpleasant taste, vomiting, heart palpitations, swollen ankles and legs, increased blood pressure, and abuse dependency. Avoid abrupt withdrawal.

Bontril / Phendimetrazine: 35 mg (tablet) and 105 ER (capsule)

Indicated for patients greater than 12 years of age for a short term use in conjunction with exercise and diet for patients with an initial body mass index of > 30 kg/m2, or > 27 kg/m2. This is an appetite suppressant that stimulates the central nervous system creating a chemical reaction reducing the desire to overeat. Some diverse reactions include but are not limited to diarrhea, restlessness, insomnia, dizziness, dry mouth, abdominal pain, constipation, urinary frequency, sweating, euphoria, tremors, headaches, and increased heart rate. Avoid abrupt withdrawal.

Tenuate / Diethylproprion: 75 mg ER (tablet)

Indicated for patients greater than 16 years of age for short term use in conjunction with exercise and diet, with initial body mass index of > 30 kg/m2, or > 27 kg/m2. This is an appetite suppressant that stimulates the central nervous system creating a chemical reaction reducing the desire to overeat. Some adverse reactions include but are not limited to diarrhea, restlessness, insomnia, dizziness, dry mouth, abdominal pain, constipation, urinary frequency, sweating, euphoria, tremors, headaches, and increased heart rate. Avoid abrupt withdrawal.

Certain precautions should be taken for patients who are pregnant or breastfeeding, allergic to any medications or taking OTC and cold or cough medications that nay counteract the use of an appetite suppressant. Caution in mild hypertension, diabetes mellitus, epilepsy, history of cardiovascular and pulmonary problems, and history of drug use. Notification should be given if you have any conditions or disorders that may pose a potential risk to your health while taking a medication prescribed. By signing below you agree to the consent and terms described in the above information.

Patient Name (print) : _____ Date: _____

Patient Signature: _____


# Appetite Suppressants and Drug Screens

Appetite suppressants such as Adipex, Bontril, Tenuate , or any compounds and their generic forms are Amphetamines, therefore are highly likely to show up on an employer drug screen.

We do encourage you to check with your employer before starting any appetite suppressants to avoid any complications or issues with your employer, especially if you work in a refinery or operate any type of heavy equipment.

By signing below you do acknowledge that you have read and understand that you may be prescribed a medication that could possibly show up as an Amphetamine on an employer drug screen . You also acknowledge that MedSolution Weight Loss or Dr. Duncan Bowell are not responsible for any complications that could result from a positive drug screen due to prescribing an Amphetamine for weight loss. You also acknowledge and understand that this weight loss program is an elective program and that you will be responsible for providing any proof or documentation to your employer in the event that you do test positive for an Amphetamine on your drug screen.

Name _____ Date _____

Print Name _____

# HIPAA Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) , I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers

Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you of your Notice of privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____ Date: _____

Signature: _____

Relationship to patient: _____