HEALTHY WEIGHT SOLUTIONS

3601 West Azeele Street
Tampa, FL 33609
Office (813) 350-9500 Fax (813) 350-9544

Patient Information

Patient Demographics

Name:_____ DOB: _____ Age:____ Sex:M○F○
Address: _____ Home Phone: _____
_____ Work Phone: _____
_____ Cell Phone: _____
City State Zip County
Email: _____
Social Security #: _____

Marital Status: _____ May we contact your spouse: Y○ N○
Spouse's Name: _____

Emergency Contacts: _____
Name Relationship Phone Alternate Phone

_____
Name Relationship Phone Alternate Phone

Weight History

Current Weight: _____ Max. Weight: _____ Lowest Adult Weight: _____
Height: _____ Date of Max. Wt: _____ Date of lowest Weight: _____
Weight at high school graduation: _____

Was there a time or event in your life that you associate with the beginning of your weight gain? (pregnancy, divorce, job change etc.) _____
_____
Over what time frame did you gain weight? (gradually/abruptly)
_____

At what weight have you felt your best or *think* you would feel your best? _____

How does your weight affect your daily activities? _____
_____

Why do you want to lose weight ?

How much weight would you like to lose? _____

Highest acceptable weight: _____ Desired lowest weight: _____

How do you think your life would change if you reach your weight goal?

What are the attitudes of the following people about your attempt(s) to lose weight?

	Negative	Indifferent	Positive
Spouse			
Children			
Parents			
Employer			
Friends			

Do these attitudes affect your weight loss or gain? _____
_____

Age when you first remember being overweight: _____
Age when you first began dieting: _____

A number of different ways of losing weight are listed below. Please indicate any methods you have used by filling the appropriate blanks.

Method	Ages	Number of times tried	Weight Lost	Comments
Weight Watchers				
TOPS (Take Off Pounds Sensibly)				
Other commercial weight-loss programs:				
Registered Dietitian				
Overeaters Anonymous				
Prescription diet pills				
Non-prescription diet pills				
Herbs; herbal supplements				
Liquid diets				
Cabbage Soup Diet				
Mayo Clinic Diet				
Cleveland Clinic Diet				
Scarsdale Diet				
Physician-supervised diet				
High protein, low carbohydrate (such as Adkins, Stillman, Sugar-Busters, Protein Power)				
High carbohydrate, low fat				
Starvation				
Body wraps or passive exercise table				
Behavior modification				
Psychotherapy				
Hypnosis				
Surgery: (liposuction, gastric bypass, wired jaws, etc.)				
Diet books:				
My own system: What?				
Other				

Were any of these diets supervised or recommended by a physician? _____

What is the reason you usually go off a diet? _____

_____

Exercise History

How physically active are you? (check one)

☐ **Very active** ☐ **Active** ☐ **Average** ☐ **Inactive** ☐ **Very Inactive**

What do you do for physical activity and how often do you do it?

Activity	Number of Times/Week	How Long
☐ Walking		
☐ Bicycling		
☐ Swimming		
☐ Water exercises		
☐ Golf - walking		
☐ Golf - cart		
☐ Tennis		
☐ Aerobics		
☐ Weight training		
☐ Other		

Is there anything that prevents you from being physically active?

What activities do you like to do for fun?

Have you ever been a member of a Gym? _____

Are you still regularly exercising at that Gym? _____

If not, why did you quit and what would have improved your attendance?

Are you committed to incorporating physical activity into a long-term weight management program? ☐ **Yes** ☐ **No**

Why?

Food History

What are your favorite foods?

List any food allergies: _____

How do you decide when to stop eating? _____

Do you eat or drink for reasons other than hunger or thirst? ☐ **Yes** ☐ **No**
Do you like to drink water? ☐ **Yes** ☐ **No**
Do you drink milk? ☐ **Yes** ☐ **No**
Which? ☐ **Whole** ☐ **2%** ☐ **1%** ☐ **Skim**
Do you drink juices, sweet tea, or regular sodas? ☐ **Yes** ☐ **No**
If yes, how much a day? _____
Do you eat sweets? ☐ **Yes** ☐ **No**
If yes, how often? _____
Do you know how to measure food & beverages accurately? ☐ **Yes** ☐ **No**
Do you understand how to read food labels? ☐ **Yes** ☐ **No**
Check the equipment you already have: ☐ ***Blender*** ☐ ***Food Processor*** ☐ ***Measuring cup***
How fast do you eat? ☐ ***Slow*** ☐ ***Medium*** ☐ ***Fast***

List your typical diet:

Breakfast:

Morning Snack:

Lunch:

Afternoon Snack:

Dinner:

Evening Snack:

Medical History

Please check the box if you have the following illness:

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ GERD or Heartburn
- ☐ Joint Disease or Arthritis
- ☐ Thyroid Disease
- ☐ Sleep Apnea
  - ☐ Are you using CPAP
- ☐ Back Pain
- ☐ Venous insufficiency or leg swelling
- ☐ Leakage of urine with cough or strain
- ☐ Depression or psychiatric disorder
- ☐ Liver disease
- ☐ History of stroke
- ☐ Asthma or breathing disorder
- ☐ Cancer
- ☐ Bleeding disorder

List all additional medical illness:

Prior surgical procedures:

☐ Appendectomy ☐ Gallbladder surgery ☐ Pelvic surgery or C-Section
☐ Hernia surgery ☐ Gastric or stomach surgery ☐ Heart surgery

Other

List allergies to any medications and include type of reaction and date of allergy:

☐ Surgical tape ☐ Latex ☐ Iodine

MEDICATIONS:

Medication	Dose & Frequency	Condition
Example: Pepcid	20mg twice a day	Heartburn

Are you taking birth control pills or hormone replacement therapy? _____
Are you taking any over-the-counter meds, herbal supplements, or vitamins? _____

Please enclose an additional sheet if necessary to list ALL medications

Social History

Do you use tobacco currently? _____ How many packs/day? _____
How many years have you smoked? _____ Have you tried to quit? _____

Did you smoke in the past? _____ How many packs/day? _____
How many years did you smoke? _____ When did you quit? _____

Do you drink beer, liquor, or wine? _____ How many glasses per week? _____

Do you use any recreational drugs? _____ Which one(s)? _____
Have you ever had an addiction to drugs? _____

Psychiatric History

Check all that apply

- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Eating disorder
  - ☐ Anorexia ☐ Bulemia ☐ Binge eating syndrome
  - ☐ Night Eating Syndrome
- ☐ Other:

Sleep History

- ☐ Excessive daytime sleepiness
- ☐ Fall asleep driving or reading
- ☐ Loud snoring
- ☐ Observed apneas (breath-holding) in sleep
- ☐ Sleep alone (no witness of sleep history)
- ☐ Poor cognitive function or memory
- ☐ Wake up from snoring
- ☐ Choke or gasp when sleeping
- ☐ Tired when wake-up in the morning
- ☐ Morning headache
- ☐ Large neck
  - ☐ *17.5" Men* ☐ *16" Women*
- ☐ Frequent urination at night
- ☐ Other

Cardiac History

Please mark all that apply:

- ☐ Been seen by a cardiologist
- ☐ Chest pain or angina
- ☐ History of heart attack
- ☐ History of heart surgery
- ☐ Abnormal heart beats
- ☐ Heart murmur or abnormal valve
- ☐ Abnormal stress test or EKG
- ☐ Short of breath after walking 2 blocks
- ☐ Unable to walk on treadmill for 20 min.
- ☐ Peripheral vascular disease
- ☐ History of stroke
- ☐ Diabetes or high blood pressure

Gynecological History

Ladies only please:

Do you have regular periods (26-33 days)?	☐ **Yes**	☐ **No**
Do you have excessively heavy periods?	☐ **Yes**	☐ **No**
Have you had problems with infertility?	☐ **Yes**	☐ **No**
Have you suffered from excess body hair or acne?	☐ **Yes**	☐ **No**
Has a doctor told you that you have polycystic ovaries?	☐ **Yes**	☐ **No**
Do you have a history of gestational diabetes?	☐ **Yes**	☐ **No**
Are you current on your Pap smear & mammogram screening?	☐ **Yes**	☐ **No**

Family History

Indicate if there is a family history of:

- ☐ Obesity
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart disease
- ☐ High Cholesterol
- ☐ Osteoporosis
- ☐ Lung disease, asthma, or emphysema
- ☐ Kidney disease
- ☐ Bleeding tendency or blood disorder
- ☐ Breast cancer
- ☐ Colon cancer
- ☐ Endocrine or metabolic disorders

Physicians

Please list all physicians that are currently or recently caring for you

Primary Care Physician

Gynecologist

Cardiologist

Pulmonologist

Psychiatrist / Psychologist

Orthopedic

Other

How did you hear about Health Weight Solutions?

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Patient Informed Consent for Appetite Suppressants & **Participation In A Weight Management Program**

I. Procedure and Alternatives:

1. I, _____(patient or patient's guardian) authorize Dr. George M Northrup and his associates or assistants to assist me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program and instruction in behavior modification techniques. Other treatment options may include a variety of other diet approaches depending on the needs of the individual patient. We may utilize a very low calorie diet, or a protein supplemented diet such as a Protein Sparing Modified Fast. In certain situations, the diet approach may involve a more intense weight loss program termed a Very Low Calorie Diet (VLCD). This last diet, if utilized, requires considerably more attention and will be discussed in detail prior to use. I understand that treatment options may involve the use of appetite suppressant medications and other supplements. My treatment may necessitate the use of appetite suppressants for more than 12 weeks and when indicated in higher dose than the dose indicated in the appetite supplement 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 a shorter term studies (up to 12 weeks) using the dosages indicated in the labeling."

   "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. On occasion, an appetite supplement may be used with another appetite suppressant drug and other supplements."

   "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 side effects (as noted below)."

"I believe the probability of such side effects is outweighed by the benefit 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 used 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 heart beat and heart irregularities. Much less common to rare, but more serious risks are primary pulmonary hypertension and valvular heart disease. Primary pulmonary hypertension (PPH) is manifested by increasing shortness of breath and a progressive decrease in exercise tolerance. These and other possible risks could, on occasion, be serious or fatal.

The possible side effects with the other medications are as follows:

1. Diuretics- weakness, dizziness, ringing in the ears, muscle spasm, rash, low blood pressure, dry mouth, constipation, and blurred vision.
2. Vitamins and Minerals-nausea, rash, constipation, diarrhea.
3. Potassium-"heartburn," nausea.
4. Thyroid- vomiting, increased heart rate, chest pain; sweating, nervousness and menstrual irregularity.

I understand that if I develop side effects from the diet or the medication, I will discontinue the diet and/or medication(s) and notify the medical staff of Dr. George M. Northrup as soon as possible. I also understand that if the problem is worrisome or severe, I will go to the nearest Emergency Room or see my primary medical doctor as soon as possible. (take your medications with you)

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 that I am.

I understand that thirty to forty percent of overweight or obese patients may have or develop gallstones. A large percent of this group will develop symptomatic gallbladder disease during their lifetime. I understand that certain types of weight reduction programs may increase the chance of developing symptomatic gallbladder disease.

The programs that are most likely to cause these symptoms are:

1. A program that involves extremely low calorie intake which is normally seen with total liquid protein diets.
2. A program that has extremely rapid weight loss as one of its features.

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 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 OTHER QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK YOUR DOCTOR NOW BEFORE SIGINING THIS CONSENT FORM.

DATE:_____ TIME:_____

PATIENT:_____ WITNESS:_____
(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

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Dear Dr. _____:

On _____ I first saw_____ in my office to begin a medically supervised weight reduction program. During the history that I obtained and the physical exam that I did, I learned that he/she is being treated by you .

It is not my desire to interfere with any treatment you are giving for the above situations. However, as you know, as a person's weight drops, the need for certain medications and dosage amounts can also change. Generally this results in a decrease in a given dose. This situation is very important to recognize and prompt action is often necessary. During the time that I see our patient in common, I may find that the dosage levels must be adjusted. If so, I will make recommendations to do so, and if necessary at the time, I will make those changes as required.

I have instructed your patient to KEEP YOU INFORMED as to any changes I may find necessary to make in this office. Your patient has also been instructed to continue regular visits, as you deem necessary, with you, during the time involved in the weight management program in this office.

Periodically, during weight reduction or weight maintenance programs, appropriate laboratory examinations will be done. When these results are significantly abnormal, your patient will be requested to see you as soon as possible and I will furnish a copy of the lab reports to you- or to the patient to hand carry to you. IF these reports are acutely abnormal, I will act on them as necessary and will also get copies to you. This same process will apply to other tests (such as an abnormal EKG) that may be done in my office.

Any information that you have might be helpful to me in caring for our patient in common will be greatly appreciated.

Sincerely,
George M. Northrup, MD

AUTHORIZATION FOR RELEASE OF INFORMATION:

I,_____, authorize the release of any and all information from my clinical record as it relates to my treatment with George M Northrup, MD for the purpose of continued clinical care to _____. This consent will expire automatically in 365 days. I understand that I may revoke this consent at any time.

Patient Signature/Date: _____

HEALTHY WEIGHT SOLUTIONS

PATIENT ACKNOWLEDGEMENT OF OFFICE POLICIES

_____ Remembering the date and time of my scheduled appointment is my responsibility. Reminder calls are a courtesy and do not negate my responsibility for my sessions. I agree to provide the office a minimum of 24 hours notice if I need to cancel/reschedule my appointment.

_____ I understand I will be billed $65.00 for any appointment I fail to keep or cancel without 24 hours notice. I understand that calling on Friday does not constitute as 24 hours notice if my appointment is for the following Monday. I give my permission to keep the following credit card information on file:

VISA/ MC_____, EXP. _____/_____, BILLING ZIP _____ _____ and I understand my card will be billed in the event of the aforementioned. I understand I will receive written notification from the office if my card is charged.

_____ I understand my portion of payment for services is due at the time services are rendered.

_____ I understand if my account is turned over to a collection agency for non-payment, I will be responsible for the collection agency fee as well.

My signature below and initials above indicate that I have read and understand and I agree to comply with all the above.

_____ _____

Signature of Responsible Party Date

MEDICATION LIST
George M. Northrup, M.D.

Patient Name: _____

CURRENT MEDICATION	DOSAGE	REASON FOR MEDICATION

IN	DATE	MEDICATION	MG	DOSE	#	RF

Print All Forms