NORTH TEXAS CLINICAL WEIGHT LOSS

3730 N. Josey Lane, Suite 101, Carrollton, Texas 75007 ~ 214-731-THIN (8446)

We may utilize the appetite suppressant medication, Phentermine, together with nutritional counseling and diet recommendations, as part of our medically supervised weight loss program and because of possible complications related thereto,

YOU CANNOT TAKE THE PHENTERMINE IF ANY OF THE FOLLOWING APPLIES:

You currently have any of the following conditions:

Uncontrolled high blood pressure
Hyperthyroidism
Heart disease (including irregular beats)
Pregnancy (or are presently breastfeeding)
Seizure disorder
Glaucoma

You plan to have major surgery within the next two weeks.

You have a BMI (body mass index) of less than 27.

You are less than 16 years old. Persons between the ages of 16-18 years of age must have a BMI of no less than 30.

You are currently taking any of these medications:

Nardil
Pamate
Marplane
Coumadin
Certain cardiac drugs – ask if unsure
MAOI's within the past two weeks
Glaucoma medications (for increased pressure in your eyes)
Adderall, Concerta, or any other stimulant for Attention Deficit Disorder (ADD/ADHD) or for any other condition.

You have any other prohibitive condition as determined by the medical provider.

By signing below, I affirm that I have read and understood the above information, that I am <u>not</u> taking any of the medications listed, <u>nor</u> do I have any of the disqualifying conditions stated above.

Patient signature _____

Staff initials _____

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WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE

By signing below, you acknowledge that you have received the HIPAA Notice of Privacy Practice from North Texas Clinical Weight Loss Center, regarding the manners in which North Texas Clinical Weight Loss Center may or may not use to protect your health information for treatment, payment, and health care operation purposes. “Protected Health Information” means any information, whether oral or recorded, in any medium or form by the health care provider that relates to the past, present or future mental health or physical condition of an individual.

North Texas Clinical Weight Loss Center reserves the right to have absolute authority on any modification or amendment to this Notice from time to time. Any alterations will be made clear and posted at the patient service location. In addition, a date will be made clear when upcoming changes will come into effect and an up to date copy of any current Notice will be available upon request.

YOUR SIGNATURE BELOW ACKNOWLEDGES THAT YOU HAVE RECEIVED NOTICE

PRINTED NAME OF PATIENT _____

PATIENT SIGNATURE _____ DATE _____

INITIALS OF PARENT OR GUARDIAN, IF PATIENT IS UNDER 18 YEARS OF AGE _____

STAFF INITIAL _____

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Patient Medical History

Please fill this form out as accurately as possible as this information will assist us in assessing your particular problem areas and establishing your medical weight loss and management needs. Thank you for your time and patience in completing this form.

First Name _____ Last Name _____ Date of Birth _____ Sex: M / F

Address _____ City _____ State _____ Zip _____

Phones: Home _____ Work _____ Mobile _____

Email: _____ Occupation: _____

Marital Status: Married / Divorced / Separated / Single (never married) / Widowed

Number & Ages of Children (if any): _____

YOUR HEALTH HISTORY

To the best of your knowledge are you in good health? Yes / No

Are you under a Doctor's care at the present time? Yes / No
If yes, for what are you being treated? _____

Doctor's Name and Phone Number _____
IF YOU DON'T HAVE A FAMILY DOCTOR, WE RECOMMEND YOU ESTABLISH A RELATIONSHIP WITH ONE.

Previous diets you have followed? _____

Do you have any allergies to any medications? Yes / No
If Yes, to which medications? _____

Do you have any food allergies? Yes / No
If yes, to which foods? _____

Do you suffer from Frequent Headaches? Yes / No
(If you take medication for headaches, what do you take?) _____

Have you ever taken Phentermine? Yes / No If yes, when & for how long? _____

Are you taking any prescription and/or over the counter medications, at the present time? Yes / No
If yes, please specify:

Name of Medication	Taken for

Medical History Form, cont.

Please check all that apply:

_____ High Blood Pressure	_____ Typhoid Fever
_____ Diabetes (What Age?_____)	_____ Rheumatic Fever
_____ Cancer	_____ Gallbladder Disorder
_____ Kidney Disease	_____ Cholera
_____ Thyroid Dysfunction	_____ Arthritis
_____ Heart Disease/Stroke	_____ Measles
_____ Chest Pain	_____ Mumps
_____ HIV / AIDS	_____ Scarlet Fever
_____ Hepatitis (type _____)	_____ Whooping Cough
_____ Tuberculosis	_____ Bleeding Disorder
_____ High Cholesterol	_____ Gout
_____ Swelling of the Feet or Hands	_____ Malaria
_____ Asthma	_____ Osteoporosis
_____ Pneumonia	_____ Tonsillitis
_____ Migraines / Headaches	_____ Pleurisy
_____ Epilepsy	_____ Liver Disease
_____ Constipation	_____ Chicken Pox
_____ Glaucoma	_____ Infertility
_____ Polio	_____ Eating Disorder
_____ Jaundice	_____ Psychiatric Illness/Disorders
_____ Lung Disease	_____ ADD/ADHD
_____ Ulcers	_____ Nervous Breakdown
_____ Anemia	_____ Alcohol Abuse
_____ Menopause	_____ Drug abuse

Other Serious Illness/Disease (Please explain) _____

_____

History of Past Surgeries/Hospitalizations:

Specify: _____ Date: _____

Specify: _____ Date: _____

Specify: _____ Date: _____

_____

Daily Activity Level

Select one only:

_____ **INACTIVE**. No regular exercise and a sit-down job.

_____ **LIGHT TO MODERATE**. Occasionally involved in activities such as weekend golf, tennis, swimming or cycling.

_____ **HEAVY/VIGOROUS**. Participation in extensive physical exercise for at least 60 minutes.

Rate your energy level: ____ (1=Low, 10=High)

When you are under stress do you tend to overeat? Yes / No

Do you think you are currently undergoing a stressful situation? Yes / No

What is your “Comfort Food?” _____

Any other foods that you feel have attributed to your putting on weight? If so, which?
_____

Current Weight _____(lbs.) Height _____ Desired Weight _____(lbs.)

Weight at 20 years of age_____(lbs.) Weight one year ago_____(lbs.)

What time frame would you like to be at your desired weight? _____

Do you smoke? Yes / No If yes, how many cigarettes/packs a day: _____ For how many years? ____

If you smoked previously, when did you finally quit? _____

FAMILY MEDICAL HISTORY

Father: If living, current age ____ Is he in good health? Yes / No If deceased, age at death ____

Mother: If living, current age ____ Is she in good health? Yes / No If deceased, age at death ____

Has any **Blood Relative** (i.e. Father, Mother, Brother, Sister) had any of the following Diseases?

Heart Disease	Who? _____
High Cholesterol	Who? _____
Diabetes	Who? _____
Cancer	Who? _____
Obesity	Who? _____
Glaucoma	Who? _____
Asthma	Who? _____
Epilepsy	Who? _____
High Blood Pressure	Who? _____
Kidney Disease	Who? _____
Tuberculosis	Who? _____
Psychiatric Disorder	Who? _____
Heart Disease/Stroke	Who? _____
HIV/Hepatitis	Who? _____

The above information is correct to the best of my knowledge.

Signature _____ **Date** _____

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Please list 5 SIGNIFICANT reasons you personally want to lose weight. (i.e. what really motivated your decision to get started now)

1._____

_____

2._____

_____

3._____

_____

4._____

_____

5._____

_____

WHAT TO DO ABOUT THE MUNCHIES?

List AS MANY SPECIFIC things you can do instead of eating when you get the urge to munch or overeat (i.e. hobbies, exercise, chores, etc.).

In order to triumph over cravings or overeating, you must have thought ahead and have made plans of action ready to implement when needed.

Home:

1._____

2._____

3._____

Work or any other relevant situation/place:

4._____

5._____

6._____