CAROLINA MEDICAL CONSULTANTS, PA

WEIGHT LOSS PROGRAM CONSENT FORM

I, _____, authorize Sheryl Lamb, APRN and associated health care providers, 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 on behavior modification techniques, and may involve the use of anti-obesity medications. Other treatment options may include a very low-calorie diet or a protein-supplemented diet. I further understand that if medications are used, they have been used safely and successfully in private medical practices with experienced obesity medicine specialists 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 having excess weight or obesity. Risks of this program are usually temporary, reversible, and may include but are not limited to nervousness, sleeplessness, headaches, electrolyte abnormalities, dry mouth, gastrointestinal disturbances, weakness, fatigue, pancreatitis, psychological problems, gallstones, high blood pressure, rapid or slowing of the heartbeat and heart irregularities, and risk of weight regain. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are 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 over time.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees that the program will be successful. I also understand that obesity is a chronic, lifelong 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 it has been fully explained to me. My questions have been answered to my complete satisfaction.

_____ _____

Patient's Name (printed) Witness

_____ _____

Patient Signature Date

(or signature of person with authority to consent for patient)

WEIGHT LOSS GOALS

Before you begin your weight-loss journey, it is important to spend time reflecting on why YOU want to lose weight. Make sure that that these are personal motivators and are not intended to please others.

Reviewing this list frequently will help keep you on track and focused on your personal commitment to take control of your health!

1._____

2._____

3._____

4._____

5._____

Describe the physical benefits you hope to get by losing weight:

_____

_____

Describe the functional benefits you hope to get by losing weight:

_____

_____

Describe the medical benefits you hope to get by losing weight:

_____

_____

Describe the psychological benefits you hope to get by losing weight:

_____

_____

EATING BEHAVIOR QUESTIONNAIRE

Answer the questions below by selecting the answer best describing your eating behavior in the past few days. Circle the number that corresponds to your answer, with (0) being 'never', and (10) being always.

1. Are you preoccupied with thoughts of food or eating?										
Never		Rarely		Sometimes		Often		Always		
0	1	2	3	4	5	6	7	8	9	10
2. Do you eat to comfort yourself?										
Never		Rarely		Sometimes		Often		Always		
0	1	2	3	4	5	6	7	8	9	10
3. Do you crave specific foods?										
Never		Rarely		Sometimes		Often		Always		
0	1	2	3	4	5	6	7	8	9	10
4. Once you start eating, do you find it difficult to stop?										
Never		Rarely		Sometimes		Often		Always		
0	1	2	3	4	5	6	7	8	9	10
5. Do you find it difficult to stick to an eating plan?										
Never		Rarely		Sometimes		Often		Always		
0	1	2	3	4	5	6	7	8	9	10
6. Do you eat rapidly, more rapidly than those around you?										
Never		Rarely		Sometimes		Often		Always		
0	1	2	3	4	5	6	7	8	9	10
7. Do you "graze" or eat continually during any part of a 24-hour day?										
Never		Rarely		Sometimes		Often		Always		
0	1	2	3	4	5	6	7	8	9	10
8. Are you in control of your eating?										
Never		Rarely		Sometimes		Often		Always		
0	1	2	3	4	5	6	7	8	9	10
9. Do you eat more when under stress?										
Never		Rarely		Sometimes		Often		Always		
0	1	2	3	4	5	6	7	8	9	10
10. Do you eat more during highly emotional times?										
Never		Rarely		Sometimes		Often		Always		
0	1	2	3	4	5	6	7	8	9	10

WEIGHT LOSS CLINIC
NEW PATIENT DEMOGRAPHIC/MEDICAL HISTORY FORM

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

Date of Birth: _____/_____/_____ Date of Visit: _____/_____/_____

Phone: (Home/Cell)_____ (Work) _____ Gender: M / F

How does your weight is affect your life and health? _____

_____

Weight History

When did you become overweight?

☐ Childhood ☐ Teens ☐ Adulthood ☐ Pregnancy ☐ Menopause

Did you ever gain more than 20 pounds in less than 3 months? Y / N If so, how long ago? _____

As best you can remember, how much did you weigh one year ago? _____

Five years ago? _____ 10 years ago? _____

Triggers for your weight gain (check all that apply):

☐ Stress ☐ Marriage ☐ Divorce ☐ Illness ☐ Medication abuse ☐ Travel ☐ Injury

☐ Nightshift work ☐ Insomnia ☐ Quitting (circle all that apply): Smoking / Alcohol / Drugs

Previous weight-loss programs (check all that apply):

☐ Weight Watchers ☐ Nutrisystem ☐ Jenny Craig ☐ LA Weight Loss ☐ Atkins

☐ South Beach ☐ Zone diet ☐ Medifast ☐ Dash diet ☐ Paleo diet

☐ HCG diet ☐ Mediterranean diet ☐ Ornish diet ☐ Other: _____

What was your maximum weight loss? _____

What are your greatest challenges with dieting? _____

_____

Have you ever taken medication to lose weight? (check all that apply):

☐ Phentermine(Adipex) ☐ Meridia ☐ Xenecal/Alli ☐ Phen/Fen

☐ Phendimetrazine(Bontril) ☐ Topamax ☐ Saxenda ☐ Diethylpropion

☐ Bupropion(Wellbutrin) ☐ Belviq ☐ Qsymia ☐ Contrave

Other: _____

Prior weight loss medication information continued:

What worked? _____

What didn't work? _____

Why or why not? _____

Nutritional History

How often do you eat breakfast? _____ days per week at _____:_____ a.m.

Number of times you eat per day: _____

Do you get up at night to eat? Y / N If so, how often? _____ times

Food triggers (check all that apply):

☐ Stress ☐ Boredom ☐ Anger ☐ Seeking Reward ☐ Parties ☐ Eating Out

☐ Fast Food ☐ Other: _____

Food cravings:

☐ Sugar ☐ Chocolate ☐ Starches ☐ Salty ☐ High Fat ☐ Large Portions

Favorite foods: _____

Medical History

Exercise type: _____

Duration: _____ hours _____ minutes Number of times per week: _____

What prevents you from exercising? _____

How many hours do you sleep per night? _____ Do you feel rested in the morning? _____

Past medical history (check all that apply):

☐ Heart attack	☐ Angina	☐ Gall bladder stones	☐ Sleep apnea
☐ High blood pressure	☐ Stroke	☐ Indigestion/reflux arthritis	☐ Thyroid
☐ High cholesterol	☐ Diabetes	☐ Celiac disease	☐ Anxiety
☐ High triglycerides	☐ Gout	☐ Pancreatitis	☐ Depression
☐ Infertility	☐ Polycystic Ovarian Syndrome		

☐ Cancer (type/s): _____

Have you ever be diagnosed with an eating disorder? Y / N If yes, which one? _____

Past surgical history (check all that apply):

☐ Gastric bypass ☐ Gastric banding ☐ Gastric sleeve ☐ Gall bladder ☐ Heart bypass

☐ Hysterectomy ☐ Other: _____

Medications (list all current medications and dosages):

_____ _____ _____ _____

_____ _____ _____ _____

Allergies:

(Medications)_____

(Food)_____

Social History

Smoking: ☐ Never ☐ Current smoker (_____ packs/day) ☐ Past smoker (quit _____ years ago)

Alcohol: ☐ Never ☐ Occasional ☐ Regularly (_____ drinks per day)

Prior treatment for alcoholism? Y / N

Drugs: ☐ Never ☐ Current ☐ Past ☐ Type of drugs: _____

Marijuana: ☐ Never ☐ Current user (_____ times/day)

Family History

Obesity (check all that apply): ☐ Mother ☐ Father ☐ Sister ☐ Brother

☐ Daughter ☐ Son

Family History Continued

Diabetes (check all that apply): ☐ Mother ☐ Father ☐ Sister ☐ Brother

☐ Daughter ☐ Son

Other (check all that apply): ☐ High blood pressure ☐ Heart disease ☐ High cholesterol

☐ High triglycerides ☐ Stroke ☐ Thyroid problems ☐ Anxiety ☐ Depression

☐ Bipolar disorder ☐ Alcoholism ☐ Cancer (type/s): _____

Other: _____

Gynecologic History

Age periods started? _____ Age periods ended _____

Periods are: Regular / Irregular Heavy / Normal / Light

Number of pregnancies: _____ Number of children: _____

Age of first pregnancy: _____ Age of last pregnancy: _____

System Review : (Check all that apply)

☐ Recent weight loss more than 10 pounds

☐ Recent weight gain more than 10 pounds

☐ Acne	☐ Skin rash	☐ Cough
☐ Snoring	☐ Shortness of breath	☐ Chest pain
☐ Difficulty breathing when flat	☐ Fainting/Blacking out	☐ Palpitations
☐ Swelling ankles/extremities	☐ Abdominal pain	☐ Bloating
☐ Constipation	☐ Diarrhea	☐ Food intolerance
☐ Dysphagia/difficulty swallowing	☐ Indigestion	☐ Nausea/vomiting
☐ Increased appetite	☐ Decreased appetite	☐ Heartburn
☐ Gas and bloating	☐ Urinary frequency/urgency	☐ Slow urine flow
☐ Nighttime urination	☐ Blood in stools	☐ Back pain (upper)
☐ Back pain (lower)	☐ Joint pain	☐ Muscle aches/pain
☐ Dizziness	☐ Headaches	☐ Seizures
☐ Weakness/low energy	☐ Anxiety	☐ Depression
☐ Insomnia	☐ Memory loss	☐ Inability to concentrate
☐ Mood changes	☐ Nervousness	☐ Loss of interest
☐ Cold intolerance	☐ Excessive sweating	☐ Hair changes
☐ Heat intolerance	☐ Blood clots	☐ Fatigue/tiredness

(Women only)

☐ Absence of periods	☐ Hot flashes	☐ Change in bladder habits
☐ Abnormal/excessive menstruation	☐ Facial hair	

Additional Comments/Concerns:

_____

_____

_____