Patient Basic Information

To be filled out by the patient. Print clearly, or type into this PDF before printing.

Bring this completed packet to your appointment, or complete it online at amwl.co/forms/ - the online version is faster and reaches us before you arrive. Questions? Call 636-333-2235, or text 636-218-8778 any time.

PATIENT

LAST NAME | FIRST NAME | M.I. | NICKNAME

DATE OF BIRTH | AGE | SEX ASSIGNED AT BIRTH | SSN

CONTACT

STREET ADDRESS | APT / SUITE

CITY | STATE | ZIP CODE

CELL PHONE | HOME PHONE | EMAIL

PREFERRED WAY TO BE CONTACTED | HOW DID YOU HEAR ABOUT US?

EMERGENCY CONTACTS AND PHYSICIAN

CONTACT 1 - NAME | RELATIONSHIP | PHONE

CONTACT 2 - NAME | RELATIONSHIP | PHONE

PHYSICIAN | PRACTICE | PHONE

FINANCIAL POLICY

Thank you for selecting Arnold Medical Weight Loss for your health care. 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.

Payment for all services will be due at the time services are rendered.

For your convenience we accept cash, Visa, MasterCard, Discover, and CareCredit. We do not accept personal or third-party checks, and we do not bill insurance.

☐ **I have read and understand all of the above and have agreed to these statements.**

Patient Medical History

CURRENT HEALTH

1. Are you in good health at the present time, to the best of your knowledge? ☐ Yes ☐ No
2. Are you under a doctor's care at the present time? ☐ Yes ☐ No
3. Are you taking any medications at the present time? ☐ Yes ☐ No

All prescription and over-the-counter drugs

Drug	Dosage

ALLERGIES

Are you allergic to any medications? ☐ Yes ☐ No

ANY HISTORY OF THE FOLLOWING

4. High blood pressure? ☐ Yes ☐ No
5. Diabetes? ☐ Yes ☐ No
6. Heart disease? ☐ Yes ☐ No
7. Chest pain? ☐ Yes ☐ No
8. Feet swelling? ☐ Yes ☐ No
9. Headaches? ☐ Yes ☐ No
10. Constipation? ☐ Yes ☐ No
11. Glaucoma? ☐ Yes ☐ No
12. Sleep apnea? ☐ Yes ☐ No

SURGERIES

13. Any surgery? ☐ Yes ☐ No

Type of surgery	Date

Patient Medical History (continued)

YOUR PAST MEDICAL HISTORY - CHECK ALL THAT APPLY

- ☐ Gallbladder Disorder
- ☐ Tonsillitis
- ☐ Scarlet Fever
- ☐ Anemia
- ☐ Arthritis
- ☐ Chicken Pox
- ☐ Liver Disease
- ☐ Alcohol Abuse
- ☐ Eating Disorder
- ☐ Heart Valve Disorder
- ☐ Cancer
- ☐ Jaundice
- ☐ Nervous Breakdown
- ☐ Ulcers
- ☐ Rheumatic Fever
- ☐ Gout
- ☐ Blood Transfusion
- ☐ Lung Disease
- ☐ Measles
- ☐ Bleeding Disorder
- ☐ Thyroid Disease
- ☐ Kidneys
- ☐ Pleurisy
- ☐ Drug Abuse
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Pneumonia
- ☐ Heart Disease
- ☐ Whooping Cough
- ☐ Osteoporosis
- ☐ Psychiatric Illness

OTHER

YOUR FAMILY MEDICAL HISTORY

To the best of your ability. Blank means not known.

	Father	Mother	Brother(s)	Sister(s)	Close relatives
Age if living?					
General health?					
Diseases?					
Overweight?					
Cause of death?					
High blood pressure?					
Kidney disease?					
Heart disease / stroke?					

Nutritional Evaluation

1. MAIN REASON FOR YOUR DECISION TO LOSE WEIGHT

CURRENT WEIGHT (LB) | HEIGHT | 2. DESIRED WEIGHT (LB) | 3. IN HOW MANY MONTHS?

4. WEIGHT AT AGE 20 (LB) | WEIGHT ONE YEAR AGO (LB) | 6. MOST EVER WEIGHED (LB) | WHEN?

5. WHEN DID YOU BEGIN GAINING EXCESS WEIGHT? (REASONS IF KNOWN)

7. Is your spouse, fiance(e), or partner overweight? ☐ Yes ☐ No

HOW YOU EAT NOW

8. HOW OFTEN PER WEEK DO YOU EAT OUT?

9. HOW OFTEN PER WEEK DO YOU EAT FAST FOOD?

10. FOODS YOU ARE ALLERGIC TO

11. FOODS YOU STRONGLY DISLIKE

12. FOODS YOU CRAVE

13. TIMES OF DAY OR MONTH YOU CRAVE FOOD

14. Do you drink coffee or tea? ☐ Yes ☐ No

15. Do you wake up hungry during the night? ☐ Yes ☐ No

16. PREVIOUS DIETS YOU HAVE FOLLOWED - NAME/DESCRIPTION AND YOUR RESULTS

LIFESTYLE CONSIDERATIONS

1. Do you drink alcohol? ☐ Yes ☐ No

IF YES - HOW OFTEN?

ROUGHLY HOW MANY DRINKS?

2. Tobacco smoking habits

☐ Have never smoked ☐ Currently smoke ☐ Quit smoking

QUIT HOW MANY YEARS AGO?

IF CURRENTLY SMOKING - HOW MUCH PER DAY?

3. Activity level (choose only one)

☐ Inactive ☐ Light activity ☐ Moderate activity

☐ Heavy activity ☐ Vigorous activity

Inactive: no regular physical activity with a sit-down job. Light: no organized physical activity during leisure time. Moderate: occasionally involved in activities such as weekend golf, tennis, or jogging. Heavy: consistent lifting, stair climbing, or regular jogging or swimming 3 times per week. Vigorous: extensive physical exercise at least 60 minutes per session, 4 times per week.

Patient Informed Consent for Appetite Suppressants

CONSENT

Procedure and alternatives

1. I authorize Dr. J. W. Campbell and whomever he designates as his assistants 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. 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.

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 (see Risks 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 suppressant.

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. 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.

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.

No guarantee

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.

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.

☐ **I have read and fully understand this consent form. My questions have been answered to my complete satisfaction, and I consent to treatment.**

PATIENT (OR GUARDIAN) SIGNATURE

DATE SIGNED

Physician's 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 SIGNATURE

DATE SIGNED

Acknowledgements

HIPAA PRIVACY NOTICE

Our Notice of Privacy Practices describes how medical information about you may be used and disclosed, and how you can get access to that information. It is available at the office on request and published at amwl.co/privacy.html.

☐ **I have received a copy of the HIPAA privacy notice.**

CONSENT TO TREATMENT - PATIENTS WHO CAN BECOME PREGNANT

I understand that phentermine and other anorectic medications should not be taken during pregnancy, due to the risk of damage to the fetus. The medications have been explained to me fully and I am aware of the risks involved.

To the best of my knowledge, I am not pregnant. I am aware of the precautions that should be taken to avoid pregnancy while I am on the medication. If I become pregnant, I will advise both this clinic and my OB/GYN immediately.

☐ **I have read and understand the above, and to the best of my knowledge I am not pregnant.**

PATIENT CONSENT FOR APPETITE SUPPRESSANTS AND WEIGHT LOSS PROGRAM

I have read and fully understand this consent form. 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 whatsoever concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

☐ **I confirm the information in this packet is complete and accurate to the best of my knowledge.**

PATIENT (OR GUARDIAN) SIGNATURE

DATE SIGNED

WITNESS SIGNATURE

DATE SIGNED

Return this packet to Arnold Medical Weight Loss, 4163 Crescent Dr., St. Louis, MO 63129. Questions? Call 636-333-2235. You can also complete it online at amwl.co/forms/.