

# 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: \_\_\_\_\_  
Email: \_\_\_\_\_  
Social Security #: \_\_\_\_\_

City State Zip County

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<br>(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<br>(such as Adkins, Stillman,<br>Sugar-Busters, Protein Power) |      |                       |             |          |
| High carbohydrate, low fat  |      |                       |             |          |
| Starvation  |      |                       |             |          |
| Body wraps or passive<br>exercise table   |      |                       |             |          |
| Behavior modification   |      |                       |             |          |
| Psychotherapy   |      |                       |             |          |
| Hypnosis  |      |                       |             |          |
| Surgery: (liposuction, gastric<br>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 |
|--|----------------------|----------|
| <input type="checkbox"/> Walking         |                      |          |
| <input type="checkbox"/> Bicycling       |                      |          |
| <input type="checkbox"/> Swimming        |                      |          |
| <input type="checkbox"/> Water exercises |                      |          |
| <input type="checkbox"/> Golf - walking  |                      |          |
| <input type="checkbox"/> Golf - cart     |                      |          |
| <input type="checkbox"/> Tennis          |                      |          |
| <input type="checkbox"/> Aerobics        |                      |          |
| <input type="checkbox"/> Weight training |                      |          |
| <input type="checkbox"/> Other           |                      |          |

Is there anything that prevents you from being physically active?

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What activities do you like to do for fun?

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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?

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

Why?

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## 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:

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

**List all additional medical illness:**

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**Prior surgical procedures:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Appendectomy   | <input type="checkbox"/> Gallbladder surgery        | <input type="checkbox"/> Pelvic surgery or C-Section |
| <input type="checkbox"/> Hernia surgery | <input type="checkbox"/> Gastric or stomach surgery | <input type="checkbox"/> Heart surgery               |
- Other

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

- |  |                                |                                 |
|--|--------------------------------|---------------------------------|
| <input type="checkbox"/> Surgical tape | <input type="checkbox"/> Latex | <input type="checkbox"/> Iodine |
|--|--------------------------------|---------------------------------|

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**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*

|                       |
|-----------------------|
| <b>Social History</b> |
|-----------------------|

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? \_\_\_\_\_

|                            |
|----------------------------|
| <b>Psychiatric History</b> |
|----------------------------|

Check all that apply

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

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### Sleep History

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

### Cardiac History

Please mark all that apply:

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

### Gynecological History

Ladies only please:

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

### Family History

Indicate if there is a family history of:

- |  |  |
|--|--|
| <input type="checkbox"/> Obesity             | <input type="checkbox"/> Lung disease, asthma, or emphysema  |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Kidney disease                      |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Bleeding tendency or blood disorder |
| <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Breast cancer                       |
| <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Colon cancer                        |
| <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> 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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# HEALTHY 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 SIGNING 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.

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Physician's Signature

# HEALTHY WEIGHT SOLUTIONS

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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

