Premier Physicians Weight Loss and Wellness Center

Dr. Dana Trippi Dr.Erik Evensen

Patient Name: (Last) _____ (First) _____ (MI)___

Name you prefer to be called: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cellular: _____

(Please indicate with an * the telephone number you prefer to be contacted)

E-mail Address: _____

Birthday: ____/____/_____ Age: ____ Sex: M F

Social Security: _____ Drivers License: _____

Employment Information:

Patient Employer: _____ Occupation: _____

Work Phone Number: _____ Ext: _____

In Case of Emergency:

Name: _____ Relationship: _____ Phone: _____

Patients Spouse: _____ Phone: _____

Family Physicians: _____ Phone: _____

Referred by: _____

Financial Policy:

Thank you for choosing Premier Physicians for your health care needs. We are honored to be of service to you and your family.

Cash Pay Patients: Please be advised that the non-refundable payment of $50 will be due prior to the initial assessment and will be applied towards initial payment of $199. (Includes: EKG, and initial provider consultation). Follow up visits are $67 and medications and injections are additional.

PEBP Insured: There are no Co-pays for weight management visits. Copies of Medical Records are $0.60 per page. Whether a cash-pay patient or insured patient a $50 fee will apply to "no shows" or rescheduled appointments without a 24-hour notice and your credit card will be charged. For your convenience we accept cash, debit cards, most major credit cards and CareCredit. We do not accept ***personal checks.***

I have read and understand all of the above and agree to these statements.

_____ _____

Patient Signature **Date**

Medical History

Please list the following:

Primary Care Physician: _____ **Phone:** _____

Cardiologist: _____ **Phone:** _____

Endocrinologist: _____ **Phone:** _____

Pulmonary: _____ **Phone:** _____

OB/GYN: _____ **Phone:** _____

- ☐ **Asthma**
- ☐ **Cushing's Disease**
- ☐ **Diabetes II**
- ☐ **Heart Burn/Acid Reflux**
- ☐ **High Cholesterol**
- ☐ **Blood Clots**
- ☐ **High Blood Pressure**
- ☐ **Hypothyroidism**
- ☐ **Incontinence**
- ☐ **Infertility**
- ☐ **Insomnia**
- ☐ **Metabolic Syndrome**
- ☐ **Fatty Liver**
- ☐ **Arthritis/Disorder of Knees**
- ☐ **Arthritis/Disorder of Hips**
- ☐ **Arthritis/Disorder of Back**
- ☐ **Polycystic Ovaries**
- ☐ **Podiatric (Foot) Disorder**
- ☐ **Sleep Apnea**
- ☐ **Congestive Heart Failure**
- ☐ **Breast Cancer**
- ☐ **Colon Cancer**
- ☐ **Coronary Artery Disease**
- ☐ **Stroke**
- ☐ **Glaucoma**
- ☐ **Hepatitis**
- ☐ **Irritable Bowel Syndrome**
- ☐ **Leukemia**
- ☐ **Heart Attack**
- ☐ **Ovarian Cancer**
- ☐ **Prostate cancer**
- ☐ **Seizure Disorder**
- ☐ **Substance Addiction**
- ☐ **Uterine Cancer**
- ☐ **Valvular Heart Disease**

Other Conditions not Listed: _____

_____

Medical problems that run in the family: _____

_____

Please place a check mark in the box of the medical problems that you have been diagnosed with. Also, please fill in any other medical conditions that you have which are not listed.

Medications

Please place a check mark in the box of any medications that you are currently taking. Also, please complete the right portion so that we know any additional medications and your dose and time schedule.

Current Medications:

- ☐ **Abilify**
- ☐ **Actos/Pioglitazone**
- ☐ **Avandia/Rosiglitazone**
- ☐ **Benadryl/Diphenhydramine**
- ☐ **Birth Control Pills**
- ☐ **Cardura/Doxazosin**
- ☐ **Claritin/Loratidine**
- ☐ **Decadron**
- ☐ **Depakote/Valproic Acid**
- ☐ **Elavil/Amitriptyline**
- ☐ **Estrogen Replacement**
- ☐ **Haldol/Haloperidol**
- ☐ **Hytrin/Terazosin**
- ☐ **Inderal/Propanalol**
- ☐ **Insulin**
- ☐ **Lopressor/Toprol XL**
- ☐ **Lyrica**
- ☐ **Minipress/Prazosin**
- ☐ **Neurontin/Gabapentin**
- ☐ **Pamelor/Nortriptyline**
- ☐ **Prednisone**
- ☐ **Remeron/Mirtazapine**
- ☐ **Risperidal/Risperidone**
- ☐ **Steroid/Cortisone Injections**
- ☐ **Tegretol/Carbatrol**
- ☐ **Tenormin/Atenelol**
- ☐ **Zyprexa/Olanzapine**
- ☐ **Naturopathic/Homeopathic Meds**
- ☐ **OTC:** _____

_____
_____
_____
_____
_____

Allergies to Medications

Medications:	**Reactions:**
_____	_____
_____	_____

Additional Medications/Dosages:

Surgical History

Please place a check mark in the box of any surgeries that you have had. Also, please include any additional Surgeries not listed.

- ☐ **Back Surgery**
- ☐ **Cholecystectomy**
- ☐ **Gastric Bypass**
- ☐ **Duodenal Switch**
- ☐ **Lap Band**
- ☐ **Hernia Repair**
- ☐ **Hip Surgery**
- ☐ **Hysterectomy**
- ☐ **Tonsils and Adenoids**
- ☐ **Knee Surgery**
- ☐ **Shoulder surgery**
- ☐ **Plastic Surgery:** (please list) _____

Additional Surgeries

_____
_____
_____
_____
_____

Psychiatric History

Please place a check mark in the box of any psychiatric diagnosis that you may have experienced or have been diagnosed with currently or in the past. Also, please complete the right portion so that we know any additional diagnoses you have had.

- ☐ **Bulimia Nervosa**
- ☐ **Anorexia Nervosa**
- ☐ **Binge Eating Disorder**
- ☐ **Depression**
- ☐ **Anxiety**
- ☐ **Obsessive Compulsive Disorder**
- ☐ **Bipolar Disease**
- ☐ **Schizophrenia**

Additional Psychiatric History

_____
_____
_____
_____
_____

Do you think of suicide? **Yes ☐ No ☐**

Have you ever attempted suicide?
Have you seen a psychologist or Therapist currently or in the past? **Yes ☐ No ☐**

If so, when and what for: _____
_____
_____

How much time do you spend each day thinking about food, shape and weight?

_____
_____

Yes ☐ No ☐

Gynecological History

*Please fill in the following information if you are a **Female**.*

- **Are you possibly pregnant?** Yes ☐ No ☐
- **Are you nursing?** Yes ☐ No ☐
- **Date of last menstrual period:** _____

Social History

Please fill in the following information.

- **Are you currently smoking?** Yes ☐ No ☐
- **Do you have a history of smoking?** Yes ☐ No ☐
- **Do you drink alcohol?** Yes ☐ No ☐
  If so, do you have a history of heavy drinking? Yes ☐ No ☐
  How much do you/did you drink? _____

- **Do you do street drugs?** Yes ☐ No☐
- **Do you have a history of street drug use?**
  If so, what kind? _____

- **What do you consider your support system?** _____
  _____

Review of Symptoms

Please check a box if you have had or are experiencing any of these symptom.

☐ Fatigue	☐ Double Vision	☐ Diarrhea
☐ Difficulty Sleeping	☐ Dizziness	☐ Constipation
☐ Excessive Appetite	☐ Headache	☐ Abdominal Pain
☐Excessive Thirst	☐ Ringing Ears	☐ Nausea
☐Acne	☐ Cough	☐ Vomiting
☐ Excessive Hair	☐ Wheezing	☐ Lower Back Pain
☐ Rash	☐ Shortness of Breath	☐ Hip Pain
☐ Edema	☐ Chest Pain	☐ Excessive Urinating
☐ Hair	☐ Palpitations	☐ Loss of Urine Control

Weight History

Recent Weight Changes.

Lowest Adult Weight _____

Highest Adult Weight _____

Ideal Adult Weight _____

Events associated/caused with weight gain _____

_____

Why I am motivated to lose weight _____

_____

Activity History

The most active time in my life _____

_____

The activities I enjoy the most _____

_____

The Biggest Barrier to me being active is _____

_____

My Activity level is best described as

- ☐ **More than Average**
- ☐ **Average**
- ☐ **Less than Average**

Weight Loss Attempt History

Please fill in the following information.

Diets

- ☐ American Heart Diet _____lbs lost
- ☐ Atkins _____lbs lost
- ☐ Blood Type _____lbs lost
- ☐ Cabbage soup _____lbs lost
- ☐ Deal-A-Meal _____lbs lost
- ☐ Diet for Dummies _____lbs lost
- ☐ Duke Diet _____lbs lost
- ☐ Isagenix _____lbs lost
- ☐ Jenny Craig _____lbs lost
- ☐ Low Fat _____lbs lost
- ☐ Master Cleanser _____lbs lost
- ☐ Nutrisystem _____lbs lost
- ☐ Opti/MediFast _____lbs lost
- ☐ Ornish _____lbs lost
- ☐ Protein Power _____lbs lost
- ☐ SlimFast _____lbs lost
- ☐ South Beach _____lbs lost
- ☐ Sugar Busters _____lbs lost
- ☐ Suzanne Somers _____lbs lost
- ☐ You On A Diet _____lbs lost
- ☐ Zone _____lbs lost
- ☐ Other _____

Exercise

- ☐ Gym Membership _____lbs lost
- ☐ Home Equipment _____lbs lost
- ☐ Other Cardio _____lbs lost
- ☐ Running _____lbs lost
- ☐ Walking _____lbs lost
- ☐ Weights _____lbs lost
- ☐ Yoga _____lbs lost
- ☐ Other _____lbs lost

Programs

- ☐ Bridges _____lbs lost
- ☐ Deal-A-Meal _____lbs lost
- ☐ Duke Center _____lbs lost
- ☐ Inpatient Medical _____lbs lost
- ☐ LA Weight Loss _____lbs lost
- ☐ LEARN Program _____lbs lost
- ☐ Out Patient Medical _____lbs lost
- ☐ Weight Watchers _____lbs lost
- ☐ Other _____lbs lost

Medications

- ☐ Wellbutrin _____lbs lost
- ☐ Topirimate/Topamax _____lbs lost
- ☐ Tenuate _____lbs lost
- ☐ Orlistat/Xenical/Alli _____lbs lost
- ☐ Bontril/Phendimetrazine _____lbs lost
- ☐ Phen-Fen _____lbs lost
- ☐ Phentermine _____lbs lost
- ☐ Other _____

Supplements

- ☐ Chromium _____lbs lost
- ☐ Dexatrin _____lbs lost
- ☐ Hoodia _____lbs lost
- ☐ Laxatives _____lbs lost
- ☐ L-Carnitine _____lbs lost
- ☐ Lipotropics _____lbs lost
- ☐ Metabo-Life _____lbs lost
- ☐ Slim-Quick _____lbs lot
- ☐ Trim Spa _____lbs lost
- ☐ Vit B12 _____lbs lost
- ☐Other _____

Diet History

Please describe a typical:

Breakfast	Lunch	Dinner
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe your snack habits:

What _____ **When** _____ **Where:** _____

How often do you eat out? _____

What restaurants do you go to frequently? _____

How often do you eat fast food? _____

Who plans your meals? _____

Do you use a shopping list? _____

What time of day and what day/days do you shop for food? _____

_____

Foods that you like: _____

Foods that you dislike: _____

Foods that you crave: _____

Food Allergies: _____

I engage in the following habits

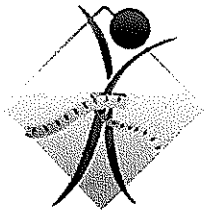
	Always	Often	Rarely	Never
Breakfast Skipping	☐	☐	☐	☐
Drink Juices/Soda	☐	☐	☐	☐
Night Eating	☐	☐	☐	☐
Emotional Eating	☐	☐	☐	☐
Add Sugar Substitute	☐	☐	☐	☐
Crave Foods during Specific times on month	☐	☐	☐	☐

Food(s) I eat that I feel the guiltiest about: _____

_____

_____

_____



Premier Physicians
Weight Loss & Wellness

PATIENT INFORMED CONSENT

Please Initial The Following Paragraphs:

_____I hereby authorize Dr. Dana Trippi, Dr. Erik Evensen, and Patricia Strobehn NP to assist me in my weight reduction efforts. I understand my treatment may involve, but is not 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 the medication will only be prescribed when the expected benefits are felt to be greater than the risks. I also understand that regular medical visits will be necessary while on the medications and that these medications must be used with caution and under direct supervision of the provider.

_____**I have read and understand the following physician statement:** "Medications including the appetite suppressants have labeling that has been agreed upon by the maker 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 dosage indicated in the labeling. As a medical provider, I have found the appetite suppressant helpful occasionally for periods in excess of 12 weeks and at times in larger doses than suggested by the labeling. As a provider, I am **NOT** required to use medications as the labeling suggests, but I am required to use labeling as a source of information, along with my own clinical experience, the experience of my colleagues, recent longer term studies, and recommendations of university based investigators. Based on this, I may choose when indicated to use the appetite suppressants for longer periods of time, and at times, in increased doses, albeit very rarely. Such usage has not been as systematically studied as the usage suggested in the labeling, and it is possible, as with most other medications that there could be serious side effects as noted below. As a provider, I need to weigh the risks and benefits of the appetite suppressant use with the risk of remaining overweight."

_____**Risk of proposed treatment:** I understand this authorization is given with the knowledge that the use of appetite suppressants involves some risk and some hazards. Most appetite suppressants should be used with extreme caution by people who suffer from glaucoma, alcoholism, psychotic illnesses, uncontrolled high blood pressure, advanced arteriosclerosis, thyroid over activity, people who are on certain other medications, i.e. monoamine oxidase inhibitors (MAOIs), certain serotonin type migraine medications, antimanic agents (lithium), some over the counter decongestants, and any other over the counter or prescription form anorectic agents. The more common side effects of appetite suppressants include, but are not limited to nervousness, diarrhea or constipation, sleeplessness, headache, dry mouth, dizziness, temporary memory loss, weakness, allergic reactions, psychological imbalances, high blood pressure, palpitations and heartbeat irregularities, and gallstones. Although only seen in rare cases, pulmonary hypertension or heart valve disease may develop. These conditions are serious and can be fatal. More studies are currently being done to document this further. I am willing to undergo studies as indicated by my weight loss physician if necessary for the purpose of ruling out underlying disease that may be a contraindication to the use of appetite suppressant.

_____**Patient responsibility:** As the patient, I understand it is my responsibility to follow 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. I agree to notify my weight loss provider of any medical problems that I may have, that they are not aware of, or any results of labs/tests, ordered and reviewed by any other physician. I further acknowledge that I enter into this program in full knowledge and understanding that no physician, provider or staff of the weight loss physician has prior knowledge as to whether I would or would not have adverse effects due to the fact that each individual has a different biological and chemical make-up. 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. I understand that a balanced calorie counting program without the use of appetite suppressants may likely prove successful if followed, even though I would be hungrier than without the suppressant. I also understand that there are also risks of remaining overweight or obese. I understand that abrupt discontinuation of the appetite suppressant may result in lethargy or depression.

I understand that during the program, medications will be discontinued if:

1) I become pregnant, try to become pregnant, or suspect I am pregnant
2) I develop a contraindication or serious side effect of the medication
3) I do not comply with medical requirements, i.e. visits, med doses, etc.
4) I fail to lose and/or maintain weight appropriately
5) I use another medication that is not compatible
6) I have a planned surgery. Meds are to be stopped at least 2 weeks prior

I understand that occasionally other medications such as antidepressants, diabetic medications, diuretics, and anti-seizure medications are used for the purpose of aiding weight loss. I understand that these are considered off label use for weight loss, but can at times be of significant benefit. I understand that all medications carry a risk of side effects and that I need to weight the risk and benefits of all medications before use.

_____**No guarantee:** I understand that much of the success of the program will depend on my effort, and that there is no guarantee that the program will be successful. I understand that I will have to continue with sensible and nutritional eating habits and regular exercise all my life if I am to be successful long term.

_____**Patient consent/waiver:** I have read and fully understand this document and authorize and accept the proposed care regardless of risk. I affirm that my questions have been satisfactorily answered at this time. I realize that I should not sign this form if all items are not understood by me or if questions have not been answered to my satisfaction. I hereby release all providers and any and all employees from any liability associated and connected with my participation in this weight loss program. I accept the risks as discussed above, in hopes of obtaining desired beneficial results of weight loss treatment.

_____**Labs/EKG:** I understand that it is my sole responsibility to follow up on pending labs and/or EKG results if I choose not to continue with this weight loss program prior to evaluation and interpretation of the labs and/or EKG results. I understand that any pending labs and/or EKG may reflect abnormalities which would need follow through with a primary care physician. I understand it is my responsibility to give Premier Physicians the name of a primary care physician where labs and/or EKG can be sent for follow through and interpretation.

Patient signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

Provider Declaration: I have explained the contents of this document to the patient and have answered all the patient's related questions. 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 concerning an overweight status. After being adequately informed, the patient has consented.

Provider signature: _____ Date: _____