Welcome To Our Practice!
Please Answer The Following Questions So We Can Better Assist Your Healthcare Needs
PATIENT INFORMATION

(Please Print)

Name:_____DOB:_____

Address_____

City_____State _____ Zip Code_____

Social Security #_____

*Phone#(*Home:)_____(Mobile:)_____

Marital Status: Single / Married / Divorced / Widowed / Separated **Please Circle:** M / F

Primary Care Physician: _____ Phone#_____

Employer and Occupation:_____

Women Only (Date of last period:_____) or _____ Menopausal

Are you Pregnant,Breastfeeding or have abnormal periods? (circle all that apply) Yes or No

What Form of contraception do you use (Including tubal ligation/male sterilization)_____

Additional Habits

Past or current smoker? Yes or No Do you drink caffeine? Yes or No
Do you consume alcohol? Yes or No If yes, how often?Occasional/ Daily/Weekly
Do you currently use any illegal drugs? (i.e. cocaine, heroin, marijuana, etc.) Yes or No

Current Medical History

Have you recently experienced ANY of the following symptoms listed below? Please circle any that apply

Weakness	Thick Tongue	Swollen Feet
Slow Speech Movement	Hoarseness	Poor Memory
Heart Palpitations	Coldness or Cold Skin	Painful Menstrual Cycle
Loss Of Appetite	Nervousness	Brittle Nails
Diminished Sweating	Depression	Dry, Coarse Skin/Hair
Swelling of Face	Constipation	Tired Fatigue

❑ None of the above

Family History (Please list mother,Father,Siblings,Aunt/Uncle,or Grandparents)

Conditions:

Heart Disease_____
Cancer_____
Diabetes_____
Hyperthyroidism_____
High Cholesterol_____
High Blood Pressure_____
Stroke_____
Kidney Liver Disease_____
Mental Illness (depression,bipolar)_____
Drug/ Alcohol Abuse_____

M/A Initials_____

Medical conditions that YOU have been diagnosed with

- ❑ Heart Disease / Heart Attack / Heart Failure/ Pacemaker / Heart Murmur/ Heart Valve Problems
- ❑ Glaucoma (Open/Narrow Angle)
- ❑ Obstructive Sleep Apnea (use a cpap)
- ❑ Thyroid Disorders Low / High
- ❑ Depression / Anxiety / Bipolarism / Other psychiatric conditions
- ❑ Diabetes : Type 1 or Type 2 / Gestational Diabetes / Insulin Resistance
- ❑ Kidney Diseases / Liver Disease
- ❑ History of passing out (Syncope)
- ❑ Dysmetabolic Syndrome
- ❑ Polycystic Ovarian Syndrome
- ❑ Insomnia/ other sleep disorders Other:_____

Weight Loss History

My Obesity Began: • Childhood • Puberty • Adult • After Pregnancy Other:_____
Have you attempted losing weight on your own **without** medication in the past? If yes, why do you feel it did not work for you?

- ❑ No
- ❑ Yes,_____

Which of the following do you think would best help you on your weight loss journey?

_____Learn proper portion size and how to control them _____Healthy snack/meal options

_____Learn to keep track of calorie intake _____What my daily calorie intake should be

_____Learn what times are best for higher calorie meals _____Keeping a food journal

_____How much water should I drink per day

_____Knowing which diet adherence is best for me □ carb restricted □ calorie restricted □ fat restricted

□ Weight Watchers □ Vegan □ Clean eating □ High protein □ Diabetic diet □ portion control

Past or Current Vitamin Deficiencies (Please circle any that apply)

Daily multi-vitamin	Vitamin C, D,	Vitamin B12	Potassium	Omega 3 Fatty Acid	Magnesium
Calcium	Iron	Probiotic	Fiber	Sleep aid	Folate

Medication Schedule

Medication	**Reason for taking**	**Dosage**	**Frequency**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Hospitalizations or surgeries:_____

Restrictions: Have you ever had or currently have any **exercise restrictions**?
No or Yes,_____

Have you ever had or currently have any **food restrictions**?

No or Yes,_____

M/A Initials_____

Informed Consent for Treatment

We want you to know that medical weight loss is an important medical decision in your health care. We are informing you through lectures and printed materials that we strive to work with you carefully and safely to help you achieve a medically significant weight loss. To help achieve this loss and help you in maintaining the weight loss long term, you must understand that we may prescribe various different nutritional plans, exercise programs and when appropriate use medications both short term and long term. You will be informed on how the medications work, possible side effects and know possible consequences of the medications, dietary suggestions and exercise activities planned. Sometimes the use of medications, length of use and/ or medication dosing may be used in an "off label" manner. This means the doctor may be using the medications safely in a manner other than initially approved by the FDA. The use of medications will always be within the scope of accepted medical weight loss medicines. Please note that the use of medication for weight loss is optional and that no weight loss treatment (including the use of appetite suppressants) guarantees successful weight loss.

Your Role1. Provide honest and complete answers to questions about your health, weight problem, eating activity, medication or drug usage, and lifestyle patterns to help us help you.2. Devote the time and effort necessary to complete and comply with the course of treatment.3. Allow us to share information with your personal physician (only if needed) 4. Please keep follow-up dates so that we can help you the best 5. Advise the clinic staff and Dr. of any concerns, problems, complaints, symptoms, or questions you may develop.6. Inform your personal physician of your weight loss efforts.

Possible side effects 1. Reduced weight. By reducing your caloric intake, you may see a variety of temporary and reversible side effects including, but not limited to, increased urination, momentary dizziness, reduced metabolic rate, cold sensitivity, slower heart rate, dry skin, fatigue, constipation, diarrhea, bad breath, muscle cramps, changes in menstrual pattern, dry or brittle hair or hair loss. Medication side effects may include any of the above plus dry mouth, mild headaches, and very rarely a racing or pounding heart rate or an elevation in blood pressure or other more rare side effects. This will be closely monitored as safety is our number one priority.2. Reduced potassium levels or electrolyte abnormalities. Always inform us if you are on or plan to begin a water pill. 3. Gallstones. Overweight people are at risk for having or developing gallstones. One study reports that 1 in 10 persons entering a weight loss program may have silent or undiagnosed gallstones. Active weight loss can produce new stones or cause established stones to develop symptoms. The pain is usually in the right upper abdomen and may spread to the back. Gallbladder problems may require medications or even surgery to remove the gallbladder. Notify your primary doctor or us if you develop symptoms of gallstones including abdominal pain, fever, nausea, and vomiting.4. Pancreatitis. Inflammation of the bile ducts or pancreas gland may be associated with gallstones, and may be precipitated by eating a large meal after a period of strict dieting. It may require hospitalization, and rarely can be associated with life threatening complications. Notify us or your primary physician if you develop symptoms such as pain in the left upper abdominal quadrant, fever, or vomiting . Pregnancy. Notify us if you become pregnant. Some overweight patients have irregular ovulation and weight loss may increase ovulatory regularity and the chance of becoming pregnant. If pregnant, you must change your diet to avoid further weight loss. A restricted diet can damage a developing fetus. Also, any weight loss medications must be discontinued if pregnancy occurs since we do not want you to continue to lose weight during that time. You should take precautions to avoid becoming pregnant during weight loss.6. Sudden death. Patients with obesity, especially those with associated high blood pressure, diabetes, or heart disease have a higher risk of sudden death and development of a serious potentially fatal disease known as primary pulmonary hypertension. Rare instances of sudden death have occurred while obese patients are undergoing weight loss even in a medically supervised program. No cause and effect relationship with the diet program and sudden death has been established.7. Risk of weight regain. Obesity is a chronic condition. The majority of patients who lose weight have a tendency to regain unless in some type of maintenance program and long-term efforts at controlling the weight are continued. We will provide you with a maintenance plan and a plan to help prevent weight regain.

RULES FOR USE OF WEIGHT LOSS CONTROL MEDICATIONS NOTE: SIGNING THIS FORM DOES NOT GUARANTEE THAT YOUR PHYSICIAN WILL FIND YOU TO BE AN APPROPRIATE CANDIDATE FOR WEIGHT LOSS MEDICATIONS, BUT ONLY THAT YOU HAVE READ, UNDERSTAND, AND AGREE TO THE TERMS OF MEDICATION USE SHOULD YOU AND YOUR PHYSICIAN DECIDE UPON THEIR USE NOW OR IN THE FUTURE.Many weight loss medications are considered “controlled medications.” By law, a controlled medication can only be received from one facility at the same time. I agree that only Horizon Weight Loss will prescribe scheduled weight loss medications for me. I agree that it is my responsibility to inform my doctor and any other doctors from whom I receive treatment of this contract, and that it is my responsibility to inform any and all doctors from whom I receive treatment if I am prescribed and/or taking any scheduled medications. Horizon Weight Loss may also notify my other doctors of the terms of this contract. I understand that the use of weight loss medications is contraindicated with certain medical histories, allergies, or other medication use. I agree that I will be completely honest in disclosing this information & will notify my HWL physician of changes to my medical history or new medication usage. I understand that failure to do so can be dangerous to my health.I agree to take the medication only as prescribed by Horizon Weight Loss. I understand that taking medications in any way other than prescribed may be dangerous to my health. I understand medications are typically only considered after a trial of weight loss with only nutritional/behavioral changes. If benefit outweighs the risks after this point, the lowest effective dose will be tried prior to increasing dosages. I agree to arrange for prescription refills for scheduled medications from Horizon Weight Loss only during regular clinic hours. I understand that controlled medications are not refilled in advance to time of refill. Medications are typically dispensed only in one month increments and only via physician approval during physician times with appropriate vital signs. I understand that missing my follow up date may mean being out of the medications for a small time period as controlled medications are not refilled via phone. I understand that Horizon Weight Loss is not obligated to replace any medications or prescriptions that are lost or stolen for any reason. I understand that medication prescriptions can be filled typically at Horizon Weight Loss. Permission for HWL to notify area pharmacies of the terms of this agreement. I will not use any illegal drugs or substances. I will not obtain or use any controlled substances illegally. I will not share, sell, or trade my medication with anyone. I understand doing so is illegal, will

result in my discharge from my physician's care, and may cause harm to the other person including possible death. I will not allow any other individual to take my medication under any circumstances. I understand that the use of many weight loss medications beyond 3 months is considered off-label usage. I understand I am to report any side effects or adverse reactions of medications to my HWL provider. I authorize my HWL physician to cooperate with any investigation of my drug use by legal authorities. This includes, but is not limited to, the release of my medical and pharmacy records and answering questions about me .My physician may sometimes taper and/or stop my medication to evaluate its effect on my weight loss and/or hunger and health. I will continue to comply with all parts of the agreement during those evaluation periods. **Kasper Consent** I understand that Kentucky law requires physicians prescribing controlled medications (including weight loss medications) to monitor patients' use of these medications. This monitoring includes an initial drug screening PANEL (IF needed) & KASPER report. I understand KASPER reports list what controlled substance prescriptions I have filled in the past several years. Further monitoring may include random drug screens, random pill counts, and repeat KASPER reports every three months while participating in the HWL program. Therefore, I understand that I am to bring in my unused weight loss medications to my appointments as they may be randomly required. I will cooperate with random pill counts. I will allow random drug tests of my urine and/or blood. I understand that I am responsible for any cost of them. I understand that this required monitoring could result in the delay and/or inability of my physician to prescribe these types of medications to me. I understand that weight loss medications may assist in weight loss, but that there is no guarantee they will do so. I understand weight loss medications can only be used with proper nutritional and behavioral changes. Failure to comply with nutritional and behavioral changes may result in my physician discontinuing medications. If weight loss is not improved with use of medications, I understand my physician will need to stop or change medications. I understand that weight loss medications are just one option to assist in weight loss, but are not required to lose weight. There are many options for weight loss although all patients will be instructed on nutritional, behavioral, and psychological changes. Just like any medication, weight loss medications can have a risk of side effects. Such side effects may include (but are not limited to), dry mouth, constipation, anxiety, jittery sensation, headache, insomnia, allergic reaction, heart palpitation (rare), elevated blood pressure (rare). Addiction is listed as a potential side effect (although this has not been reported if used as prescribed.) I understand it is my responsibility to notify my HWL physician if I have any side effects. If weight loss medications are used over 1 month, they should be tapered off unless you become pregnant or have a serious side effect from the medication in which case they can be stopped immediately. Failure to taper off of weight loss medications may result in rebound hunger, fatigue, depression, gain in weight, and other symptoms.I understand that if I desire to discontinue medications for any reason (including simple inability to continue the program), I will contact HWL to obtain a proper exit plan based on my current medical conditions. **Unused medications may be returned to HWL for proper disposal, or follow the guidelines at www.fda.gov/consumer.** *A copy of this contract can be found on HWL's website at horizonweightloss.com You may request a copy of this signed contract.*

Patient's Signature_____ Date:_____

Witness Signature_____ Date:_____

M/A Initials_____

Your Rights and Confidentiality You have the right to leave treatment at any time without any penalty, although you do have a responsibility to make sure we know you are discontinuing treatment. Your personal physician must be able to assume your medical care. From time to time, patient treatment information is used in the collection of statistics to compare results, and improve the treatment of obesity. This information may be shared with other practitioners, researchers, and the scientific and medical community. Strict confidentiality of individual personal information and records will be maintained.Please note that our Physicians do not take calls outside HWL's office hours. If you feel you are experiencing a medical emergency at any time, go to the nearest emergency room immediately for treatment.THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION (HIPAA)Uses and Disclosures of Information that We May Make Without Written Authorization: For treatment, payment, health care operations, as required by law, abuse or neglect, or communicable diseases, public health activities, health oversight activities, judicial and administrative proceedings, law enforcement, organ donation, research, workers compensation, appointments and services, marketing, business associates, military, inmates or person in police custody, coroners, medical examiners, funeral directors.Uses and Disclosures of Information That We May Make Unless You Object: We may use and disclose protected health information in the following instances without your written authorization unless you object. (Disaster Relief & Persons Involved in your case.) If you object, please notify the Privacy Contact identified at the end of this document. Persons Involved in Your Healthcare: Unless you object, we may disclose protected health information to a member of your family, relative, close friend, or other person identified by you who is involved in your health care or the payment for your health care. We will limit the disclosure to the protected health information relevant to that person's involvement in your health care or payment. We may leave messages for you to call us or on your phone unless you direct otherwise.**Notification**: Unless you object, we may use or disclose protected health information to notify a family member or other person responsible for your care of your location and condition. Medical Residents, Medical Students, and Training Physicians may observe or participate in your treatment or use your PHI to assist in their training. You have the right to refuse to be examined, observed, or treated by them. Newsletter and Other Communications - We may use your PHI to communicate to you by newsletters, mailings, or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our practice is participating.Your Right Concerning Your Protected Health Information: You have the following rights concerning your protected health information. To exercise any of these rights, you must submit a written request to Horizon Weight Loss.1. To request additional restrictions.2. To receive communications by alternative means.3. To inspect and copy records.4. To request amendment to your record.5. To request accounting of certain disclosures.6. To receive a copy of our complete confidentiality notice.7. To receive a copy of the invoice/ bill for office visit.8. To receive notice of a breach 9. Right to restrict certain disclosure to your health plan.Complaints you may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Office Manager. All complaints must be in writing. We will not retaliate against you for filing a complaint.Changes to this notice are located on Horizon Weight Loss's Website: horizonweightloss.com Privacy Officer Contact: If you have any questions about this notice, request a copy of the complete notice or if you want to object to or complain about any use of disclosure of exercise any right as explained above, please contact our Active Medical Director at 2220 Grandview Drive Ft. Mitchell KY 41017.

Patient's Responsibility I understand that it is my responsibility to maintain a physician / patient relationship with my primary doctor. It is also my responsibility to ensure that a complete physical examination has been performed, as well as having performed satisfactory laboratory tests that include CBC, fasting blood sugar, thyroid panel or TSH, lipid profile, serum,potassium, liver and renal function test. I agree to notify the attending physician or a staff of HWL of any abnormalities regarding the tests in question. I, the undersigned, have reviewed this information on this document, and have had an opportunity to ask questions and have them answered to my satisfaction.

Patient's Signature _____Date:_____

Physician's Signature_____ Date:_____

M/A Initials_____