DR. GEOFF MEDICAL WEIGHT LOSS

CLIENT INFORMED CONSENT FOR APPETITE SUPPRESSANTS

I have requested and authorized **DR. GEOFF MEDICAL WEIGHT LOSS** to assist me in my weight reduction efforts. I understand that my treatment may involve, but not be limited to the use of appetite suppressants.

I understand that if after my initial consultation, I decided that I do not want to participate in the program, or should the physician/nurse practitioner determine that based on the exam the use of appetite suppressants is not indicated, I will not be eligible for a refund.

I understand it is my responsibility to follow all instructions carefully and to report to the provider treating me all medical problems or symptoms that I feel may be related to my weight control program as soon as they occur.

I understand that discontinuation of pharmacological agents may occur at any time under my health care providers discretion.

I acknowledge that in initiation therapy there are potential risks involved:

1. **Most common side effects include, but are not limited to: Nervousness, Over Stimulation, Restlessness, Dizziness, Headache, Dry Mouth, and Anxiety, Changes in Mood, Rapid Heart Rate, and Medication Allergies (rash, hives).**
2. **Increased Blood Pressure.**
3. **Developing primary pulmonary hypertension.**
4. **Potential of causing birth defects.**
5. **Increased difficulty in controlling diabetes, hypertension, and other chronic diseases.**
6. **Developing Regurgitant Cardiac Valvular disease.**
7. **Adverse effects may occur with altering the dose or stopping my medications without first consulting my doctors.**

I have read and fully understand this consent form. I have had the opportunity to discuss any questions about my weight control program. My provider has answered all of my questions.

X_____ _____ _____

CLIENT SIGNATURE DATE TIME

_____ _____

WITNESS MEDICAL BOARD NUMBER

- *SITE:*
- *Gibsonia*
- *Greensburg*
- *Indiana*
- *Irwin*
- *Penn Hills*

YEARLY CLIENT UPDATE SHEET

Name: _____
Address: _____
_____
Email Address: _____
Date of Birth: _____

Preferred # to Call

Home #: _____ □
Cell #: _____ □
Work #: _____ □

If we need to contact you for any reason:

May we call and/or leave a message on your home phone and home voice mail?	**Y** or **N**
May we call and/or leave a message on your cell phone and cell voice mail?	**Y** or **N**
May we call and/or leave a message on your work phone and work voice mail?	**Y** or **N**
May we contact you in writing at the address above (ex. via US Mail)?	**Y** or **N**
May we contact you via the email address above?	**Y** or **N**

Preferred Method of contact? _____

EMERGENCY CONTACT:

If we need to contact you and can't reach you by one of the above, methods, who may we call and leave a message with (name and number(s))?

1. _____
2. _____

Who may we discuss your personal health information with? This information will only be about the weight loss program (name and number(s)).

1. _____
2. _____

CLIENT SIGNATURE: _____

DATE COMPLETED: _____

Dr. Geoff Medical Weight Loss

Gibsonia
Greensburg
Indiana
Irwin
Penn Hills

CLIENT WEIGHT LOSS HISTORY QUESTIONNAIRE

DAY: _____ DATE: _____

NAME: _____

ADDRESS: _____

HOME PHONE: _____ BUSINESS PHONE: _____

PLEASE COMPLETE THE FOLLOWING (STRICTLY CONFIDENTIAL):

1. *When did you begin to gain weight?*
   - □ After childbirth
   - □ After marriage
   - □ After an employment change
   - □ During a stressful period
   - □ Other_____

2. *How long have you been overweight*?
   - □ 1 year or less
   - □ 2-5 years
   - □ 6-10 years
   - □ >10 years

3. *What do you feel is the reason for your weight problem?*
   - □ Frequently overeating
   - □ Enjoy fattening foods
   - □ Lack of activity
   - □ Heredity
   - □ Other

4. *How many meals do you eat daily?*
   _____

5. *How many serious attempts have you made at dieting?* _____

6. *How long have you been able to stick to a diet?*
   - □ 1-2 months
   - □ 2-6 months
   - □ 7-12 months
   - □ Over 12 months

7. *What other weight reduction method have you tried?*
   - □ Weight Watchers
   - □ Other diet centers
   - □ Diet books
   - □ Physicians

8. *Why have you dropped out of diets before?*
   - □ Boredom
   - □ Hunger
   - □ Stress
   - □ Need assistance
   - □ Others

9. *What is the nature of your difficulties while dieting?* _____
   _____

10. *Are you under a physician's care?*
    □ Yes □ No

11. *Have you been advised by your physician to lose weight?*
    □ Yes □ No

12. *Do you have any physical problems that you know are associated with your weight?*
    _____
    _____

13. *Why do you want to lose weight?*
    - □ Promotes social activity
    - □ Appearance
    - □ Special occasion *(please list)*
      _____
    - □ Health reasons
    - □ To please family/friends
    - □ Other

14. *Has your husband or wife encouraged you to lose weight?* □ Yes □ No
    Explain: _____
    _____

15. *How important is it to you to lose weight?*
    - □ Extremely important
    - □ Very important
    - □ Important
    - □ Not very important

16. *Do you work outside the home?*
    - □ No
    - □ Part-time
    - □ Full-time

    Occupation _____

17. *Sex:* □ Female □ Male

18. *Age:*
    - □ Under 18
    - □ 18-24
    - □ 25-34
    - □ 35-49
    - □ 50-64
    - □ Over 64

19. *Marital Status:*
    - □ Married
    - □ Divorced
    - □ Single
    - □ Widowed
    - □ Living with a partner

20. *Number of children:*_____
    *Ages:*_____

21. *Are any of your children overweight?* _____

22. *What is your current weight?*
    _____ lbs.

23. *What was your highest weight in the last 5 years?*
    _____ lbs.

24. *What was your lowest weight in the last 5 years?*
    _____ lbs.

25. *What is your target weight?*
    _____ lbs.

Dr. Geoff Medical Weight Loss

Client HISTORY

Gibsonia
Greensburg
Indiana
Irwin
Penn Hills

Day: _____ Date: _____

HISTORY FORM

Name *(print)* _____Phone_____
Address _____ DOB _____
_____ Age _____
Primary Physician _____ Sex _____
MD Address _____ MD Phone #_____
Allergies _____
Current Medication(s) _____
_____
_____
HT _____ WT _____ BP _____ BMI _____

PERSONAL DATA

1. *Have you or any blood relative ever had any of the following conditions?*

CONDITION	YES	NO	WHEN	CLIENT	BLOOD RELATIVE
Arthritis					
Asthma					
Bone Disease					
Cancer/Site					
Cholesterol					
Depression					
Diabetes/Type					
Glaucoma					
Gout					
Heart Disease *(describe)*					
High BP					
Kidney Problems *(describe)*					
Liver Problems *(describe)*					
Lung Problems					
Migraine					
Psychiatric Problems *(describe)*					
Seizures					
Thyroid Problems					
Ulcer					
Other					

CLIENT HISTORY (PAGE 2)

CLIENT NAME _____ DATE_____

2. Have you ever had surgery? _____ Yes _____ No
   Type and Date: _____
   _____
   _____
   _____
3. Do you smoke cigarettes/cigar/chew? _____ Yes _____ No
   If yes, Amt: _____ Day/Week/Month (circle one)
4. Did you ever smoke? _____ Yes _____ No When did you quit? _____
   How long did you smoke? _____
5. Do you drink beer, distilled spirits or wine? _____ Yes _____ No
   If yes, Amt: _____ Week/Month/Year (circle one)
6. Female: Are you pregnant? _____ Yes _____ No Could you possibly are pregnant? _____ Yes _____ No Are you Breast-Feeding? _____ Yes _____ No
7. Have you ever been on a diet program before? _____ Yes _____ No
   What program? _____ When: _____
   Were medications prescribed? _____ Yes _____ No
   If yes, what medications? _____
8. Are you currently taking any Over-The-Counter diet medication, and if so, what? _____
   _____
9. Have you Gained/Lost more than 15lbs. in the last year? _____ Yes _____ No
   If yes, how many lbs _____ Gained _____Lost
10. How did you hear about our program? _____
11. Do you take Over-The-Counter medications? _____ Yes _____ No
    If yes, please complete the following:

CONDITIONS	MEDICATION	HOW OFTEN
Allergies		
Colds		
Headaches		
Insomnia		
Pain (where?)		
Other		

Client Signature: _____

Staff Signature: _____