**WEIGH TO HEALTH**
**Weight Loss Clinic**
Cindy Stephens DNP, RN, FNP-BC.
Family Nurse Practitioner
1340-L Patton Avenue
Asheville NC 28806

# PATIENT MEDICAL HISTORY FORM

## PLEASE PRINT AND BRING WITH YOU, DO NOT EMAIL DUE TO HIPPA REGULATIONS

(PLEASE PRINT CLEARLY AND USE REVERSE SIDE IF MORE SPACE IS NEEDED)

NAME:_____ DOB:_____

ADDRESS: CITY STATE ZIP

_____ _____ _____ _____

PRIMARY PHONE CELL WORK PHONE EXT

_____ _____ _____ _____

EMAIL ADDRESS MAYWE CONTACT YOU BY: ☐ MAIL ☐ TELEPHONE ☐ E-MAIL.

_____

FEMALES: ARE YOU PREGNANT? ☐ YES ☐ No ☐ MAYBE DATE OF LAST MENSTRUAL PERIOD:

_____

ARE YOU BREASTFEEDING? ☐ YES ☐ No

MEDICATION HISTORY: LIST THE CURRENT MEDICATIONS YOU ARE TAKING:

_____

_____

ALLERGIES'. ANY ALLERGY TO MEDICATIONS? PLEASE LIST:

_____

OTHER ALLERGIES (FOOD, POLLEN, ETC.):

_____

YOUR MEDICAL HISTORY:

| | YES | NO | | YES | NO | | YES | No |
|---|---|---|---|---|---|---|---|---|
| CANCER | | | DIABETES | | | HEART ATTACK | | |
| ANGINA | | | HIGH BLOOD PRESSURE | | | STROKE | | |
| HIGH CHOLESTEROL | | | HIGH TRIGLYCERIDES | | | EXERCISE RESTRICTIONS | | |
| SEVERE DEPRESSION | | | POLYCYSTIC OVARIES | | | DRUG ABUSE | | |
| ANOREXIA | | | BULIMIA | | | THYROID DISEASE | | |
| TESTICULAR CANCER | | | PROSTATE CANCER | | | BREAST CANCER | | |
| OVARIAN CANCER | | | ENDOMETRIOSIS | | | REACTION TO DIET PILLS | | |
| GLAUCOMA | | | NARCOLEPSY | | | HIV | | |
| HEPATITIS C | | | AGITATED STATES | | | | | |

**ARE YOU CURRENTLY UNDER TREATMENT BY A PHYSICIAN?** ☐ **YES** ☐ **No** Name: _____

IF YES, BRIEFLY EXPLAIN _____

_____

**HEIGHT** _____

**WEIGHT HISTORY**

1. WHEN DID YOUR WEIGHT PROBLEM BEGIN? _____
2. IS ANYONE IN YOUR FAMILY OVERWEIGHT? _____ WHO? _____
3. DO YOU CRAVE CERTAIN FOODS? _____ WHAT AND WHEN? _____

   _____
4. DO YOU FEEL YOU ARE A COMPULSIVE OVEREATER? _____
5. DID YOUR WEIGHT PROBLEM BEGIN ☐ AFTER MENOPAUSE □ PREGNANCY □ TUBAL LIGATION ☐ HYSTERECTOMY ☐ AGE 40?
6. DOES ANYONE IN YOUR FAMILY SUFFER FROM ☐ OBESITY ☐ THYROID ☐ CUSHING'S ☐ HEART DISEASE (HIGH BLOOD PRESSURE, STROKE) ☐ DIABETES

**HOW WERE YOU REFERRED TO WEIGH TO HEALTH**? ☐ Magazine Ad ☐ Internet ☐ Word of Mouth

☐ Other: _____

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**I certify the above statements to be true and I consent to treatment by Dr. Stephens and her staff**.

_____ _____

Signed Date

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# Patient Information Form

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

Name you prefer to be called:

_____

Employment Information:

Patient Employer:_____ Occupation _____

Employer Address:_____

City:_____State:_____Zip:_____

Work phone number:_____Ext._____

In Case of Emergency

Name:_____ Relationship: _____Phone:_____

Patient's Spouse:_____ Phone: _____

Family Physician: _____Phone:_____

Referred by:_____

**Financial Policy**

Thank you for selecting Dr. Stephens and the WEIGH TO HEALTH Weight Loss Clinic for your health care needs. We are honored to be of service to you.

**This is to inform you that payment for all services is due at the time the services are rendered. We prefer cash, debit cards and Visa & MasterCard credit cards rather than checks. We do not participate with any insurance program nor do we file insurance claims. If you wish to file a claim with your insurance provider, we will be happy to provide you with a copy of a bill which you can file. We require 24 hour cancellation in advance to avoid a missed appointment charge.**

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I understand that if I do not pay in full at the time of a visit, I will not be seen again until my balance is paid in full and for all future visits, I will be required to pay prior to being seen.

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

_____ _____

Patient's Date

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## INFORMED CONSENT FOR MEDICAL TREATMENT

I (please print) _____ hereby request, consent to, and authorize the **WEIGH TO HEALTH** weight Loss Clinic, supervised by Dr. Cindy Stephens, Dr. Rebecca A. Clemenzi, or a **WEIGH TO HEALTH** provider to provide me with drug and hormone therapy. The following has been communicated to me in language that I understand: the nature of the treatment, the risks of treatment, possible complications, expected benefits or effect of the treatment including:

### Anorectics (Diet Pills)

Diet pills are used to decrease appetite and decrease cravings. Possible side effects include dry mouth, constipation, insomnia, headaches, nervousness, stomach pain, increased sweating, acne, hair loss and menstrual irregularity, erectile dysfunction, irregular heart beat (arrhythmia) fast heart rate, elevation in blood pressure. Patients with the following medical conditions may be ineligible for the diet pill and are more likely to experience negative or even fatal side effects from diet pills: coronary artery disease, history of stroke or heart attack, history of a stent placement, history of heart arrhythmias (irregular heart beat), uncontrolled blood pressure, hyperthyroidism, history of drug abuse, history of sensitivity to stimulant drugs, narrow angle or closed angle glaucoma, agitated states, uncontrolled bipolar disorder, schizophrenia, severe depression, use of monoamine oxidase inhibitors within the last 14 days. I understand that I cannot take the following substances with a diet pill: alcohol, any stimulant drug used for ADD, memory loss or narcolepsy, over the counter diet pills and any other prescription diet pills.

### HCG Injection

The HCG injection is used for its effect on loss of inches, appetite suppression, and sense of well-being. There have been no studies done on long-term side effects from this hormone. Possible side effects while taking the hormone include: menstrual irregularities, breast tenderness, especially in patients who have fibrocystic breasts, ovarian pain in patients with a history of polycystic ovaries and acne. Patients with the following medical conditions may be ineligible for the HCG injection and are more likely to experience negative side effects from the hormone: history of testicular cancer, ovarian cancer, endometrial (uterine) cancer, breast cancer, prostate cancer, and history of blood clots or a clotting disorder.

Patients undergoing therapy at the WEIGH TO HEALTH Weight Loss Clinic must undergo regular medical checkups to evaluate for side effects of treatment.

The final decision for or against therapy will be made by the doctor; therapy may be stopped at any time if medical complications occur or if I fail to participate in the plan of care. I have read the previous information and I understand it. Any questions which may have occurred to me have been answered to my satisfaction. I have listed any and all of the above conditions that apply to me on my patient history form.

_____ _____

Patient Date

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## Patient Acknowledgement of Notice of Privacy Practices

I understand that the WEIGH TO HEALTH Weight Loss Clinic is committed to treating and using protected health information about me responsibly.

I understand that my health record is the physical and legal property of the WEIGH TO HEALTH Weight Loss Clinic, but the information belongs to me. I have access to inspect, amend or obtain a copy of my health information. Cost may incur for copies of my records.

I understand that the WEIGH TO HEALTH Weight Loss Clinic is required to maintain the privacy of my health information. The WEIGH TO HEALTH Weight Loss Clinic will require my authorization to release my health information to outside sources with the exception of disclosures for purposes of treatment, payment, and healthcare operations within the structure of the WEIGH TO HEALTH Weight Loss Clinic. These may be allowed access to my health information: WEIGH TO HEALTH Weight Loss Clinic staff and providers and, in addition, business associates of WEIGH TO HEALTH Weight Loss Clinic may, from time to time, have access to my health information, but I am assured that proper Business Associates Agreements are in place, insuring the protection of my health information. Upon the providers best judgment, he or she may disclose to a family member, relative or close personal friend or other person he or she identifies, health information relevant to that person's involvement in my care and he or she may notify these individuals of my location and general condition. My health information may be used for research data, public health or legal authorities and/or law enforcement purposes which include, but is not limited to, reporting a crime, responding to a court order or responding to other legal process. I understand you will release my health information if required by law to do so. You may disclose my health information when you are complying with legally required health oversight activities, such as audits and inspections, necessary to ensure compliance with government regulations and laws. You may disclose my information when you believe in good faith that such disclosure is necessary to prevent a serious threat to my safety. The WEIGH TO HEALTH Weight Loss Clinic may call me with appointment reminders, cancellations and may leave voice mail messages about these or other matters about my health information at my home or place of employment.
I have read and understand the above,

_____
Patient

_____
Date

_____
Witness