Patient Information Form

Patient Name: (Last)______________________________(First)____________________________(MI)___

Name you prefer to be called: ____

Patient Address: ____

City: ____ State: _______________ Zip: ________________

Home Phone: ____________________________________Cellular: ___________________________

Email Address: ____

Birthdate: _______________________________________Age: _________Sex: M F

Employment Information:

Patient Employer: ________________________________ Occupation: ______________________________

Employer Address: ____

City: ____ State: _______________ Zip: ________________

Work phone No: ___________________________________Ext. _____________________________________

In Case of Emergency:

Name: ___________________________________Relationship: _______________ Phone: ______________

Family Physician: ____ Phone: ______________

How did you hear about us? ____

Financial Policy:

Thank you for selecting Dr. Spurlock and PhySlim for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard and cash.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

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

____ ____

Patient's Signature Date

Medical History

1. Are you in good health at the present time to the best of your knowledge? Yes No
   Explain a "no" answer:

2. Are you under a doctor's care at the present time? Yes No
   If yes, for what?

3. Are you taking any medications at the present time? Yes No

Prescription Drugs:
Drug: Dosage:

Over-the-Counter medications, vitamins, etc.:
Product: Dosage:

4. Any allergies to any medications? Yes No
   Please list:

5. History of High Blood Pressure? Yes No

6. History of Diabetes? Yes No
   At what age: _____________

7. History of Heart Attack or Chest Pain or other heart condition? Yes No

8. History of Swelling Feet Yes No

9. History of Frequent Headaches? Yes No
   Migraines? Yes No Medications for Headaches: _____________________________

10. History of Constipation (difficulty in bowel movements)? Yes No

11. History of Glaucoma? Yes No

12. History of Sleep Apnea? Yes No

13. Gynecologic History:
    To your knowledge, are you currently pregnant? Yes No
    Pregnancies: Number: ________________ Dates: ____________________________

14. Serious Injuries: Yes No
    Specify (list all) Date

15. Any Surgery: Yes No

Specify: (List all) Date

16. Family History:

	Age	Health	Disease	Cause of Death	Overweight?
Father:					
Mother:					
Brothers:					
Sisters:					

Past Medical History: (check all that apply)

_______ Polio
_______ Jaundice
_______ Kidneys
_______ Lung Disease
_______ Rheumatic Fever
_______ Ulcers
_______ Anemia
_______ Tuberculosis
_______ Drug Abuse
_______ Pneumonia
_______ Cholera
_______ Arthritis
_______ Measles
_______ Mumps
_______ Scarlet Fever
_______ Whooping Cough
_______ Bleeding Disorder
_______ Gout
_______ Heart Valve Disorder
_______ Gallbladder Disorder
_______ Eating Disorder
_______ Malaria
_______ Cancer
_______ Osteoporosis
_______ Tonsillitis
_______ Pleurisy
_______ Liver Disease
_______ Chicken Pox
_______ Nervous Breakdown
_______ Thyroid Disease
_______ Heart Disease
_______ Psychiatric Illness
_______ Alcohol Abuse
_______ Typhoid Fever
_______ Blood Transfusion
_______ Other: _______________

Diet History

1. Present Weight: _____________ Height (no shoes): ______________ Desired Weight: _____________
2. In what time frame would you like to be at your desired weight? _______________________________
3. Weight at 20 years of age: ___________ Weight one year ago: _____________
4. What is the main reason for your decision to lose weight? _____________________________________

5. When did you begin gaining excess weight? (Give reasons, if known): ________________________

____

6. What has been your maximum lifetime weight (non-pregnant) and when? ______________________

7. Previous diets you have followed: Give dates and results of your weight loss:

8. Is your spouse, fiancée or partner overweight? Yes No

9. By how much is he or she overweight? ____

10. How often do you eat out? ____

11. What restaurants do you frequent? ____

12. How often do you eat "fast foods?" ____

13. Who plans meals? ___________________ Cooks? ___________________ Shops? _____________

14. Do you use a shopping list? Yes No

15. What time of day and on what day do you usually shop for groceries? ________________________

16. Food allergies: ____

17. Food dislikes: ____

18. Food(s) you crave: ____

19. Any specific time of the day or month do you crave food? __________________________________

20. Do you drink coffee or tea? Yes No How much daily? ___________

21. Do you drink cola drinks? Yes No How much daily? ___________

22. Do you drink alcohol? Yes No

What? ____________________ How much daily? ___________________ Weekly? _____________

23. Do you awaken hungry during the night? Yes No

What do you do? ____

24. What are your worst food habits? ____

25. Snack Habits:

What? ______________________ How much? _____________________ When? _________________

______________________ _____________________ _________________

26. When you are under a stressful situation at work or family related, do you tend to eat more? Explain:

____

____

27. Do you think you are currently undergoing a stressful situation or an emotional upset? Explain:

____

____

28. Typical Breakfast | Typical Lunch | Typical Dinner

Typical Breakfast	Typical Lunch	Typical Dinner
________________________	_____________________	_________________________
________________________	_____________________	_________________________
________________________	_____________________	_________________________
________________________	_____________________	_________________________

29. Activity Level: **(answer only one)**

____Inactive—no regular physical activity with a sit-down job.
____Light activity—no organized physical activity during leisure time.
____Moderate activity—occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
____Heavy activity—consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week..
____Vigorous activity—participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

30. Please describe your general health goals and improvements you wish to make: _________________

____

____

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.

Weight Loss Program Consent Form

I ______________________________________ authorize Dr. Spurlock, PhySlim LLC, and whomever they designate as their assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

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 obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

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 to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Date: ___________________________________ **Time:** ___________________________________

Patient: _________________________________
(Or person with authority to consent for patient)