Patient's Name_____ M F Age _____

Birth-date_____ E-mail address_____

Address_____

City_____ State_____ Zip Code_____

Cell Phone Number_____ Cell Phone Carrier_____

(We send auto text reminders)

May we leave a detailed message at this number? _____

How did you hear about us? Friend Web Site Facebook

Yellow Pages Newsletter Groupon

Person to notify in case of an emergency:

_____ Phone_____

We keep a record of the health care services we provide you. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may ask to see your record or get more information by contacting this office.

Our Notice of Privacy Practices describes in more detail how your health information may be used or disclosed and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Patient (Print first and last name) Date of Birth

_____ _____

Patient or legally authorized individual Date

_____ _____

Printed name if signed on behalf of patient Relationship to Patient

OFFICE STAFF ONLY: A Pro _____ Master List _____ Nwsltr ____

Patient's Name_____ M F Age _____

Family Physician _____

Date of last Physical Exam: _____

Present Health Status:

Are you in good health to the best of your knowledge? Yes No

Are you under a doctor's care at the present time? Yes No

If yes, for what? _____

Are you taking any medications at the present time?

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Medication: _____ Dose: _____

Health History:

History of High Blood Pressure? Yes No

History of Diabetes? Yes No

At what age? _____

History of Heart Attack or Chest Pain? Yes No

History of swelling feet? Yes No

History of frequent Headaches? Yes No

History of Migraines? Yes No

Medication prescribed for headaches: _____

History of Constipation or difficulty with Bowel Movements? Yes No

History of Glaucoma? Yes No

Serious Injuries? Yes No

Specify: _____ Date: ____

Surgical Procedures? Yes No

Specify: _____ Date: ____

Specify: _____ Date: ____

Specify: _____ Date: ____

Gynecologic History:

Pregnancies Number: _____ Dates: _____

Natural Delivery of C-Section (specific): _____

Hormone Replacement Therapy? Yes No

Birth Control Pills? Yes No

Type: _____

Family History:

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

Please tell us about any blood relative who has had any of the following:

Glaucoma Who: _____

Asthma Who: _____

High Blood Pressure Who: _____

Kidney Disease Who: _____

Diabetes Who: _____

Tuberculosis Who: _____

Psychiatric Disorder Who: _____

Heart Disease/Stroke Who: _____

Past Medical History (Please check all that apply)

_____ Polio	_____ Measles	_____ Tonsillitis
_____ Jaundice	_____ Mumps	_____ Pleurisy
_____ Kidneys	_____ Scarlet Fever	_____ Liver Disease
_____ Lung Disease	_____ Whooping Cough	_____ Chicken Pox
_____ Rheumatic Fever	_____ Bleeding Disorder	_____ Nervous Breakdown

_____ Ulcers
_____ Anemia
_____ Tuberculosis
_____ Drug Addiction
_____ Pneumonia
_____ Cholera
_____ Arthritis
_____ Gout
_____ Heart Valve Disorder
_____ Gallbladder Disorder
_____ Disordered Eating
_____ Malaria
_____ Cancer
_____ Osteoporosis
_____ Thyroid Disease
_____ Heart Disease
_____ Psychiatric Illness
_____ Alcohol Addiction
_____ Typhoid Fever
_____ Blood Transfusion
_____ Other: _____

Nutritional Evaluation:

Present Weight: _____ Height (no shoes): _____ Desired Weight _____

In what time frame would you like to be at your desired weight? _____

Birth Weight: _____ Weight at 20 years of age: _____ Weight one year ago: _____

What is the main reason for your decision to lose weight? _____

When did you being gaining excess weight? Give reasons, if knowns. _____

_____

What has been your maximum lifetime weight (non-pregnant) and when? _____

Previous diets you have followed: Dates and results of your weight loss:

_____ _____

_____ _____

Is your spouse, fiancé or partner overweight? Yes _____ No _____

By how much is he or she overweight? _____

How often do you eat out? _____

What restaurants do you frequent? _____

Do you eat “fast food?” _____

Who plans meals? _____ Cooks? _____ Shops? _____

Do you use a shopping list? Yes _____ No _____

What time of day and on what day do you shop for groceries? _____

Food Allergies: _____

Food dislikes: _____

Food you crave: _____

Any specific time of the day or month you crave specific foods? _____

Do you drink coffee or tea? _____Yes _____ No How much daily? _____

Do you drink soft drinks? _____ Yes _____ No How much daily? _____

Do you drink alcohol? _____ Yes _____ No How much daily? _____

What? _____ How much? _____ How much weekly? _____

Do you use a sugar substitute? _____ Butter? _____ Margarine? _____

Do you awaken hungry during the night? _____ Yes _____ No

What are your worst food habits? _____

Snack Habits:

What? _____ How much? _____ When? _____

_____ _____ _____

When you are under a stressful situation, work or family related, do you tend to eat more?

_____

_____

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

_____

_____

Smoking Habits (Select one please)

_____ You have never smoked cigarettes, cigars or a pipe.

_____ You quit smoking _____ years ago and have not smoked since.

_____ You have quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke.

_____ You currently smoke _____ cigarettes per day.

Typical Breakfast	Typical Lunch	Typical Dinner
_____	_____	_____
_____	_____	_____
_____	_____	_____
Time eaten: _____	Time eaten: _____	Time eaten: _____
Where: _____	Where: _____	Where: _____
With whom: _____	With whom: _____	With whom: _____

Describe your usual energy level: _____

Activity Level: (Please select one)

____ Inactive: no regular 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.

Behavior Style: (Please select one)

_____ You are always calm and easygoing.

____ You are usually calm and easygoing.

____ You are sometimes calm with frequent impatience.

____ You are seldom calm and persistently driving for advancement.

____ You are never calm and have overwhelming ambition.

____ You are hard-driving and can never relax.

Please describe your general health goals and improvements you wish to make: _____

_____

_____

_____

Thank you for your time and patience in completing this form. The information provided will assist us in assessing you background and establishing your medical management.

Madsen Medical Spa - Patient Informed Consent for Appetite Suppressants

I. Procedure And Alternatives:

1. I, _____ (patient or patient's guardian) authorize Dr. Paul Madsen, M.D. to assist me in my weight reduction efforts. I understand my treatment may involve, but not be 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.

2. I have read and understand my doctor's statements that follow:

"Medications, including the appetite suppressants, have labeling worked out between the makers 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 dosages indicated in the labeling.

"As a bariatric physician, I have found the appetite suppressants helpful for periods far in excess of 12 weeks, and at times in larger doses than those suggested in the labeling. As a physician, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer term studies and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses.

"Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted be-low).

"As a bariatric physician, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses. However, you must decide if you are willing to accept the risks of side effects, even if they might be serious, for the possible help the appetite suppressants use in this manner may give."

3. I understand it is my responsibility to follow the 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 will notify the physician if I am taking any anti-depressant medications.

4. 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.

5. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an exchange eating program without the use of the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

II. Risks of Proposed Treatment:

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks and in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heart beat and heart

irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

III. Risks Associated with Being Overweight or Obese:

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

IV. No Guarantees:

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 I will have to continue watching my weight all of my life if I am to be successful.

V. Patient's Consent:

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, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

WARNING

IF YOU HAVE ANY QUESTIONS AS TO 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: _____ WITNESS: _____

(or person with authority to consent for patient)

VI. PHYSICIAN DECLARATION:

I have explained the contents of this document to the patient and have answered all the patient's related questions, and, 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 of continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving the appetite suppressants in the manner indicated above.

_____

Physician's Signature

Madsen Medical Spa - Weight Loss Program Consent Form

I _____ authorize Dr. Paul Madsen , M.D. 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 concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Date: _____ Time: _____

Witness: _____ Patient's signature:_____

(Or person with authority to consent for patient)