DOCTORS DIET PROGRAM Rx
OF BOWLING GREEN, KY

1220 Ashley Circle
Bowling Green, KY 42104
(270) 780-9333

Patient Information

Date: _____

*Last Name: _____ *First: _____ *MI: _____

*Social Security #_____-_____- _____ **(OR)** *Driver's License #_____

*Date Of Birth: _____/_____/_____ * Street Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: (_____) _____ Cell #: (_____) _____

Work #: (_____) _____ E-mail Address: _____

We sometimes need to call you regarding your care, please circle the # we should use to call you or leave a message during the day.

Employer: _____ Employer's Address: _____

Spouse's Name: _____ Spouse's Day #:_____

Spouse's Employer: _____ Spouse's Work #:_____

Nearest Relative **Not** living with you: _____

Address: _____City:_____ State: _____ Zip: _____

Home Telephone: (_____) _____ Work #: (_____) _____

How did you hear about us?

Please check:
Newspaper _____ Radio _____Television _____Mailing _____Radio _____Internet _____Co-worker _____Friend

Patient History

*Last Name: _____ *First: _____ *MI: _____

*Date of Birth: _____/_____/_____ Today's Date: _____/_____/_____

Chief Health Complaints: 1.)_____

2.) _____

Please use back if necessary

Regular Medications, Vitamins, or Herbal Supplements (please state the purpose for each):

_____

_____

Name and City of Primary Physician: _____

Do you currently have or have you ever had:

Diabetes	Y	N	Parkinson's Disorder	Y	N
Heart Attack	Y	N	Depression / Psychiatric problem	Y	N
Stroke	Y	N	Hepatitis / Liver Disease	Y	N
Heart Rhythm Disease	Y	N	Kidney Disease / Gallstones	Y	N
Thyroid Disorder	Y	N	Seizures	Y	N
Alcoholism/Alcohol Abuse	Y	N	Glaucoma	Y	N
Recreational Drug Use	Y	N	Surgeries (In or Out Patient)	Y	N

Do you smoke? Y N Packs per Day: _____ Do you Drink? Y N Frequency: _____

Have you ever been told to limit your exercise for medical reasons? Y N

If Yes to ANY of the above please explain:

_____

_____

Please use back if necessary

Any current medical problems? Y N If yes, please list: _____

Any drug allergies? Y N If yes, please list: _____

Any food allergies? Y N If yes, please list: _____

Please use back of this page if needed

Family History

Please check all that apply.

Health Problems	Family Member
Overweight	Mother_____ Father_____ Brother_____ Sister_____
Heart Disease	Mother_____ Father_____ Brother_____ Sister_____
High Blood Pressure	Mother_____ Father_____ Brother_____ Sister_____
High Cholesterol	Mother_____ Father_____ Brother_____ Sister_____
Parkinson's disease	Mother_____ Father_____ Brother_____ Sister_____
Sleep Apnea	Mother_____ Father_____ Brother_____ Sister_____
Stroke	Mother_____ Father_____ Brother_____ Sister_____
Thyroid Disorder	Mother_____ Father_____ Brother_____ Sister_____
Type 2 Diabetes	Mother_____ Father_____ Brother_____ Sister_____

Other diseases: _____

CONSENT OF TREATMENT (FEMALE ONLY)

I understand that Phentermine and other anorectic medications should not be taken during pregnancy, due to the chance of damage to the fetus. The medications have been explained to me fully and I am aware of the risks involved.

To the best of my knowledge, I am not pregnant. I am aware of the precautions that should be taken to avoid pregnancy while I am on the medication. If I become pregnant, I will advise The Doctor's Diet Program and my OB/GYN immediately.

Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Patient Informed Consent for Appetite Suppressants

I. Procedure And Alternatives

1.) I, _____ (patient or guardian) authorize Dr. Rick Welch and/or his associates to assist me in my weight reduction and maintenance efforts. I understand my treatment may involve, but is not limited to, the use of appetite suppressants for more than 12 weeks and when indicated in higher doses than the dose indicated on the 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 mentioned, and 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, 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 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 a bariatric physician, I believe the probability of side effects is outweighed by the benefits of the use 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 that it is my responsibility to follow the instructions carefully and to report to my any significant medical problems that may be related to my weight control program as soon as possible.

4.) I understand my continuing to receive appetite suppressants will depend on my progress in weight reduction and weight maintenance.

5.) I understand there are alternative ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, balanced calorie counting program or an exchange eating program without the use of the appetite suppressants would likely prove successful if followed, even though I would probably be hungrier without the use of 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, high blood pressure, rapid heartbeat and heart irregularities. These and other possible risks such as primary pulmonary hypertension

could on occasion, be serious or fatal. I understand that appetite suppressants should not be used while pregnant or while seeking to become pregnant and that all sexually active women should use some appropriate method of birth control when using appetite suppressants.

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, heart attack heart disease, and arthritis. 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.

V. No Refunds

I understand that fees are paid at the time of service or in advance. I also understand that fees are not refundable.

VI. No Primary Care

I understand that Dr. Welch and/or his associates are treating me ONLY for my weight problem. They are not responsible for the diagnosis and/or treatment of any other medical conditions

VII. **Patient's Consent**

I have read the following and truly 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 this treatment 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 the risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

WARNING!

If you have any questions regarding this program, ask PRIOR to signing this form.

Patient / Guardian Signature:_____ Date:_____

VIII. PHYSICIAN DECLARATION:

I have explained the contents of this document to the patient and have answered all the patient's questions, and, to the best of my knowledge, feel the patient has been adequately informed concerning the benefits and risks associated in the use of the appetite suppressants as well as the alternative programs and risks of continuing in an overweight state. The patient has consented to therapy involving the appetite suppressants in the manner indicated above.

Physician's signature:_____ Date: _____