DOCTORS DIET PROGRAM RX
OF BOWLING GREEN, KY

2424 Airway Drive
Bowling Green, KY 42103
(270) 780-9333
Fax (270) 780-0455
www.DoctorsDietofKY.com

Patient Information

Date: _____/_____/_____

Last Name: _____ First Name: _____ M.I._____

Social Security #: _____(or) Driver's License #_____

Date of Birth_____/_____/_____ Age: _____ Gender: ☐ Male ☐ Female

Address: _____City: _____State: _____ Zip: _____

Home Phone: (_____) _____Cell Phone: (_____) _____

Work Phone: (_____) _____E-Mail: _____

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: _____Occupation: _____

Employer Address: _____City: _____State: _____ Zip: _____

Emergency Contact: _____Relationship: _____Phone: _____

Name of Spouse: _____Phone: _____

Family Physician: _____Phone: _____

Thank you for selecting Doctor's Diet Program 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 of services rendered. For your convenience, we accept cash, Visa, Mastercard and Discover. Fees are **non-refundable**.

How did you hear about us?

Please check:

Newspaper_____ Radio____ Television_____ Mailing____ Internet_____ Co-Worker___ Friend_____

New Patient Medical History Form

Name_____D.O.B._____

Medical History

Past medical history (check all that apply):

☐ Heart attack ☐ Angina ☐ Gall bladder stones ☐ Sleep apnea
☐ High blood pressure ☐ Stroke ☐ Indigestion/reflux ☐ Thyroid
☐ High cholesterol ☐ Diabetes ☐ Celiac disease ☐ Anxiety
☐ High triglycerides ☐ Gout ☐ Pancreatitis ☐ Depression
☐ Infertility ☐ Polycystic Ovarian Syndrome
☐ Cancer (type/s): _____

Have you ever been diagnosed with an eating disorder? ☐ Y ☐ N If yes, which one? _____

Past surgical history (check all that apply):

☐ Gastric bypass ☐ Gastric banding ☐ Gastric sleeve ☐ Gall bladder ☐ Heart bypass
☐ Hysterectomy ☐ Other: _____

Comments: _____

Medications: (list all current medications and dosages):

_____ _____ _____ _____

_____ _____ _____ _____

Allergies:

Medications: _____

Food: _____

Comments: _____

Social History

Smoking: ☐ Never ☐ Current smoker (_____ packs/day) ☐ Past smoker (quit _____ years ago)

Alcohol: ☐ Never ☐ Occasional ☐ Regularly (_____ drinks per day)

Prior treatment for alcoholism? ☐ Y ☐ N

Drugs: ☐ Never ☐ Current ☐ Past ☐ Type of drugs: _____

Marijuana: ☐ Never ☐ Current user (_____ times/day)

Comments: _____

Family History

Obesity (check all that apply): ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Diabetes (check all that apply): ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Other: (check all that apply):

☐ High blood pressure ☐ Heart disease ☐ High cholesterol
☐ High triglycerides ☐ Stroke ☐ Thyroid problems ☐ Anxiety ☐ Depression
☐ Bipolar disorder ☐ Alcoholism ☐ Cancer (type/s): _____
☐ Other: _____

Comments: _____

New Patient Medical History Form

Name_____D.O.B._____

Weight History

When did you become overweight?

☐ Childhood ☐ Teens ☐ Adulthood ☐ Pregnancy ☐ Menopause

Did you ever gain more than 20 pounds in less than 3 months? Y / N If so, how long ago? _____

As you can remember, how much did you weigh one year ago? _____ Five years ago? _____ 10 years? _____

Triggers for your weight gain (check all that apply):

☐ Stress ☐ Marriage ☐ Divorce ☐ Illness ☐ Medication abuse ☐ Travel ☐ Injury
☐ Nightshift work ☐ Insomnia ☐ Quitting (circle all that apply): Smoking / Alcohol / Drugs

Previous weight-loss programs (check all that apply):

☐ Weight Watchers ☐ Nutrisystem ☐ Jenny Craig ☐ LA Weight Loss ☐ Atkins
☐ South Beach ☐ Zone diet ☐ Medifast ☐ Dash diet ☐ Paleo diet
☐ HCG diet ☐ Mediterranean diet ☐ Ornish diet ☐ Other: _____

What was your maximum weight loss? _____
What are your greatest challenges with dieting? _____
_____

Have you ever taken medication to lose weight? (check all that apply):

☐ Phentermine (Adipex) ☐ Meridia ☐ Xenecal/Alli ☐ Phen/Fen
☐ Phendimetrazine (Bontril) ☐ Topamax ☐ Saxenda ☐ Diethylpropion
☐ Bupropion (Wellbutrin) ☐ Belviq ☐ Qsymia ☐ Contrave

Other: _____

What worked? _____

What didn't work? _____

Why or why not? _____

Nutritional History

How often do you eat breakfast? _____ days per week at _____ a.m.
Number of times you eat per day: _____
Do you get up at night to eat? Y / N If so, how often? _____ times
Daily servings of: _____ Vegetables _____ Fruits _____ Meat _____ Dairy
Sweet beverages (check all that apply):

☐ Soda ☐ Juice ☐ Sweet tea ☐ Coffee/tea If so, how many times per day? _____

Number of times per week you eat fast food: _____ Breakfast _____ Lunch _____ Dinner
Eating triggers (check all that apply):

☐ Stress ☐ Boredom ☐ Anger ☐ Seeking Reward ☐ Parties ☐ Eating Out
☐ Fast Food ☐ Other: _____

Food cravings:

☐ Sugar ☐ Chocolate ☐ Starches ☐ Salty ☐ High Fat ☐ Large Portions

Favorite foods: _____

Comments: _____

New Patient Medical History Form

Name_____D.O.B._____

Gynecologic History (Women Only)

Age periods started _____ Age periods ended _____ Last Mammogram: ___/____/____ ☐ Unknown

Periods are: Regular / Irregular Heavy / Normal / Light Last GYN exam: ___/____/____ ☐ Unknown

Number of pregnancies: ___ Number of children: ___ Age at first pregnancy: ___ Age at last pregnancy: ____

System Review

(Check all that apply)

☐ Recent weight loss more than 10 pounds ☐ Recent weight gain more than 10 pounds

☐ Acne	☐ Skin rash	☐ Cough
☐ Snoring	☐ Shortness of breath	☐ Chest pain
☐ Difficulty breathing when flat	☐ Fainting/Blacking out	☐ Palpitations
☐ Swelling ankles/extremities	☐ Abdominal pain	☐ Bloating
☐ Constipation	☐ Diarrhea	☐ Food intolerance
☐ Dysphagia/difficulty swallowing	☐ Indigestion	☐ Nausea/vomiting
☐ Increased appetite	☐ Decreased appetite	☐ Heartburn
☐ Gas and bloating	☐ Urinary frequency/urgency	☐ Slow urine flow
☐ Nighttime urination	☐ Loss of urine control	☐ Blood in stools
☐ Back pain (upper)	☐ Back pain (lower)	☐ Joint pain
☐ Muscle aches/pain	☐ Dizziness	☐ Headaches
☐ Seizures	☐ Weakness/low energy	☐ Anxiety
☐ Depression	☐ Insomnia	☐ Memory loss
☐ Inability to concentrate	☐ Mood changes	☐ Nervousness
☐ Loss of interest	☐ Cold intolerance	☐ Excessive sweating
☐ Hair changes	☐ Heat intolerance	☐ Blood clots
☐ Fatigue/tiredness		

Comments: _____

(Men only)

☐ Difficulty with erections ☐ Loss of interest in sex ☐ Low testosterone

Last PSA: ____/_____/____ ☐ Unknown

Comments: _____

(Women only)

☐ Absence of periods	☐ Hot flashes	☐ Change in bladder habits
☐ Abnormal/excessive menstruation	☐ Facial hair	☐ Loss of interest in sex
☐ Difficulty getting pregnant		

Comments: _____

Activity:

Exercise type: _____

Duration: _____ hours _____ minutes Number of times per week: _____

What prevents you from exercising? _____

How many hours do you sleep per night? _____ How many times do you get up during the night? _____

Do you feel rested upon awakening? _____

Comments: _____

History of Patient Reviewed by: _____

DOCTORS DIET PROGRAM Rx
OF BOWLING GREEN, KY

2424 Airway Drive
Bowling Green, KY 42103
(270) 780-9333
Fax (270) 780-0455
www.DoctorsDietofKY.com

Weight Loss Program Consent Form

I, _____, authorize Dr. Richard Welch and associated health care providers, 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 on behavior modification techniques, and may involve the use of anti-obesity medications. Other treatment options may include a very low-calorie diet or a protein-supplemented diet. I further understand that if medications are used, they have been used safely and successfully in private medical practices with experienced obesity medicine specialists 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 having excess weight or obesity. Risks of this program are usually temporary, reversible, and may include but are not limited to nervousness, sleeplessness, headaches, electrolyte abnormalities, dry mouth, gastrointestinal disturbances, weakness, fatigue, pancreatitis, psychological problems, gallstones, high blood pressure, rapid or slowing of the heartbeat and heart irregularities, and risk of weight regain. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are 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 over time.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees that the program will be successful. I also understand that obesity is a chronic, lifelong condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

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.

I have read and fully understand this consent form and it has been fully explained to me. My questions have been answered to my complete satisfaction.

_____ _____

Patient's Name (printed) Witness

_____ _____

Patient Signature Date

(or signature of person with authority to consent for patient)

DOCTORS DIET PROGRAM RX
OF BOWLING GREEN, KY

2424 Airway Drive
Bowling Green, KY 42103
(270) 780-9333
Fax (270) 780-0455
www.DoctorsDietofKY.com

Control Medications Rules for use of Anti-Obesity

NOTE: SIGNING THIS FORM DOES NOT GUARANTEE THAT YOUR PROVIDER(S) AT DOCTOR'S DIET PROGRAM WILL FIND YOU TO BE AN APPROPRIATE CANDIDATE FOR ANTI-OBESITY MEDICATIONS, BUT ONLY THAT YOU HAVE READ, UNDERSTOOD, AND AGREE TO THE TERMS OF MEDICATION USAGE SHOULD YOU AND DR. RICHARD WELCH DECIDE UPON THEIR USAGE NOW OR IN THE FUTURE.

Many anti-obesity medications are considered "controlled medications." By law, a controlled medication can only be prescribed from one facility at a time; therefore, I agree that only Doctor's Diet Program will prescribe anti-obesity medications for me. I agree that it is my responsibility to inform my physician(s) at Doctor's Diet Program and any other providers from whom I receive treatment of all medications prescribed to me. **I understand that the use of anti-obesity medications is contra-indicated with certain medical histories, allergies, or other medication use**. I agree that I will be completely honest in disclosing this information and will notify my physician(s) at Doctor's Diet Program of any changes to my medical history or medication usage. I understand that failure to do so can be dangerous to my health.

I agree to take the medication only as prescribed and directed by Dr. Richard Welch. I understand that taking medications in any way other than as directed and prescribed could affect my health and be dangerous. I also understand that medications are typically considered after a trial of failed weight loss with only nutritional/behavior modifications. If I am deemed a candidate for the medication program at Doctor's Diet Program, I am aware that the lowest effective dosage will be tried prior to increasing dosages.

I will not share, sell, or trade my medication with anyone. I understand that doing so is illegal and will result in my discharge from the care of Doctor's Diet Program.

I understand that the use of some of the anti-obesity medications beyond 12 weeks is considered "off label" or not initially approved by the U.S. Food and Drug Administration (FDA). I understand that my physician(s) at Doctor's Diet Program are experienced specialist(s) in obesity medicine who will, at times, elect/choose, when indicated, to use the anti-obesity medication(s) for longer periods of time as deemed appropriate for my individual treatment.

I understand that I am to report any side effects or adverse reactions of my medications to the physician(s) at Doctor's Diet Program.

I understand that it is my responsibility to follow the instructions carefully and that the purpose of this treatment is to assist me in my desire to decrease my body weight for improvement of health and to maintain weight loss. I understand that the purpose of medications for weight loss is to be used as an adjunct to a program that includes nutrition and/or physical activity and/or behavior modification.

I agree that my physician(s) at Doctor's Diet Program may sometimes taper and/or stop my medication to evaluate its effect on my weight loss and/or hunger and health.

I understand that much of the success of the program will depend on my efforts and that there are **NO GUARANTEES** in medical treatment in the disease of obesity. I also understand that I will have to continue monitoring my weight after active weight loss.

Patient Signature: _____ Date: _____

DOCTORS DIET PROGRAM RX
OF BOWLING GREEN, KY

2424 Airway Drive
Bowling Green, KY 42103
(270) 780-9333
Fax (270) 780-0455
www.DoctorsDietofKY.com

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.

Patient Signature: _____Date: _____

Provider Signature: _____Date: _____

Patient's Consent

I have read and truly understand the consent forms 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, please ask **PRIOR** to signing this form.

Patient/Guardian Signature_____ Date: _____

Physician's 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: _____