MetaMorphosis MD
Patient Intake Forms

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

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Cellular: _____

Birthdate: _____**Age:** _____Sex: M F

EMAIL ADDRESS :_____

Education: Elementary High School/Tech School 2-yr College 4-yr College Grad. School (Circle Highest Level)

Employment Information:

Patient Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip_____

Work phone No: _____Ext. _____

In Case of Emergency:

Name: _____Relationship: _____ Phone:_____

Family Physician: _____ Phone:_____

Referred by: _____

PAST MEDICAL HISTORY:

☐Hypertension ☐Overweight or Obese ☐Gastrointestinal Issues_____

☐Diabetes, Type_____ ☐High Cholesterol ☐Kidney Disease_____

☐ Sleep Apnea ☐Allergies ☐Insomnia

☐Heart Disease, Heart Attack ☐ Depression or Anxiety

☐Cancer, Type and treatments_____

Other Past Medical History:_____

OTHER PAST HISTORY (Please check if you have had any of the following):

☐ Allergies, Type: _____ ☐ Birth defects or abnormalities

☐ Exposed to tuberculosis ☐ Measles ☐

☐ Influenza ☐ Mumps ☐ Diphtheria ☐ Rheumatic]

☐ Fever German Measles (3 day) ☐ Polio ☐ Whooping Cough

☐ Frequent Colds ☐ Chickenpox ☐ Tonsillitis

☐ Scarlet Fever ☐ Pneumonia

PAST SURGERIES:(dates) _____

_____

Current Medications (and vitamins, birth control pills):_____

_____

_____

Allergies to medicines, foods, etc_____

Family History:

Father: Health _____ Age _____ Deceased _____ at age _____ Cause _____

Mother: Health _____ Age _____ Deceased _____ at age _____ Cause _____

# of siblings:_____ # living_____ #deceased: _____ Cause _____

Family Diseases: Check diseases known in your blood relatives (not yourself)

☐ High blood pressure	☐ Allergy	☐ Heart trouble	☐ Anemia
☐ Migraine	☐ Bleeding (abnormal)	☐ Dropsy	☐ Epilepsy
☐ Strokes	☐ Cancer	☐ Diabetes	☐ Nervous breakdown
☐ Kidney disease	☐ Syphilis or (bad blood)	☐ Suicide	☐ **Obesity**
☐ Arthritis	☐ Rheumatic	☐ Fever	

Examinations:

Date of last physical examination _____ Reason:_____

Hospitalizations _____ Dates _____ Reason:_____

X-Rays: Chest _____Stomach _____ Gallbladder _____ Kidney _____Colon _____

Other _____Date of last laboratory tests:_____

_____

Do you now have or have had any of the following?

☐ Itching ☐ Eczema ☐ Hives ☐ Joint pains ☐ Muscle aches

☐ Arthritis ☐ Limitation of motion ☐ Backache ☐ Leg pains ☐ Heel Pains

☐ Pain or stiffness (neck) ☐ Goiter ☐ Swelling, enlarged glands

☐ Asthma ☐ Lung disease ☐ Raise sputum ☐ Emphysema Bronchitis

☐ Heart trouble ☐ High blood pressure ☐ Shortness of breath ☐ Palpitation or fluttering

☐ Chest pain☐ Lips or nails turn blue ☐ Tire easily ☐ Swelling of ankles

☐ Indigestion ☐ Nausea or vomiting ☐ Abdominal pain ☐ Gas or bloating ☐ Diarrhea

☐ Hard bowel movements No. of bowel movements - daily _____ ☐ Colitis

☐ Jaundice ☐ Hemorrhoids (piles) ☐ Bleeding or black stools ☐ Hernia

☐ Urinary System ☐ Kidney disease ☐ Bladder disease ☐ Kidney stones

☐ Painful urination ☐ Pus or blood in urine ☐ Albumen or sugar in urine

☐ Dribbling of urine ☐ Varicose veins ☐ Nervousness or anxiety

☐ Trouble sleeping ☐ Headaches ☐ Bored or depressed

☐ Nervous breakdown

☐ Fainting ☐ Convulsions ☐ Numbness

☐ Loss of consciousness ☐ Neuritis or Neuralgia ☐ Paralysis

☐Other Review of Systems_____

Menstrual History:

Menstruation began at age:_____28 day cycle? _____ If no, how many days? _____

Duration of bleeding:_____Pain with periods?_____

Amount of flow : Light _____ Med. _____Heavy _____

Date of 1st day of last: _____menstrual period:_____

Bleeding between periods:_____Bleeding after intercourse:_____

Irritation or discharge:_____Itching or burning_____

Weight History:

When did you first become overweight? (your age then)_____(year)

_____

How did your weight gain start? Describe any circumstances: _____

_____

What do you think is the cause of your weight problem:_____

_____

Your present weight: _____ your weight goal: _____height: _____

What was your highest weight? (excluding pregnancy) _____your age then _____# of years ago:_

What was your lowest weight? _____your age then _____# of years ago:_____

Have you ever stayed the same weight for 10 years or more? Yes/ No

Have you attempted to lose weight before? _____ most lbs lost:_____how long it took:_____

Describe previous methods of weight loss (e.g. diets, pills, injections, hypnosis, acupuncture) and describe your results:_____

_____

Where and when do you do most of your overeating?_____

_____

How many meals do you eat a day? _____ How many times do you snack a day? _____How many times a week do you eat out? _____What foods do you eat when snacking?

_____

_____

HOW MOTIVATED ARE YOU TO LOSE WEIGHT NOW? (1- NONE, 10 – VERY MOTIVATED)

_____

Do you currently have any medical concerns? Please List:_____

Weight Questionnaire:

1.What personal goals do you hope to achieve as a part of your weight loss program?

__ Weight loss through diet change
__ Weight loss through increased exercise
__ Improved health through increased exercise
__ Improved health through diet change
__ Improved knowledge about exercise
__ Improved knowledge about nutrition
__ Improved knowledge about exercise
__ Other: _____

2.Complete the following statement: "In general, my overall health is..."

__ Excellent
__ Very good
__ Good
__ Fair
__ Poor

3. During the last 7 days, on how many days were you physically active for a total of at least 30-60 minutes per day?

__ 0 days
__ 1 days
__ 2 days
__ 3 days
__ 4 days
__ 5 days
__ 6 days
__ 7 days

4.On an average day, how many hours do you watch TV, play video games, or spend on a computer for reasons unrelated to work?

__ I do not watch TV, play video games, or spend extra time on the computer on an average day
__ 1 hour per day
__ 2 hours per day
__ 3 hours per day
__ 4 hours per day
__ 5 or more hours per day

5. During the past 7 days, how many times did you eat fruit or drink 100% fruit juice?

__ I did not eat fruit during the past 7 days
__ 1-3 times during the past 7 days
__ 4-6 times during the past 7 days
__ 1 time per day
__ 2 times per day
__ 3 times per day
__ 4 or more times per day

6.During the past 7 days, how many times did you eat vegetables?

__ I did not eat vegetables during the past 7 days
__ 1-3 times during the past 7 days
__ 4-6 times during the past 7 days
__ 1 time per day
__ 2 times per day
__ 3 times per day
__ 4 or more times per day

7. During the past 7 days, how many times did you drink soda or pop such as Coke, Pepsi, or Sprite (including diet sodas)?

__ I did not drink soda during the past 7 days
__ 1-3 times during the past 7 days
__ 4-6 times during the past 7 days
__ 1 time per day
__ 2 times per day
__ 3 times per day
__ 4 or more times per day

8. During the past 7 days, how many times did you consume milk, yogurt, or cheese?

__ I did not consume these during the past 7 days
__ 1-3 times during the past 7 days
__ 4-6 times during the past 7 days
__ 1 time per day
__ 2 times per day
__ 3 times per day
__ 4 or more times per day

What beverage are you most likely to drink?

__ Water
__ Milk
__ Soda or pop (diet included)
__ Kool Aid, Fruit Punch, or juice drink
__ Energy/sport drink (Gatorade, Red Bull, etc)
__ 100% fruit juice
__ Wine, beer, or some other alcoholic Beverage

10.In the past 7 days, how many times have you had a snack or meal at a fast food restaurant?

__ I have not eaten at a fast food restaurant in the past 7 days
__ 1-3 times in the past 7 days
__ 4-6 times in the past 7 days
__ 7 or more times in the past 7 days

11 Please rate your knowledge of nutritional needs

__ Not knowledgeable
__ Somewhat knowledgeable
__ Knowledgeable
__ Very knowledgeable

12. Please rate your knowledge of exercise/physical activity needs

__ Not knowledgeable
__ Somewhat knowledgeable
__ Knowledgeable
__ Very knowledgeable

13. In the past 7 days, how many meals did you skip?

__ 1 meal
__ 2 meals
__ 3 meals
__ 4 meals
__ 5 meals
__ 6 meals
__ 7+ meals

14.How would you describe your weight?

__ Very underweight
__ Slightly underweight
__ About the right weight
__ Slightly overweight
__ Very overweight

15.Please rate your knowledge of your health:

__ Not knowledgeable
__ Somewhat knowledgeable
__ Knowledgeable
__ Very knowledgeable

16. Questions/Comments

_____
_____
_____
_____
_____
_____
_____
_____

_____
_____
_____
_____

Medical Weight Management
Weight History

I.Food Issues
(please check each statement if true most of the time)
__ I eat the wrong things
__ I eat for comfort when stressed
__ I am hungry most of the time
__ I do not eat an unusual amount
__Other (please specify) _____
_____

II.Exercise
(please check each statement if true)
__ I have been athletic in the past, but I am no longer
__ I have joint and/or pain problems that limit my exercise
__ I regularly exercise now
__ Realistically, I do not have time to exercise
__ Other (please specify) _____
_____

III.Psychological Concerns
(please check each statement if true most of the time)
__ I overeat for stress relief and emotional comfort
__ I am depressed about my weight
__ I have been a victim of abuse, and this affects my weight
__ I feel discouraged and/or hopeless about my weight
__ Other (please specify) _____
_____

IV. Medical Complications
(please check each statement if true most of the time)
__ I sleep less than 7 hours a night
__ I feel unrefreshed and tired during the day despite sleeping
__I snore at night
__ My metabolism or thyroid function is probably abnormal

__ I occasionally binge and purge
__ I am very concerned about diabetes and heart disease
__ Other (please specify) _____
_____

V.Current or Previous Medical Issues
(please check each condition you either previously had
or currently have)
__ Heart trouble
__ Stroke
__ High blood pressure
__ Diabetes (I, II)
__ Seizures
__ Glaucoma
__ Stomach acid
__ Headaches
__ Gall stones
__ Severe depression
__ Manic/bipolar
__ Obesity in the family
__ Tired/fatigue
__ Tobacco use (please specify type and
amount) _____
__ Alcohol use (please specify type and
amount) _____
__ Other (please specify) _____

VI.Current Medications
(please check each med
you are currently taking)
__ Hormones
__ Birth control pills
__ Steroids
__ Water pills
__ Blood pressure medications
__ Antidepressants, Lithium, MAOI, or any
other psychiatric medication
__ Other
(please include vitamins and
herbals _____
_____
_____

VII.Miscellaneous Medication Information
(please check all that apply)
__ Have you ever taken thyroid medication?
__ Have you ever gained weight with
certain medications such as :
__Paxil
__Zoloft
__Lexapro
__ other
__ Have you lost weight with prescription
appetite suppressants from a doctor?
__ Are you allergic to any medications? ___

VIII.Female Patient History
(If you are a female, please complete sections I and II)
I.Please initial, indicating you understand and agree with the following statements:
__ I am not pregnant. I understand that
weight control and weight reducing diets and medication must be stopped
immediately at any sign of pregnancy.
__ I will notify this office if I become pregnant.
__ I understand breast and pelvic exams need to be done on a regular
basis, but these exams are not part of my treatment at this clinic. I am
responsible for obtaining these exams through my family physician or gynecologist.

II.Please check all that apply:
__ Have you ever had a breast operation?
__ Has a doctor diagnosed fibrocystic disease in your breast?
__ Do you examine your breasts monthly?
__ Do you have regular breast exams by your doctor?
__ Have you had a mammogram?
__ Do you have pain in your breasts?
__ Discharge from a nipple?
__ Recent change in breast size or shape?
__ Definite lump in breast?
__ Vaguely lumpy breasts?
__ Are you still menstruating?
__ Are your periods at regular monthly intervals?
__ Do your periods cause you to be puffy and retain fluids?
__ Do you have painful menstrual cramps?
__ Do you have PMS (premenstrual tension syndrome)?
__ Are you on birth control pills?
__ Do you use methods of birth control regularly?

Clinic Procedures

Please initial, indicating that you understand and agree with the following statements. Then sign below.

If under the age of twenty one (21), a parent or guardian must also sign.

_____ The number of patients we see each day is limited and by appointment only. Missed appointments cause additional expense and inconvenience to other patients. Please notify us twenty four (24) hours in advance if you are unable to keep your appointment.

_____ Most health insurance companies do not provide coverage for the treatment of obesity. Therefore, MetaMorphosis MD does not take any form of payment from third party companies and all services must be paid for at the time services are rendered by cash, debit or credit card (VISA, Mastercard only).

_____ I understand any treatments rendered are solely for the purpose of weight control. The diagnosis and treatment of other illnesses and disease are not the responsibility of this clinic. If I become ill, I should contact my personal physician or visit an urgent care facility. If I become ill, I will discontinue any diet or medication from this clinic until it is determined safe to resume the weight control program. (Please call if uncertain)

_____ If my treatment included the prescription of appetite suppressant medication, I will carefully follow the instruction given, notify the doctor of any change in my medical history (especially heart or blood pressure problems) and not resell the medication nor will I share it with any friend or family member, ever. I will not visit other doctors for the purpose of obtaining additional or duplicate medication of the same type.

Patient's signature: _____

Date: ___/___/_____

Guardian's signature (if applicable): _____

Date: ___/___/_____

Weight Loss Professional's signature: _____

Date: ___/___/_____

Patient Informed Consent to Use Appetite Suppressants

Please carefully read the following statements. On the next page, please sign indicating that you
understand and adhere to these policies and procedures.

I.Procedures and Alternatives

_____ I have read and understand the following statements:

1.All prescription medications, including appetite suppressants, have labeling approved by the Food and Drug Administration (FDA). This labeling found on most appetite suppressants is based upon medical studies of less than twelve weeks using the dosages indicated on the labels.

2.Notwithstanding such labeling, I understand that my physician,, based upon his experience, the experience of his colleagues and other factors, may recommend the use of such medications for a period of time or at doses in excess of those recommended by
the manufacturer's label. I further understand that such usage may not have been as systematically studied as that suggested by the labeling, and it is possible, as with many other medications, that serious side effects could occur.

3.After consulting my physician, I believe that the probability of such side effects is outweighed by the potential benefit of the appetite suppressants being prescribed and/or provided to me, not withstanding the fact that the dosage and/or term may exceed those recommended by the manufacturer.

_____ I understand that it is my responsibility to follow my physician's instructions carefully and to report any medical problems immediately, regardless of whether I think that they may be related to my weight loss control program. I further affirm that I am not now pregnant and will
report any pregnancy to my physician immediately.

_____ I understand that there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain my weight loss. In particular, a balanced diet combined with physical exercise is recommended, with or without the use of appetite suppressants. I understand that a program including a revised diet and physical exercise could prove

successful without appetite suppressants if I followed it, even though I may be hungrier than if I used the appetite suppressants.

II.Risks of Proposed Treatment

_____ I understand that this authorization is given to me with the knowledge that the use of appetite suppressants poses various risks, including, but not limited to, pulmonary hypertension, nervousness, sleeplessness, headaches, dry mouth, weakness, fatigue, psychological problems, medical allergies, high blood pressure, rapid heart beat and heart irregularities. These and other possible risks could occasionally be serious or even fatal.

III. Risks Associated With Being Overweight or Obese

_____ I understand that remaining overweight or obese poses certain risks, including tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis, and certain cancers. I understand that these risks may be modest if I am not very overweight, but that these risks increase significantly with any weight gain.

IV. No Guarantees

_____ I understand that much of the success of this program will depend on my efforts. Notwithstanding my efforts, I understand 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 my life if I am to be successful long term.

V. Patient's Consent

_____ I have read and fully understood this consent form, that attached Weight Loss Consumers Bill of Rights (see page 5 of this document), and I have had all concerns addressed by the physician. Moreover, I have been informed by my physician of the nature, risks, possible alternative treatments, possible consequences and possible complications involved in the use of appetite suppressants for the treatment of obesity and for weight loss. Nevertheless, I authorize my physician to administer the treatment to me.

Patient's signature: _____

Date: ___/___/_____

Guardian's signature (if applicable): _____

Date: ___/___/_____

Weight Loss Professional's signature: _____

Date: ___/___/_____

FINANCIAL POLICY AT METAMORPHOSIS MD

Thank you for selecting MetaMorphosis MD for your weight management. We are honored to be of service to you. 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.

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

All Statements on this patient intake form are accurate and true to the best of my knowledge. I understand that treatments will be based on the information provided herein. If I willingly withhold knowledge from my treating physician, I accept full liability from any consequences arising there from.

Patient's Signature Date

LAB CONSENT

PLEASE INITIAL ONE OF THE FOLLOWING:

_____I have received lab within one year and will bring a copy before my next visit to have filed in my records at MetaMorphosis MD.

_____I have not had lab drawn within one year but will schedule an appointment with my primary care physician to have these lab tests performed. I will bring a copy of this lab as soon as possible to be filed in my records.

_____I am 35 years old or younger and I have no history of any medical illnesses. I do not have medical insurance so I decline to have lab tests taken at this time. I understand the risks and accept responsibility for any medical problems, including fatal illnesses, that may arise from taking any weight loss supplements.

_____

Patient's Signature and Date