Patient Name: _____ **DOB:** _____ **Today's Date:**_____

VENTURE MEDICAL WEIGHT LOSS

PATIENT INTAKE FORMS

FOR THE INITIAL APPOINTMENT OR AFTER A 2-YR GAP

Information that is collected contributes to the treatment for obesity according to the Obesity Algorithm recommended by the Obesity Society and that is required to be collected it by the government of commonwealth of Kentucky

PATIENT INFORMATION (Please Print) **Today's Date: _____**

Name: _____ DOB: _____Please Circle: M / F

(Last) (First) (MI) mm/dd/yyyy

Address_____

City_____ State _____ Zip Code_____

Social Security #_____

(needed for Government required review and reporting of Prescriptions of Controlled Substances to

KASPER = KY All Controlled Substance Patient Electronic Record)

Phone# (mobile) (_____)-_____-_____

E-mail:_____

Do you currently have a PCP (Primary Health Care Provider?) YES / NO

Primary Care Provider: _____ Phone#_____

(We will discuss your health with your Primary Care Provider if necessary and required by law)

Emergency contact Name: _____

Relation: _____ Contact number: _____

(We will contact your Emergency contact if necessary in case of an emergency)

What is your occupation?

……

Patient Name: _____ **DOB:** _____ **Today's Date:**_____

Intake-Weight History:

1. What is the least have you weighed (16 years or older)?.....lbs
2. What is the most have you weighed (16 years or older)?.....lbs
3. What was your greatest amount of weight loss, and what strategies did you use to lose weight at that time?

   ……
4. After losing weight in the past, were you able to maintain it? Keep it off? YES NO
5. If you maintain your weight? How long before you regained weight? _____
6. How long have you been at your current weight? (within +/- 10 lbs) _____
7. At what ages have you been overweight? (*check all that apply*)

   ☐ Childhood (under 12 years old)
   ☐ Adolescence (12 to 18 years old)
   ☐ Early adulthood (18 to 40 years old)
   ☐ Middle adulthood (40 to 65 years old)
   ☐ Late adulthood (65 years and older)
8. What do you think was the cause of your weight gain? (*check all that apply*)

   ☐ Genetics
   ☐ Unhealthy diet
   ☐ Not enough physical activity
   ☐ Pregnancy
   ☐ Medical Problem
   ☐ Menopause
   ☐ Quitting smoking
   ☐ Medications
   ☐ Depression/grief/stress
   ☐ I don't know
9. What are your concerns about excess weight?

   ☐ Self-esteem
   ☐ Body-image
   ☐ Poor Health
   ☐ Relationships

   Other Concerns: ……..
10. What methods have you tried to lose weight in the past: (*check all that apply*)

    ☐ Nothing
    ☐ Keeping track of food
    ☐ Counting calories
    ☐ Exercise
    ☐ Specific eating plans (Atkins/keto, South Beach, etc)
    ☐ Other …….
    ☐ Commercial diet programs (Jenny Craig/Weight Watchers, etc)
    ☐ Working with a registered dietitian
    ☐ Weight-loss medication
    ☐ Weight-loss surgery
11. What are your barriers to losing weight and/or keeping it off?

    ☐ Lack of time
    ☐ Family commitments
    ☐ Work commitments
    ☐ Weather
    ☐ Illness/Injury
    ☐ Boredom
    ☐ Life-events
    ☐ Lack of consistency

12. How may we help you manage your weight and eating habits? (*check all that apply*)

- ☐ Diet and nutrition education
- ☐ Portion control education
- ☐ Meal planning education
- ☐ Stress-induced eating education
- ☐ Binge-eating education
- ☐ Food preparation education

13. Are you interested in any of the following treatment options? (*check all that apply*)

- ☐ Weight-loss handouts/books
- ☐ Weight-loss websites
- ☐ Commercial weight-loss programs
- ☐ Registered dietitian consultation
- ☐ Health psychologist consultation
- ☐ Weight-loss medication (oral)
- ☐ Weight-loss medication (injections)
- ☐ Bariatric surgery
- ☐ I am not ready at this time

Intake-Weight loss goals:

What goal weight would you consider yourself to be healthy : _____ lbs.

How long do you think is reasonable to achieve your goal weight:_____ months _____ years

How would you rate your ability (can) and motivation (want) today to lose weight by the following methods?

Behavioral Modifications: (keeping food diary/app, change eating times, reduce tobacco/alcohol, sleep better)	0	1	2	3	4	5	6	7	8	9	10
Follow Exercise Prescription:	0	1	2	3	4	5	6	7	8	9	10
Follow a Diet Prescription:	0	1	2	3	4	5	6	7	8	9	10
Take Weight-Loss medications:	0	1	2	3	4	5	6	7	8	9	10
Undergo Weight-Loss Surgery:	0	1	2	3	4	5	6	7	8	9	10

Are you having any of the following difficulties that you would like to discuss strategies for?

- ☐ 1.Diabetes/Prediabetes
- ☐ 2.Eating Healthy
- ☐ 3.Controlling Portions
- ☐ 4.Lowerings Carbs/Hidden Sugars
- ☐ 5.Increasing Proteins
- ☐ 6.Being Active/Find Time for Fitness
- ☐ 7.Tracking Food Intake
- ☐ 8.Maximizing Mobility/Minimizing Injury
- ☐ 9.Mental Health/Managing Stress
- ☐ 10.Sleeping Better
- ☐ 11.Getting Back on Track
- ☐ 12.Manage Anxiety/Negative Thinking
- ☐ 13.Reading Food Labels
- ☐ 14.Hydration
- ☐ 15.Eat Healthy Enjoyable Food
- ☐ 16.Add Fiber to Food
- ☐ 17.Lower Salt Intake
- ☐ 18.Making Healthy Meals
- ☐ 19.Cardio and Strength
- ☐ 20.When Weight Loss Stalls/Plateaus
- ☐ 21.Balancing work/home life
- ☐ 22.Anything else? (write below

Intake 3-Medication History:

1. Please carefully examine the following rather long list of the brand names and generic names of **medications which can cause weight gain**. Please let us know if you take any of the following medications and we may be able to suggest an alternative choice. (***circle all that apply***)

Neuroleptics:	Thioridazine, haloperidol, olanzapine, quetiapine, risperidone, clozapine
Antidiabetic agents:	Insulin, sulfonylureas, thiazolidinediones, Pioglitazone, Actos, Glipizide Glyburide, Glimepiride, Chlorpropamide, Tolbutamide, Glucotrol, Glucotrol XL, Diabeta, Micronase, Glynase, Amaryl, Diabinese
Steroid hormones:	Glucocorticoids, progestational steroids, and oral contraceptive pills
Tricyclic antidepressants:	Amitriptyline, nortriptyline, imipramine, doxepin, Elavil, Endep, Vanatrip Doxepin,Trimipramine
Other Neurologic medications:	Adapin, Dilenor, Sinequan, Tofranil, Aventyl, Pamelor, Surmontil, Remeron, Lithium, Eskalith, Eskalith, Lithobid, HaloperidoL, Loxapine, Clozapine, Chlorpromazine, Fluphenazine, Risperidone, Olanzapine, Quetiapine, Oxilapine, Clozaril, FazaClo, Thorazine, Risperdal, Zyprexa, Seroquel
Monoamine oxidase inhibitors:	Phenelzine
Selective serotonin reuptake inhibitors (SSRIs):	Paroxetine Sertraline, Fluvoxamine, Zoloft, Paxil, Pexeva, Luvox
Other antidepressants:	Mirtazapine, duloxetine
Anticonvulsants:	Valproate, carbamazepine, gabapentin, pregabalin, vigabatrin, Depakote, Depakene, Stavzor, Carbatrol, Epitol, Equetro, Tegretol, Horizant, Neurontin
Antihistamines:	Cyproheptadine, Diphenhydramine, Aler-Dryl, Benadryl, Diphenhist, Nytol, Siladryl, Silphen, Sominex, Unisom
Beta-blockers/alpha-blockers:	Propranolol, doxazosin, Atenolol, Metoprolol, Inderal, InnoPran, Pronol, Lopressor, Toprol, Tenormin

2. For your safety and treatment in a weight loss program that could utilize controlled substances such as Phentermine (Adipex), Laws of the commonwealth of KY require obtaining a medication review report (KASPER) for each patient. This report contains all controlled substances that are prescribed to you within the past year. Patients are also required to undergo random drug screening when in the program. Please report for **ANY and ALL medications** you are **CURRENTLY prescribed** or **have been prescribed in the PAST YEAR** (past 12 months). Please also report any other controlled substances in use (Mariuana, Cocaine, CBD, Delta-9, or others). Testing positive on a drug screening test does not necessarily preclude you from treatment of obesity. When in doubt about a medication whether it is controlled or not, the best strategy is to report it. **As required we routinely check for a history of ALL controlled substance medications in KY and other states, including CBD**

products, please do not forget to list every possible controlled substance.

Medications (list all medications that you take, prescribed, OTC, vitamins, natural supplements)

Medication	Reason for taking	Dosage	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

☐ **I do not take any medications** _____

Patient signature

3. Have you taken any weight loss medications before today? NO / YES **(if yes fill out below)**
4. When was the last time you took weight loss medications? _____

Medication Name	Dosage	Lost Weight?	List Side effects, if any
_____	_____	NO / YES	_____
_____	_____	NO / YES	_____
_____	_____	NO / YES	_____

5. Are you allergic to any medications? (e.g. penicillin) or Do you have no known drug allergies?

_____

Patient Name: _____ **DOB:** _____ **Today's Date:**_____

Intake 4-Comprehensive Social History:

A. Safety:

Because we care for the safety of all our patients, we ask you the following questions from the Guidelines of United States Preventive Services Task Force: Please consider your living situation and respond below.

1. Within the last year, have you been humiliated or emotionally abused in other ways by anyone? YES NO
2. Within the last year, have you been afraid of anyone? YES NO
3. Within the last year, have you been raped or forced to have any sexual activity by anyone? YES NO
4. Within the last year, have you been kicked, hit, slapped or physically hurt by anyone? YES NO

Please know that this is a safe place to discuss any safety issues privately and confidently with our staff or physicians. We will try to help you in every way possible as the situation warrants.

B. Lifestyle and Behavioral History:

1. How often do you consume alcohol? _____drinks/day; _____x's/week or x's/month (enter zero "0" if you don't drink)
2. Do you use cocaine, marijuana or other drugs? YES NO If YES, what? _____
3. If you used to use cocaine, marijuana or other drugs, when did you quit? _____
4. If you consume alcohol, please respond to the following questions:
    a. Have you ever felt you ought to cut down on your drinking or drug use? YES NO
    b. Have people annoyed you by criticizing your drinking or drug use? YES NO
    c. Have you felt bad or guilty about your drinking or drug use? YES NO
    d. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)? YES NO
5. Do you smoke cigarettes or Vape? YES NO If yes, how much per day? _____
6. If YES, do you wish to quit smoking? YES NO If yes, what have you tried?

    _____
7. If you used to smoke, when did you quit? _____

C. Dieting History and Eating Habits:

1. Are you an emotional or stress eater? YES / NO
2. Which emotions trigger eating for you? (e.g. sadness, happiness, anger, etc.)_____
3. What is your current diet? (low/high calorie, low/high fat, low/high carbohydrate, mostly fast food, fried foods, vegetarian, vegan etc.)? _____
4. How many times per day do you eat? _____
5. Do you eat multiple small meals or a couple large meals each day? _____
6. Do you currently monitor your macronutrient intake (such as carbohydrates/fats/proteins)? YES / NO
7. Do you keep a food diary or use a Phone-based App ? YES / NO (If yes, which app do you use?)
8. Do you try weight loss diets or specialized diets YES NO

9. Do you engage in Excessive/compulsive exercise? YES NO
10. Do you find yourself Binge eating (spells of eating a lot of food at once)? YES NO
11. Do you or have you ever self-induced vomiting to reduce calories? YES NO
12. Have you tried laxative, diuretic, or over-the-counter diet pills to lose weight? YES NO
13. Have you ever chewed food and spit it out to lose weight? YES NO
14. Do you obsess with food cleanliness? YES NO
15. Do you feel overweight despite weight loss or low body weight? YES NO
16. Do you have any impulsive or irregular eating habits? YES NO
17. Have you ever used Insulin for weight loss? YES NO
18. Do you get distressed with feelings of disgust, depression, or guilt around food? YES NO
19. Please list what you typically eat and drink for meals and snacks. Please provide as much detail as you can. (*portion size, method of preparation, etc.*)

Meal	Food and beverages that I usually eat
Breakfast	
Snack	
Lunch	
Snack	
Dinner	
Snack	

20. Do you normally plan your meals and snacks? Circle NO or YES
21. Please check a box to tell us how often you eat or drink the following:

	Never	Once a week	Several times/week	Every day
Fast food				
Fruits and vegetables				
Any sugary drinks (soda, juice, sweet tea, sports drinks)				

Patient Name: _____ **DOB:** _____ **Today's Date:**_____

D. Physical Activity:

1. Restrictions: Have you ever had or currently have any exercise restrictions? YES NO
   (if yes, specify)_____
2. What is the most physically active thing you do in the course of the day? (examples may include walking as needed, walking the dog, stair climbing, house or yard work, exercising) _____
3. How do you spend your working day and leisure time? _____
   _____
4. What types of physical activity do you enjoy? How often do you do them?_____
   _____
5. How many hours of TV do you watch every day? How many hours are you at a computer or desk every day? _____
6. Are you currently exercising regularly? YES NO
7. If you answered yes consider the following questions:
   a. How many days per week do you exercise? _____
   b. How many minutes per exercise session? _____
   c. What type of activity do you engage in? _____
   d. What is the intensity of your exercise?
      Low (dog-walking), moderate (breaking sweat), or vigorous (huffing/puffing/out of breath
8. If answered NO consider the following questions:
   a. How do you feel about/what are your thoughts on initiating/are you ready to initiate physical activity?
      _____
   b. What are the barriers to initiating physical activity for you (i.e., access to gym, access to a safe environment, injuries, or physical limitations)? _____
   c. What are the benefits of physical activity for you? _____
   d. Describe your previous experiences with exercise? _____
   e. Do you have any negative feelings about exercise or had any bad experiences with exercise?
      _____
   f. Do you have a support system to encourage you to exercise or exercise with you? YES NO
   g. Realistically how much time are you able to commit to exercise? _____

E. Sleep:

1. What time do you usually go to bed? _____
2. What time do you usually wake up in the morning? _____
3. Do you fall asleep within 30 minutes of lying on the bed? YES NO
4. How many times do you wake up at night? _____
5. What is the reason you wake up at night? _____

6. Do you feel well rested in the morning? YES NO
7. How many times have you used sleep aids in the past month? _____
8. Do you snore? (loud enough to be heard through closed doors) YES NO
9. Has your bed partner witnessed you stop breathing during sleep? YES NO
10. Would you fall asleep riding as a passenger in a car for up to an hour? YES NO
11. Do you feel tired during the day? YES NO

E. Stress:

Use a scale of 0 = never; 1 = rarely; 2 = few times; 3 = many times; 4 = very often;

_____ 1. In the last month, how often have you felt that you were unable to control the important things in your life?

_____ 2. In the last month, how often have you felt confident about your ability to handle your personal problems?

_____ 3. In the last month, how often have you felt that things were going your way?

_____ 4. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
Trouble concentrating on things such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
Thinking that you would be better off dead or that you want to hurt yourself in some way				
Totals				

If you checked off any problem on the above chart, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult	Somewhat Difficult	Very Difficult	Extremely Difficult
0	1	2	3

Patient Name: _____ **DOB:** _____ **Today's Date:**_____

Intake 5 -Medical and Surgical History:

A. Review of Systems:

Please check if you have been diagnosed with or have experienced any of the following symptoms

SKIN

- ☐ Rashes
- ☐ Itching
- ☐ Change in hair or nails

HEAD

- ☐ Headaches
- ☐ Head injury

EYES

- ☐ Glasses or contacts
- ☐ Change in vision
- ☐ Eye pain
- ☐ Double vision
- ☐ Flashing lights
- ☐ Glaucoma/Cataracts
- ☐ Yellowing of the Eyes

EARS

- ☐ Change in hearing Ear pain
- ☐ Ear discharge
- ☐ Ringing
- ☐ Dizziness

NOSE/SINUSES

- ☐ Nose bleeds
- ☐ Nasal stuffiness
- ☐ Frequent colds

ALLERGIES

- ☐ Hives
- ☐ Swelling of lips or tongue
- ☐ Hay fever
- ☐ Asthma
- ☐ Eczema/Sensitive
- ☐ Sensitivity to drugs, food, pollens, or dander

MOUTH/THROAT

- ☐ Bleeding gums
- ☐ Sore tongue
- ☐ Sore throat
- ☐ Hoarseness

NECK

- ☐ Lumps
- ☐ Swollen glands
- ☐ Goiter
- ☐ Stiffness

BREAST

- ☐ Lumps
- ☐ Pain
- ☐ Nipple discharge

RESPIRATORY/CARDIAC

- ☐ Shortness of breath
- ☐ Cough
- ☐ Production of phlegm, color
- ☐ Wheezing
- ☐ Coughing up blood
- ☐ Chest pain
- ☐ Fever
- ☐ Night sweats
- ☐ Swelling in hands/feet
- ☐ Blue fingers/toes
- ☐ High blood pressure
- ☐ Skipping heart beats
- ☐ Heart murmur
- ☐ Hx of heart Medication

- ☐ Bronchitis/emphysema
- ☐ Rheumatic heart disease

GASTROINTESTINAL

- ☐ Change of appetite orWeight
- ☐ Problems swallowing
- ☐ Nausea
- ☐ Heartburn
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Constipation
- ☐ Diarrhea
- ☐ Change in bowel habits
- ☐ Abdominal pain
- ☐ Excessive belching Excessive flatus
- ☐ Yellow color of skin (Jaundice)
- ☐ Hepatitis
- ☐ Food intolerance
- ☐ Rectal bleeding/Hemorrhoids

URINARY

- ☐ Difficulty in urination
- ☐ Pain or burning on urination
- ☐ Frequent urination at night
- ☐ Urgent need to urinate
- ☐ Incontinence of urine
- ☐ Dribbling
- ☐ Decreased urine stream
- ☐ Blood in urine
- ☐ UTI
- ☐ Stones
- ☐ Prostate enlargement
- ☐ Infection

PERIPHERAL VASCULAR

- ☐ Leg cramps
- ☐ Varicose veins
- ☐ Clots in veins

MUSCULOSKELETAL (BONEs & JOINTS)

- ☐ Pain
- ☐ Swelling
- ☐ Stiffness
- ☐ Decreased joint motion
- ☐ Broken bone
- ☐ Serious sprains
- ☐ Arthritis
- ☐ Gout

NEUROLOGIC

- ☐ Headaches
- ☐ Seizures
- ☐ Loss of Consciousness/Fainting
- ☐ Paralysis
- ☐ Weakness
- ☐ Loss of muscle size
- ☐ Muscle spasm
- ☐ Tremor
- ☐ Involuntary movement
- ☐ Incoordination
- ☐ Numbness
- ☐ Feeling of "pins and needles/tingles"

HEMATOLOGIC

- ☐ Anemia
- ☐ Easy bruising/bleeding
- ☐ Past Transfusions

ENDOCRINE

- ☐ Abnormal growth
- ☐ Increased appetite
- ☐ Increased thirst
- ☐ Increased urine production

- ☐ Thyroid trouble
- ☐ Heat/cold intolerance
- ☐ Excessive sweating
- ☐ Diabetes

PSYCHIATRIC

- ☐ Tension/Anxiety
- ☐ Depression/suicide ideation
- ☐ Memory problems
- ☐ Unusual problems
- ☐ Sleep problems
- ☐ Past treatment with Psychiatrist
- ☐ Change in mood/change in attitude towards family/friends

CANCERS OF ANY KIND?

- ☐ YES
- ☐ NO

ANY VITAMIN DEFICIENCIES?

- ☐ YES
- ☐ NO

ANYTHING NOT MENTIONED ABOVE?

- ☐ YES
- ☐ NO

B. SURGICAL HISTORY:

Have you had any surgeries before? If so, please elaborate:

- ☐ Heart _____
- ☐ Lungs _____
- ☐ Cancer _____
- ☐ Weight-Loss_____
- ☐ Hysterectomy_____
- ☐ Bones/Joints_____
- ☐ Other _____

C. Family History (Please Check if your 1st-DEGREE RELATIVES have any of the following conditions:

- ☐ Heart Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Hyperthyroidism
- ☐ High CholesterolHigh Blood Pressure
- ☐ Stroke
- ☐ Kidney disease
- ☐ Liver Disease
- ☐ Mental Illness
- ☐ Drug/ Alcohol Abuse

Please report any history of cancers in your family, particularly if GLP-1 Peptides are an option for your treatment: GLP-1 peptides may increase the risk that you will develop **tumors of the thyroid gland**, including medullary thyroid carcinoma (MTC; a type of thyroid cancer). Laboratory animals who were given semaglutide developed tumors, but **it is not known if this medication increases the risk of tumors in humans**. Tell your doctor if **you or anyone in your family** has or has ever had MTC or Multiple Endocrine Neoplasia syndrome type 2 (MEN 2; a condition that causes tumors in more than one gland in the body, such as thyroid, parathyroid, pancreas, adrenal glands). **If so, your doctor will tell you not to use a GLP-1 peptide injection.** If you experience any of the following symptoms, call your doctor immediately: **a lump or swelling in the neck; hoarseness; difficulty swallowing; or shortness of breath.**

D. GYNECOLOGICAL HISTORY:

For our WOMEN PATIENTS ONLY: A detailed Gynecological history is important in your weight loss journey. Remember, if you are trying to or become pregnant, you should not be taking any weight loss medications.

When taking many herbal supplements and medications (Rx or OTC) including appetite suppressants such as Phentermine, Topiramate, and others, pregnancy must be avoided as there could be 1% higher probability of teratogenic (fetal) effects such as cleft palate/lip than natural incidence. Many herbal supplements and some medications can also reduce the efficacy of Oral Contraceptive Pills, and a second method of preventing pregnancy (e.g. condoms) may become necessary.

1. Please circle appropriately if you are premenopausal postmenopausal perimenopausal
2. If not postmenopausal, when was your Last Menstrual Period? _____
3. Are your menstrual periods regular? **YES or NO (Circle one)**
4. Do you have heavy menstrual periods? **YES or NO (Circle one)**
5. Have you had any fertility problems? **YES or NO (Circle one)**
6. Ever diagnosed with PCOS (polycystic ovarian syndrome)? **YES or NO (Circle one)**
7. If yes, what treatment was or is being used? _____
8. Are you using any methods to prevent pregnancy? **YES or NO (Circle one)**
9. If yes, what method are you using? _____
10. If you delivered a baby recently, are you breastfeeding? **YES or NO (Circle one)**
11. How many children do you have, if any? _____
12. How many miscarriages have you had, if any? _____
13. Describe any complications of pregnancy, if any

    _____
14. Have you had Gestational Diabetes (GD)? **YES or NO (Circle one)**
15. If you had GD, how was it treated?

    _____
16. If you have had hysterectomy (removal of your uterus),

    have your ovaries been removed as well? **YES or NO (Circle one)**
17. Ever had a DEXA scan to screen for osteoporosis? **YES or NO (Circle one)**

E. Laboratory Work-up & ECG History:

In the Commonwealth of KY, ALL weight loss clinics are required to review patient labs at least once a year as part of your weight loss treatment. Additional labs may become necessary in the course of your treatment. Additionally, all New and Re-Starting patients who intend to be prescribed with a controlled substance (such as Phentermine) are also required to submit to a Drug Screening test according to KY law 201 KAR 9:260.

Labs must include the following, please check if any of them are performed within the last 6-12 months:

- ☐ CBC (Complete Blood Chemistry, no differential necessary),
- ☐ CMP (Complete Metabolic Panel),
- ☐ Hemoglobin A1C (HbA1C),
- ☐ Fasting Lipid Profile: **10-12 hour fasting required.** (Total cholesterol, LDL, HDL, VLDL, TG),
- ☐ Thyroid Profile (TSH, with or without T3/T4),
- ☐ Baseline Drug Test (Urine or Blood), **we must perform this when you are at the clinic**
- ☐ Patients who have undergone Bariatric Surgery must also obtain Vit. A, B1, B9, B12, D, E, Iron Studies, Mg, Zinc, Uric Acid.
- ☐ If you have certain medical conditions, an EKG and clearance from your Cardiologist may be necessary.

If you have had blood-work done elsewhere, please bring a copy of your lab results, or email it to us at Labs@VentureWeightLoss.com, or keep them ready by accessing MyChart for the doctor to see. We cannot accept photographs from your phone for lab results. Our patients get a substantial discount at Labcorp locations if prepaid at this office and we enter a lab order electronically for you. Labcorp makes the results available electronically to us as well as you via the patient portal. **Once you start treatment with us, we must be able to review your lab results before your second appointment to be able to continue your treatment.**

Informed Consent

(that means, you are giving us permission to treat you for weight loss after receiving all information and making a decision to seek treatment)

We want you to know that medical weight loss is an important medical decision in your health care. We are informing you through discussions and printed materials that we strive to work with you carefully and safely to help you achieve a medically significant weight loss. To help achieve this loss and help you in maintaining the weight loss long term, you must understand we may prescribe various different nutritional plans, exercise programs, and when appropriate use medicines short term and long term. You will be informed on how the medicines work, possible side effects, and know possible consequences of the medicines, dietary, and exercise activities planned. Sometimes the use of medicines, length of use of medicine, or medication dosing may be used in an "off label" manner. This means the doctor may be using the medicines safely in a manner other than initially approved by the FDA. The use of meds will always be within the scope of accepted medical Bariatric (weight loss) medicine. Please note that the use of medications for weight loss is optional, and no weight loss treatment (including use of medications) guarantees successful weight loss.

Your Role

1. Provide honest and complete answers to questions about your health, weight problem, eating activity, medication or drug usage, and lifestyle patterns to help us help you.

2. Devote the time and effort necessary to complete and comply with the course of treatment.

3. Allow us to share information with your personal physician if necessary.

4. Make and keep follow-up appointments so that we can help you the best, allowing necessary blood tests as needed. Patients more than 15 minutes late for an appointment may be rescheduled to another day.

5. Advise the clinic staff and Dr. of any concerns, problems, complaints, symptoms, or questions you develop.

6. Inform your personal physician of your weight loss efforts and have or establish a primary physician before beginning this program.

Possible Side Effects

1. **Reduced weight**. By reducing your caloric intake, you may see a variety of temporary and reversible side effects including, but not limited to, increased urination, momentary dizziness, reduced metabolic rate, cold sensitivity, slower heart rate, dry skin, fatigue, constipation, diarrhea, bad breath, muscle cramps, changes in menstrual pattern, dry or brittle hair, or hair loss. Medication side effects may include any of the above plus dry mouth, mild headaches, and very rarely a racing or pounding heart rate or an elevation in blood pressure or other more rare side effects, particularly if you exceed the dosage without being directed by the physician. This will be closely monitored as safety is our number one priority.

2. **Reduced potassium** levels or other electrolyte abnormalities. We monitor electrolyte levels and correct them if they become too low. If they were not corrected, these can result in muscle cramps, heart rhythm irregularities and other symptoms as above. Always inform us if you are on or begin a water pill. We will be following your levels with occasional blood testing.

3. **Gallstones**. Overweight people are at risk for having or developing gallstones. One study reports that 1 in 10 persons entering a weight loss program may have silent or undiagnosed gallstones. Active weight loss can produce new stones or cause established stones to develop symptoms. The pain is usually in the right upper abdomen and may spread to the back. Gallbladder problems may require medications or even surgery to remove the gallbladder. Notify your primary doctor or us if you develop symptoms of gallstones including abdominal pain, fever, nausea, and vomiting.

4. **Pancreatitis**. Inflammation of the bile ducts or pancreas gland may be associated with gallstones, and may be precipitated by eating a large meal after a period of strict dieting. It may require hospitalization, and rarely can be associated with life threatening complications. Notify us or your primary physician if you develop symptoms such as pain in the left upper abdominal quadrant, fever, or vomiting.

5. **Pregnancy**. Notify us if you become pregnant. Some overweight patients have irregular ovulation and weight loss may increase ovulatory regularity and the chance of becoming pregnant. If pregnant, you must change your diet to avoid further weight loss. A restricted diet can damage a developing fetus. Also, any weight loss medications must be discontinued if pregnancy occurs since we do not want you to continue to lose weight during that time. You should take precautions to avoid becoming pregnant during weight loss.

6. **Sudden death**. Patients with obesity, especially those with associated high blood pressure, diabetes, or heart disease have a higher risk of sudden death and development of a serious potentially fatal disease known as primary pulmonary hypertension. Rare instances of sudden death have occurred while obese patients are undergoing weight loss even in a medically supervised program. No cause and effect relationship with the diet program and sudden death has been established.

7. **Risk of weight gain** – Obesity is a chronic condition. The majority of patients who lose weight have a tendency to regain it unless in some type of maintenance program and long-term efforts at controlling the weight are continued. Remember, your weight loss is not permanent unless your behavior modification and lifestyle changes are permanent as well. We will provide you with a plan to prevent weight from returning.

Patient

Signature_____ Date_____

Witness :_____ (Medical Staff only)

IF YOU WOULD LIKE A COPY OF THE POSSIBLE SIDE EFFECTS PLEASE ASK THE RECEPTIONIST.

RULES FOR USE OF WEIGHT LOSS CONTROL MEDICATIONS

NOTE: SIGNING THIS FORM DOES NOT GUARANTEE THAT YOUR PHYSICIAN WILL FIND YOU TO BE AN APPROPRIATE CANDIDATE FOR WEIGHT LOSS MEDICATIONS, BUT ONLY THAT YOU HAVE READ, UNDERSTAND, AND AGREE TO THE TERMS OF MEDICATION USE SHOULD YOU AND YOUR PHYSICIAN DECIDE UPON THEIR USE NOW OR IN THE FUTURE.

I, (print your name) _____, wish to enter into the weight loss program directed by Venture Medical Weight Loss LLC. I understand this program includes diet, exercise, behavioral & lifestyle changes, and appetite suppressants when appropriate. I understand that the abuse or overuse of appetite suppressants is potentially life threatening and illegal.

Appetite suppressants are controlled substances that are regulated by State and Federal Laws. I understand pursuant to State and Federal Laws prescriptions for controlled substances cannot be filled any sooner than once every four weeks. I understand I will not and cannot, for any reason, receive refills on prescriptions for appetite suppressants any earlier than once every four weeks.

I understand that it is illegal to obtain appetite suppressants from more than one physician and agree I will not obtain any appetite suppressants from other prescribing physicians. I further understand it is illegal to use more than one pharmacy to have multiple prescriptions filled for appetite suppressants. Use of appetite suppressants that are controlled substances is monitored by a Patient Drug Monitoring Program (PDMP) in each state, and is called KASPER in Kentucky. Venture Weight Loss has access to all of the 50 states in the USA that participate in the PDMP.

I agree to only participate in the weight management program directed by Venture Medical Weight Loss. I understand it is illegal to participate in any other weight management program that uses appetite suppressants while I am participating in the weight management program directed by Venture Medical Weight Loss.

I understand that if I participate in the acquisition of appetite suppressants from multiple healthcare providers, for any reason, I am participating in an illegal action and may be held liable for criminal activity.

I understand that my use or misuse of controlled substances including appetite suppressants is reportable to appropriate authorities of the commonwealth of Kentucky which also shares information with multiple patient drug monitoring programs (PDMP) of other states.

I verify I have noted any medications I **am CURRENTLY taking** or **have TAKEN** in the past 12 months. I further verify that I have correctly noted my current and past medical and surgical history, my family medical history, and have provided ALL correct information. I understand that any omissions may affect the efficacy of my treatment at Venture Weight Loss.

Date_____ Patient Signature_____

Witness_____ (Medical Staff)

KASPER (Kentucky All Substance Patient Electronic Record) Consent:

I understand that Kentucky law requires physicians prescribing controlled medications (including weight loss medications) to monitor patients' use of these medications. This monitoring includes an initial drug screening panel & KASPER report. I understand KASPER reports list what controlled substance prescriptions I have filled in the past several years. Further monitoring may include random drug screens, random pill counts, and repeat KASPER reports every three months while in the Venture Weight Loss program. Therefore, I understand that I am to bring in my unused weight loss medications to my appointments as they may be randomly required. I will cooperate with random pill counts. I will allow random drug tests of my urine and/or blood. I understand that this required monitoring could result in the delay and/or inability of my physician to prescribe these types of medications to me. I understand that weight loss medications may assist in weight loss, but that there is no guarantee they will do so. I understand weight loss medications can only be used with proper nutritional and behavioral modifications. Failure to comply with nutritional and behavioral modifications may result in physicians discontinuing medication. If weight loss is not improved with use of medications, I understand my physician will need to stop or change medications. I understand my physician can discontinue weight loss medications at any time & will do so if weight loss plateaus. I understand that if weight loss medications are used, the plan is to use them only during weight loss and then to taper off of them once goals have been met. I will be evaluated monthly to see if medications can and should be refilled. I understand that weight loss medications are just one option to assist in weight loss, but are not required to lose weight. There are many options for weight loss although all patients will be instructed on nutritional, behavioral, and psychological modifications. Just like any medication, weight loss medications can have a risk of side effects. Such side effects may include (but are not limited to), dry mouth, constipation, anxiety, jittery sensation, headache, insomnia, allergic reaction, heart palpitation (rare), elevated blood pressure (rare). Addiction is listed as a potential side effect (although this has not been reported if used as prescribed.) I understand it is my responsibility to notify my Venture Weight Loss physician if I have any side effects. If weight loss medications are used over 1 month, they should be tapered off unless you become pregnant or have a serious side effect from the medication in which case they can be stopped immediately. Failure to taper off of weight loss medications may result in rebound hunger, fatigue, depression, gain in weight, and other symptoms. I understand that if I desire to discontinue medications for any reason (including simple inability to continue the program), I will contact VMWL to obtain a proper exit plan based on my current medical conditions. Unused medications may be returned to Venture Weight Loss for proper disposal, or follow the guidelines at \Vww.fda.gov/consumer.

HIPAA Notice: Your Rights and Confidentiality You have the right to leave treatment at any time without any penalty, although you do have a responsibility to make sure we know you are discontinuing treatment. Your personal physician must be able to assume your medical care. From time to time, patient treatment information is used in the collection of statistics to compare results, and improve the treatment of obesity. This information may be shared with other practitioners, researchers, and the scientific and medical community. Strict confidentiality of individual personal information and records will be maintained. Please note that our Physicians do not take calls outside Venture Weight Loss's office hours. If you feel you are experiencing a medical emergency at any time, go to the nearest emergency room immediately for treatment.

Patient Name: _____ **DOB:** _____ **Today's Date:**_____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION (HIPAA) Uses and Disclosures of Information that We May Make Without Written Authorization: For treatment, payment, healthcare operations, as required by law, abuse or neglect, or communicable diseases, public health activities, health oversight activities, judicial and administrative proceedings, law enforcement, organ donation, research, workers compensation, appointments and services, marketing, business associates, military, inmates or person in police custody, coroners, medical examiners, funeral directors. Uses and Disclosures of information That We May Make Unless You Object: We may use and disclose protected health information in the following instances without your written authorization unless you object. (Disaster Relief & Persons Involved in your case). If you object, please notify the Privacy Contact identified at the end of this document. Persons Involved in Your Health Care: Unless you object, we may disclose protected health information to a member of your family, relative, close friend, or other person identified by you who is involved in your health care or the payment for your health care. We will limit the disclosure to the protected health information relevant to that person's involvement in your health care or payment. We may leave messages for you to call us or leave basic lab test results on your home phone unless you direct otherwise.

Newsletter and Other Communications - We may use your PHI to communicate to you by newsletters, mailings, or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our practice is participating. Your Right Concerning Your Protected Health Information: You have the following rights concerning your protected health information. To exercise any of these rights, you must submit a written request to our Privacy Officer. 1. To request additional restrictions. 2. To receive communications by alternative means. 3. To inspect and copy records. 4. To request amendment to your record. 5. To request accounting of certain disclosures. 6. To receive a copy of our complete confidentiality notice. 7. To receive a copy of the bill to submit to your insurance. We will code your visit as medically correct as possible. Please note in rare instances a new diagnosis or prescription that you submit to your insurance may affect your insurability and or your insurance rates. 8. To receive notice of a breach 9. Right to restrict certain disclosure to your health plan.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint. Privacy Officer Contact: If you have any questions about this notice, request a copy of the complete notice or if you want to object to or complain about any use of disclosure of exercise any right as explained above, please contact Dr. M. Kanvinde at our office located at 3700 Alexandria Pike Ste B, Cold Spring, KY 41076.

I, the undersigned, have reviewed this information on the front and the back page of this document, and have had an opportunity to ask questions and have them answered to my satisfaction.

Notification: Unless you authorize us in writing, we will not be able to discuss any information about your health, including your appointment times with any person. If you wish to authorize any one to receive such information please indicate below:

Person(s) Authorized to Receive Information:_____

Physician Office(s) Authorized to Receive Medical Information:_____

Contact information: _____

Patient Signature_____ Date_____

Witness :_____ (Medical Staff only)

ALL FEMALE PATIENTS SHOULD READ AND SIGN THIS PAGE

Females only: I certify that I am not pregnant or breastfeeding. I agree and understand that I must notify my prescriber if I plan to become pregnant, start breastfeeding or am unsure if I am pregnant. I agree not to take weight loss medications if I become pregnant or start breastfeeding.

PLEASE NOTE:
The medical providers and staff of Venture Medical Weight Loss recommend and strongly encourage the consistent use of contraception to avoid pregnancy during treatment with our medications for ALL females of childbearing age. This is due to the increased risk of teratogenicity (fetal harm/damage) with the use of our medications.

By signing below, I am stating that I have read this document and understand the importance of using contraceptive methods while taking these medications. I understand if I should become pregnant, I should discontinue the use of these medications immediately and report my pregnancy to Venture Weight Loss and its health care providers.

_____ _____
Signature Date

_____ _____
Printed Name Date of Birth

_____ _____
Witness Signature (Medical Staff Only) Date

THANK YOU SO MUCH FOR PATIENTLY FILLING OUT ALL THE INFORMATION REQUIRED TO SELECT THE BEST POSSIBLE MEDICAL TREATMENT FOR YOU. OUR MEDICAL ASSISTANT AND PHYSICIAN WILL SEE YOU AS SOON AS POSSIBLE.

NEXT, PLEASE ANTICIPATE:

A 5 MINUTE VISIT FROM OUR MEDICAL ASSISTANT, THEN

A DETAILED 30-45 MIN CONSULTATION WITH OUR PHYSICIAN, THEN

A 5 MINUTE CHECK-OUT PROCESS