VENTURE
MEDICAL WEIGHT LOSS

Welcome To Venture Medical Weight Loss!

Please Answer the Following Questions

So We Can Better Assist Your Health-care Needs

No need to be intimidated by the length of these intake forms. Many are simply check-marking information and reading and signing the consents. More importantly, they are required only once every 3 years!

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

Name: _____ DOB: _____

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

Address_____

City_____ State _____ Zip Code_____

Social Security #_____

(needed for reporting Prescriptions to KASPER = KY All Controlled Substance Patient Electronic Record)

Phone# (Home:)_____ (Mobile:)_____

Marital Status: Single / Married / Divorced / Widowed / Separated Please Circle: M / F

Primary Care Physician: _____ Phone#_____

Employer and Occupation: _____

Emergency contact, name, relation, and number: _____

_____

- My expectations from this program: _____
- Anything you did not like at other similar clinics you have been to, and Venture should try to avoid?
- _____

Reviewed by VMWL Staff (initials)_____

WEIGHT LOSS HISTORY

My Obesity Began: • Childhood • Puberty • Adult • After Pregnancy • Other: _____

Have you attempted losing weight on your own without medication in the past? ❑ No ❑Yes

CURRENT EATING HABITS:

Are you an emotional or stress eater? YES / NO

What are your current eating habits (low/high calorie, low/high fat, low/high carbohydrate, mostly fast food, fried foods, vegetarian, vegan etc.)? _____

How many times per day do you eat? _____

Do you eat multiple small meals or a couple large meals each day? _____

Do you currently monitor your macronutrient intake (such as carbohydrates/fats/proteins)?

YES / NO, if yes, what is the percentage of each? Carbs _____% Fat _____% Proteins _____%

Which of the following are your challenges? (circle as appropriate)

Portion size	Skipping meals	Fried foods
Too many carbs or Sweets	Eating out	Soft drinks
Too few proteins	Alcohol consumption	

Which of the following do you think would best help you on your weight loss journey? (Circle or Check all that apply):

Learn proper portion size and how to control them	Learn what times are best for higher calorie meals
Healthy snack/meal options	Keeping a food journal
Learn to keep track of calorie intake	How much water should I drink per day?
What my daily calorie intake should be	

My preferred diet: (Circle or Check all that apply):

Carb restricted	Weight Watchers	High protein
Calorie restricted	Vegan	Diabetic diet
Fat restricted	Clean eating	Portion control

LIFESTYLE:

How much television do you watch per day (hours/minutes)? _____
How often do you consume alcohol? _____x's/wk; _____x's/month; _____x's/year
Do you smoke? YES NO How much per day? _____
If you used to smoke, when did you quit? _____
Do you use cocaine, marijuana or other drugs? YES NO If YES, what? _____
If you used to use cocaine, marijuana or other drugs, when did you quit? _____
How many hours of sleep do you get nightly on average? _____
Do you consider your life, job, etc. to be stressful? _____
If so, how stressful on a scale of 1-10 (1 minimal, 10 severe) would you say your life is? _____

Which of the following seem to sabotage your weight loss efforts?

Lack of time for planning/self	Eating late

Reviewed by VMWL Staff (initials)_____

Waking up eating
Eating too fast
Always hungry
Stress/comfort eating
Enjoyment of food
Liquid calories (alcohol)

Specific cravings? _____
Boredom eating
Social event
Mindless eating/habit
Other: _____

DIETING HISTORY

How have you attempted to lose weight in the past? (exercise, diet, medications, behavioral therapy, etc.)

☐ Exercise ☐ Diet ☐ Medications ☐ Behavioral therapy ☐ Jenny Craig ☐ Wt. Watchers

☐ Nutrisystem ☐ Atkins Diet ☐ 17/21 Day Diet ☐ South Beach Diet ☐ Mediterranean Diet ☐ Other:

What were your outcomes with past weight loss attempts? _____

Your goal weight: _____ lbs.

Age when you were last at your goal weight: _____

What weight loss methods have been successful for you in the past? _____

What is the most you have weighed and what year was this? _____

What is the least you have weighed and what year was this? _____

How many days per week do you get moderate exercise? (heart pounding, breathing heavy) _____

What type(s) of exercise are you currently doing? _____

How compliant have you been with previous weight loss programs? _____

What were the barriers you faced in being compliant (time, motivation, etc.) _____

Restrictions: Have you ever had or currently have any exercise restrictions?

❑ No ❑Yes_____

Have you ever had or currently have any food restrictions?

❑ No ❑Yes_____

Do you take any of the following supplements? (Please Circle or Check all that apply)

Daily multi-vitamin	Vitamin B12	Fatty Acid	Probiotic
Vitamin C	Potassium	Magnesium	Fiber
Vitamin D	Omega 3	Calcium	Sleep aid
		Iron	Folate

Reviewed by VMWL Staff (initials)_____

MEDICAL HISTORY

When was you last physical exam? _____

Family History (Please list mother, Father, Siblings, Aunt/Uncle, or Grandparents) Conditions:

Heart Disease_____
Cancer_____
Diabetes_____
Hyperthyroidism_____

High Cholesterol_____

High Blood Pressure_____
Stroke_____

Kidney Liver Disease_____

Mental Illness (depression, bipolar)_____

Drug/ Alcohol Abuse_____

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

Review of Systems *CURRENT MEDICAL CONDITIONS*

(circle as appropriate)

Constitutional
- High Blood Pressure
- Fatigue
- Change in appetite
- Headaches/migraines

Respiratory
- Cough
- Shortness of breath
- Wheezing
- Emphysema/COPD
- Asthma

Eyes
- Glaucoma
- Eye glasses/contacts
- Blurred/double vision

Ears/nose/mouth/throat
- Hearing loss
- Nosebleeds
- Trouble swallowing
- Bleeding gums
- Sore throat
- Problems with thyroid
- Sinus Trouble

Gastrointestinal
- Constipation
- Nausea/vomiting
- Abdominal pain
- Heartburn/acid reflux
- Irritable bowel syndrome
- Hepatitis Type _____

Genitourinary
- Problems with urination
- Blood in urine
- Kidney stones
- Prostate enlargement
- Polycystic Ovarian Disease (PCOS/PCOD)

Neurological
- Headaches
- Numbness/tingling
- Tremors
- Seizures/Epilepsy
- Stroke

Musculoskeletal
- Joint pain/stiffness
- Muscle pain/weakness
- Back pain/problems
- Arthritis
- Carpal tunnel syndrome
- Fibromyalgia
- Gout

Hematologic/lymphatic
- Bleeding/bruising tendency
- Blood clots
- Cancer
- Anemia (low blood count)
- Blood Disease

Skin
- Rashes
- Lesions
- Ulcers
- Jaundice

Cardiovascular
- Chest pain/angina
- Palpitations
- Murmur
- Swelling of feet/ankles
- Congenital Heart lesion
- Heart Disease
- Pacemaker
- High Cholesterol

Psychological
- Bipolar
- Depression
- Anxiety
- Psychiatric care
- Stress

Please list any psychiatric history including diagnoses & treatments:
_____
_____
_____

Endocrine
- Thyroid issues
- Diabetes

Other
- Chemical dependency
- Chemotherapy
- Chronic fatigue syndrome
- Rheumatic Fever

Past Surgical History

PLEASE CHECK EACH SURGICAL PROCEDURE YOU HAVE HAD IN THE PAST

Cardiac Surgery **Gastrointestinal Surgery**

Pacemaker Gallbladder
Bypass Gastric bypass Date: _____ How much Weight Loss: _____lbs Able to maintain? YES NO
Stents Lap-band Date: _____ How much Weight Loss: _____lbs Able to maintain? YES NO
Hernia repair
Please list any other surgical procedures you have had not listed above: _____

_____

Laboratory Work-up & EKG History (Circle as appropriate)

Most recent date labs were performed: _____ Most recent EKG: _____

Results of Labs: N ABNL _____

Results of EKG: WNL ABNL _____

Patient requested to bring in copies of lab work and/or EKG results at next visit

PRESCRIPTION MEDICATION REVIEW

For your safety and treatment in our program, please mark **YES or NO** for **ANY and ALL medications** you are **CURRENTLY prescribed** or **have been prescribed in the PAST YEAR** (past 12 months).

MEDICATION	Y	NO
Adderall(Dextroamphetamine)		
Adipex-P (Phentermine)		
Amphetamines/Methamphetamines		
Buprenorphine		
Methylphenidate		
Methadone		
Suboxone (buprenorphine-naloxone)		
Vyvanz		

Medication Schedule Please list any additional medications you are **CURRENTLY prescribed** or **have been prescribed** in the PAST YEAR.

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

I, (print your name) _____, verify that I have correctly noted my current and past medical and surgical history, my family medical history, all current medications and have provided ALL correct information.

Date_____ Patient Signature_____

Witness_____ (Nurse or Medical Assistant or Physician)

Informed Consent for Treatment (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 individual consultation, our website links and/or 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 recommend 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.
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 rarer side effects. This will be closely monitored as safety is our number one priority.
2. Reduced potassium levels or other electrolyte abnormalities. 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 recommend you to get your levels checked 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 unless in some type of maintenance program and long-term efforts at controlling the weight are continued. 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.

GUIDLINES 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.

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 monitoring programs (PMP) of other states.

I understand that Venture Medical Weight Loss does not guarantee weight loss. Individual results of weight loss will vary and depend upon multiple factors, such as compliance with the program and individual factors.

Signature of Participant: _____ Date _____

Witness :_____ (Medical Staff only) Date _____

KASPER (Kentucky All Substance Patient Electronic Record Consent:

(that means, permission to review your prescriptions and report to the commonwealth of KY, as required by law)

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 changes. Failure to comply with nutritional and behavioral changes may result in physician 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 changes. 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 Figure 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 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.

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

My signature placed on this contract indicates that I fully understand each statement and have had the opportunity to ask any questions pertaining to this. All of my questions have been answered to my satisfaction. I understand that if I break any part of this agreement, I may be discharged from my provider's care.

Patient’s name (print) _____ Date_____

Patient’s signature_____

Witness :_____ (Medical Staff only)

HIPPA 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.

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. Notification: Unless you object, we may use or disclose protected health information to notify a family member or other person responsible for your care of your location and condition.

Person(s) Authorized to Receive Information: _____

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

Medical Residents, Medical Students, and Training Physicians may observe or participate in your treatment or use your PHI to assist in their training. You have the right to refuse to be examined, observed, or treated by them. 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 the Chief Medical Officer at our office located at 361 Cross Roads Blvd, 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.

Patient Signature_____ Date_____

Witness: _____ (Medical Staff only)