

TUCSON WOMEN'S CENTER

MEDICAL WEIGHT LOSS PROGRAM INTAKE

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

WEIGHT LOSS GOALS

1. What made you decide to make a change now?
2. Are there specific areas of your body that you would like to change?
3. Are you on a timeline (e.g. before the wedding, cruise, reunion)?
4. Do you have target values (e.g. goal weight, % body fat, BMI)?

**WEIGHT HISTORY**

5. Have you been over weight in the past?

	Yes	No
Child		
Adolescent		
Adult		

**CURRENT DIET**

6. What type of foods do you eat in an average day?

	Week day	Week end
Breakfast/snack		
Lunch/snack		
Dinner/ snack		

7. On a scale from 1-6 are you more likely to prepare your meals or eat out?

Eat in-----1-----2-----3-----4-----5-----6 Eat out

## DIETING HISTORY

Type of diet	How long did you try it?	How much did you lose?	Why did you stop?

8. Do you have a history of eating disorders? Please describe.

9. Do you exercise? If so how often and for how long?

## PAST MEDICAL HISTORY

i. Please check all that apply

<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	History of Asthma	<input type="checkbox"/>	Bleeding tendency
<input type="checkbox"/>	Breast lump or tumor	<input type="checkbox"/>	Blood clots in legs	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	STI	<input type="checkbox"/>	Kidney infection	<input type="checkbox"/>	Bladder infection
<input type="checkbox"/>	Migraine headaches	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	Sickle cell anemia
<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	Pelvic infection	<input type="checkbox"/>	Hepatitis

ii. Please check all that apply

Depression    Addiction (describe)    Eating disorder (describe)

iii. List medications that you are currently taking

iv. List drug allergies and sensitivities

- v. List previous surgeries

#### FAMILY HISTORY

	Hypertension	Heart disease	Diabetes	High cholesterol
Mother				
Father				
Siblings				

#### SOCIAL HISTORY

10. Do you have friends/family supporting you in your weight loss effort?
11. Do you smoke? Yes \_\_\_ No \_\_\_
12. Do you use any type of recreational drugs? Please list
13. How many alcohol containing drinks do you have per week?



### **Releana® Informed Consent**

**Releana®** is a prescription medication used by Tucson Women’s Center in its weight loss program.

#### **Conditions of Participation**

You will have a consultation before starting **Releana®** in combination with a VLCD (very low calorie diet). You will undergo a blood test, including a metabolic panel to measure kidney function, liver function, hemoglobin, hematocrit, glucose, lipids and thyroid function. A blood pregnancy test may also be performed.

You will be weighed, your blood pressure and pulse will be recorded, and your measurements will be recorded using pre-set measuring points.

We may take photos of you when you start the program as well as when you either finish or reach your goal weight. These photos will be kept in your chart and confidential unless specified that we may publish them for advertising purposes.

We will photocopy your driver’s license and it will be kept in your chart for physical identification.

If at any time during your office visit, you should have any questions, concerns, or problems, you are encouraged to consult with our staff. If you should experience any problems or concerns after being discharged from our office, please call (520) 323-9682, or email us at [info@tucsonwomenscenter.com](mailto:info@tucsonwomenscenter.com) with any questions.

#### **Release of Information**

On certain instances, we can release your medication to a friend/family member or mail your medication to your home. Please read the following statements and initial if you would like us to release information and/or medicine.

\_\_\_\_\_ Tucson Women’s Center may leave private information on your answering machine. For example, blood work results, confirmations, appointment time, etc.

\_\_\_\_\_ Tucson Women’s Center may (when appropriate) ship your medication to your home.

\_\_\_\_\_ Tucson Women’s Center may (when appropriate) release your medication to a friend/family member.

**Risks**

**Releana**<sup>®</sup> is virtually free of negative side effects, but because you must follow a very low calorie, low fat diet that can sometimes trigger a gallbladder attack in individuals who are genetically pre-disposed to gallbladder disease.

**With any drug there is the possibility of an allergic reaction or unusual reaction that may cause skin rash, difficulty breathing, collapse, or even death.**

Your medication will be discontinued if there is a severe adverse reaction.

**Notice of Privacy Practices**

In accordance with HIPAA federal regulations, Tucson Women’s Center will not disclose any information about you or your personal health without your permission. All information received while a patient (and if/when you decline to be a patient any longer) at Tucson Women’s Center will be kept confidential.

In certain cases, it may be necessary for Tucson Women’s Center to release confidential documents. Your Private health information may be disclosed or used for treatment, payment, or necessary health care operations. By signing this agreement, you are consenting to allow Tucson Women’s Center to do so in necessary, rare occasions.

I understand that the program and medications may involve risk. I understand that there are no refunds, returns or store credit for medication and that there is no weight loss guarantee with our program. I have read and understand the information given to me about the medications. I have asked and had answered any questions that I may have after reading this form. I understand the possible side-effects and agree to advise Tucson Women’s Center should they occur. I understand that I may quit the program at any time. I agree to stop the **Releana**<sup>®</sup> if I become pregnant and agree to advise Tucson Women’s Center should I decide to become pregnant. No adverse side effects or complications are expected, but in the event that an illness does occur, I understand that I need to contact Tucson Women’s Center. If I experience an emergency situation, I understand that I need to go to an emergency facility.

**YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE INFORMATION ABOVE, HAVE HAD YOUR QUESTIONS ANSWERED, HAVE HAD POTENTIAL SIDE EFFECTS EXPLAINED, AND AGREE TO NOTIFY TUCSON WOMEN’S CENTER OF ANY CHANGE IN YOUR HEALTH STATUS.**

\_\_\_\_\_  
Client’s Name (PLEASE PRINT)

\_\_\_\_\_  
Client’s Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

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