PINSKY MEDICAL WEIGHT LOSS

PLEASE COMPLETE THESE FORMS PRIOR TO YOUR FIRST VISIT

Date: _____

Name: _____ Age:_____ DOB:_____ Sex: M F

Email:_____ Phone _____

Street Address_____

City_____ State _____ Zip_____

Primary Care Physician: _____ Phone: _____

Other Physicians:_____

Whom do we thank for your referral to us? _____

Emergency Contact:

Name_____ Relationship to you_____

Contact info_____

Release of Medical Information:

I_____ give Dr. Mark Pinsky's office staff my permission to release medical information which includes: medication information, lab and diagnostic test results, and appointment dates and times to the following people.

1._____

2._____

3._____

I give my permission to Dr. Mark Pinsky's office staff to leave detailed messages at the following numbers.

1._____

2._____

Signature_____ Date_____

PINSKY MEDICAL WEIGHT LOSS
Medical History Form

Present Medical Status:

Any allergies to medications? Yes No
Please specify:_____

Are you taking any medications, vitamins, or herbals? Yes (please list below) No

Medication	dose	frequency	Medication	dose	frequency

Are you in good health at the present time to the best of your knowledge? Yes No
Please list all medical conditions, surgeries and hospitalizations:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Past Medical History: (check all that apply)

_____ acid reflux
_____ anxiety
_____ asthma
_____ bulimia
_____ depression
_____ eye disease
_____ gout
_____ high blood pressure
_____ irregular heart beat
_____ liver disease
_____ metabolic syndrome(pre-diabetes)
_____ polycystic ovary syndrome
_____ snoring
_____ valve disorder
_____ alcohol abuse
_____ ankle/leg swelling
_____ bone fracture (<90 days)
_____ cancer; type _____
_____ diabetes; type_____
_____ fatty liver disease
_____ heart disease
_____ high cholesterol
_____ kidney disease
_____ low back pain
_____ prior use of phen-fen
_____ stroke
_____ anorexia nervosa
_____ arthritis
_____ bipolar disease
_____ chronic pain
_____ drug use
_____ glaucoma
_____ heart attack
_____ hyperthyroidism
_____ kidney stones
_____ migraines
_____ palpitations
_____ sleep apnea
_____ ulcers

Surgeries:

_____ gall bladder removal
_____ appendix removal
_____ groin hernia

_____ hysterectomy _____ coronary stent _____ coronary angioplasty
_____ gastric bypass surgery _____ lap band _____ back surgery

Gynecologic History:

Pregnancies: Number: _____ Dates: _____
Natural Delivery or C-Section (specify): _____
Menstrual Onset: _____
Duration: _____
Are they regular: Yes No
Pain associated: Yes No
Last menstrual period: _____
Hormone Replacement Therapy: Yes No
What: _____
Birth Control Pills: Yes No
Type: _____
Last Check Up: _____

Social History:

Have you ever smoked cigarettes or used other forms of tobacco? Yes No
If yes, how many packs per day? _____
Number of years smoked? _____
If quit, when? _____

Do you drink alcohol? Yes No
How many drinks per week? _____ [1 drink is: 1 glass wine (4 oz), 1 beer (12 oz), hard liquor (1 oz)]

What is your occupation? _____

Circle appropriate choice: Married Single Divorced Widowed Domestic Partner

Do you drink coffee or tea? Yes No How much daily? _____
Do you drink non-diet cola drinks? Yes No How much daily? _____
Any other sources of caffeine? Yes No How much daily? _____
How many hours per night do you sleep (on average)? _____

Family History:

	Age	Health	Disease	Cause of Death	Overweight?
Father:					
Mother:					
Brothers:					
Sisters:					

Has any blood relative ever had any of the following:
Heart Disease/Stroke Yes No Who: _____
Diabetes: Yes No Who: _____
High Blood Pressure Yes No Who: _____
High Cholesterol: Yes No Who: _____
Kidney Disease: Yes No Who: _____
Psychiatric Disorder Yes No Who: _____

Nutrition Evaluation:

Any history of binge eating, purging or starvation? Yes No

Do you eat more than 25% percent of your calories after dinner? Yes No

Present Weight:_____ Height (no shoes): _____ Desired Weight: _____

What weight you would be satisfied with? (For example, if you did not attain your desired weight, what weight would you accept?)_____

In what time frame would you like to be at your desired weight? _____

Birth Weight:_____ Weight at 20 years of age: _____ Weight one year ago: _____

What is the main reason for your decision to lose weight? _____

When did you begin gaining excess weight? (give reasons, if known): _____

What has been your maximum lifetime weight (non-pregnant) and when?_____

How many diets have you been on (state the number)? _____

Previous diets you have followed:

_____
_____
_____
_____

Give dates and results of your weight loss:

_____
_____
_____
_____

What do you feel are your main reasons for being overweight?

_____
_____
_____

Is your spouse, fiancé or partner overweight? Yes No

By how much is he or she overweight? _____

How often do you eat out? _____

What restaurants do you frequent?_____

How often do you eat "fast foods?"_____

Who plans meals? _____ Cooks? _____ Shops? _____

Do you use a shopping list? Yes No

What time of day and on what day do you shop for groceries? _____

Food allergies: _____

Food dislikes: _____

Food you crave: _____

Any specific time of the day or month that you crave food? _____

Do you use a sugar substitute? _____ Butter? _____ Margarine? _____

Do you awaken hungry during the night? Yes No
If so, what do you do? _____

What are your worst food habits? _____

Snack Habits:

What? _____ How much? _____ When? _____

When you are under a stressful situation at work or family related, do you tend to eat more? Explain:

_____

_____

Do you think you are currently undergoing a stressful situation or an emotional upset? Explain:

_____

_____

Typical Breakfasts	Typical Morning Snacks	Typical Lunches
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Time eaten: _____	Time eaten: _____	Time eaten: _____
Where: _____	Where: _____	Where: _____
With whom: _____	With whom: _____	With whom: _____
Typical Afternoon Snacks	**Typical Dinners**	**Typical Evening Snack/Desserts**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Time eaten: _____	Time eaten: _____	Time eaten: _____
Where: _____	Where: _____	Where: _____
With whom: _____	With whom: _____	With whom: _____

Describe your usual energy level: _____

Activity Level: **(answer only one)**

___Inactive—no regular physical activity with a sit-down job.
___Light activity—no organized physical activity during leisure time.
___Moderate activity—occasionally involved in activities such as weekend golf, tennis, running, swimming or cycling.
___Heavy activity—consistent lifting, stair climbing, heavy construction, etc., or regular participation in running, swimming, cycling or active sports at least three times per week.
___Vigorous activity—participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

Behavior Style: **(answer only one)**

___You are always calm and easygoing.
___You are usually calm and easygoing.
___You are sometimes calm with frequent impatience.
___You are seldom calm and persistently driving for advancement.
___You are never calm and have overwhelming ambition.
___You are hard-driving and can never relax.

Please describe your general health goals and improvements you wish to make: _____
_____
_____

How confident are you that we can help you with your weight problem? _____
_____
_____

Why is this the right time for you to lose weight? _____
_____
_____

Are there any other issues that you think are important that we should know? _____
_____

This information will assist us in assessing your particular problem areas and establishing your medical management plan. Thank you for your time, and patience in completing this form.

Informed Consent for Weight Loss/Maintenance Medications

I. Procedure and Alternatives:

1. I,_____ (patient or patient's guardian) authorize my physician to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of weight loss medication for more than 12 weeks and when indicated, in higher doses than the dose indicated in the weight loss medication labeling.

2. I have read and understand my medicine provider statements that follow:

"Medications, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The weight loss medication labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosages indicated in the labeling.

"As a obesity medicine provider, I have found weight loss medications helpful for periods far in excess of 12 weeks, and at times in larger doses than those suggested in the labeling. As a licensed prescriber, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer term studies and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use weight loss medications for longer periods of time and at times, in increased doses.

"Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted below).

"As a obesity medicine provider, I believe the probability of such side effects is outweighed by the benefit of the weight loss medication use for longer periods of time and when indicated in increased doses. However, you must decide if you are willing to accept the risks of side effects, even if they might be serious, for the possible help the weight loss medication use in this manner may give."

3. I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight, any significant medical problem that I think may be related to my weight control program as soon as reasonably possible.

4. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive weight loss medication will be dependent on my progress in weight reduction and weight maintenance.

5. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an exchange eating program without the use of weight loss medication would likely prove successful if followed, even though I would probably be hungrier without weight loss medications.

6. I understand that topiramate may be associated with birth defects such as clefts. The estimated increase risk is 1%. Women should avoid pregnancy while on this medication, and stop it immediately should pregnancy occur. If you are considering becoming pregnant, please discuss this with your doctor, so we can discuss other options. In addition, topiramate has been associated with a 2.6% incidence of depression. If depression is suspected, please call your physician as soon as possible to discuss stopping this medication.

7. If I chose to use Qsymia (which contains topiramate) or topiramate alone, and I am a female of reproductive potential, I agree to monthly pregnancy testing that can be tested in our office or at home and report the results to the medical practice. If I become pregnant, I will stop the medication and notify my prescribing physician immediately.

II. Risks of Proposed Treatment:

I understand this authorization is given with the knowledge that the use of weight loss medications for more than 12 weeks and in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication aller-

gies, high blood pressure, rapid heart beat and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

III. Risks Associated with Being Overweight or Obese:

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

IV. No Guarantees:

I understand that much of the success of the program will depend on my efforts and 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 of my life if I am to be successful.

V. Patient's Consent:

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving weight loss medications.

VI. Refill Policy:

It is the policy of the physicians that weight loss/weight maintenance medications being controlled substances that they will not be refilled without a face-to-face visit with my physician. Please check your medication supply and attend appropriate visits with your physician so that you do not run out unexpectedly.

WARNING
IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK YOUR DOCTOR NOW BEFORE SIGNING THIS CONSENT FORM.

DATE:_____ **TIME:**_____

PATIENT:_____ **Patient**_____
(Signature) **(printed name)**

VI. MEDICAL DECLARATION:
I have explained the contents of this document to the patient and have answered all the patient's related questions, and, to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of weight loss medications, the benefits and risks associated with alternative therapies and the risks of continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving weight loss medication in the manner indicated above.

_____
Medical Provider's Signature

Updated 2-13-18

YourBetterSelf
Quicker Medical Weight Loss

Informed Consent

We want you to know...

When you decided to learn more about managing your weight, you took an important step toward improving your health. The physician who is advising you can help you develop comprehensive weight management skills while you lose a meaningful amount of weight.

The calorie deficit and portion-controlled diets (including liquid formulas) were developed over 25 years ago for weight reduction. They are used with patients who are overweight and who may have significant medical problems related to obesity. Such problems may include hypertension, coronary disease, diabetes, lung, joint or bone disease, and the need for non-emergency surgery. These methods of weight reduction have been utilized in hundreds of clinics in the United States. They have been described and evaluated in many professional medical journals since 1974. Similarly, helping modestly overweight patients attain and maintain a more cosmetically pleasing weight may appropriately, in and of itself, be considered a clinical response to weight loss treatment.

Over the past several decades obesity has moved from being considered a problem of gluttony to that of being an illness or a disease. It is now time to consider that it is not just a health problem but also a cosmetic problem worthy of being addressed on that basis.

Your role...

Your success will depend upon your commitment to understanding and fulfilling your obligations in a course of treatment. It is important that you be willing to:

- Provide honest and complete answers to questions about your health, weight problem, eating activity and lifestyle patterns so your physician can better understand how to help you.
- Devote the time needed to complete and comply with the course of treatment your physician has outlined for you, including assessment, treatment, and maintenance phases.
- Work with your physician and others who may participate in helping you manage your weight loss, including keeping a daily diary, attending your sessions regularly if appropriate, and following your diet and exercise prescription.
- Allow your physician to share information with your personal or primary physician.
- Make and keep follow-up appointments with your physician and have any blood tests taken or any other diagnostic measures made that your physician may deem necessary during your course of treatment.
- Follow your exercise program within the guidelines given to you by your physician.
- It is vitally important for you to advise the clinic staff of ANY concerns, problems, complaints, symptoms, or questions even if you may think it is not terribly important, so the healthcare professional and/or your physician can determine if you should be seen more often. Keeping the clinic informed of any questions or symptoms you have affords the best chance of intervening before a problem becomes serious.

If you do not have a personal or primary physician, you must agree to find one before you and your bariatric physician begin working together. Your healthcare professional can assist you in this process if you like. Your signature below represents your permission, understanding and commitment to the above.

Potential benefits...

Medically-significant weight loss (usually about 10 percent of initial weight, or as an example, losing 20 pounds from 200 pounds starting weight) can:

- Lower blood pressure, reducing the risks of hypertension
- Lower cholesterol, reducing the risks of heart and vascular disease
- Lower blood sugar, reducing the risks of diabetes

If you are taking medications for one or more of these conditions, dosages may need to be adjusted as your overall health improves. You agree to see your primary physician as needed to have your need for these medications reassessed. Your bariatric physician will share your results with your primary physician on a regular basis so the physician is informed about your progress.

Other benefits may also be obtained, but cannot be guaranteed. Increasing activity level can favorably affect the above conditions and may have the additional benefit of helping you sustain weight loss. Weight loss and increased activity may provide important psychological and social benefits, as well.

Possible side effects...

The possibility always exists in medicine that the combination of any significant disease with methods employed for its treatment may lead to previously unobserved or unexpected ill effects, including death. Should one or more of these ill effects occur, additional medical or surgical treatment may be necessary. In addition, it is conceivable that other side effects could occur, which have not yet been diagnosed or observed.

Reduced Weight. When you reduce the number of calories you eat to a level lower than the number of calories your body uses in a day, you lose weight. As a result of this weight loss, your body makes some other adjustments in body processes. Some of these adjustments are responsible, in some participants, for improvements in blood pressure and blood sugar. However, you also may experience other temporary side effects or discomforts, including an initial loss of body fluid through increased urination, momentary dizziness, a reduced metabolic rate or metabolism (the rate at which you convert food to energy), sensitivity to cold, a slower heart rate, dry skin, fatigue, diarrhea or constipation, bad breath, muscle cramps, a change in menstrual pattern, dry and brittle hair or hair loss. Generally, these responses are temporary and resolve when calories are increased after the period of weight loss.

Reduced Potassium Levels. The calorie level you will be consuming is 800 or more calories per day and it is important that you consume the calories that have been prescribed in your diet to minimize side effects. Failure to consume all of the food and fluids and nutritional supplements or taking a diuretic medication (water pill) may cause low blood potassium levels or deficiencies in other key nutrients. Low potassium levels can cause serious heart irregularities. When someone has been on a reduced calorie diet, a rapid increase in calorie intake, especially overeating or binge-eating, can be associated with bloating, fluid retention, disturbances in salt and mineral balance, or gallbladder attacks and abdominal pain. For these reasons, following the diet carefully and following the gradual increase in calories after weight loss, as prescribed by your physician and/or primary physician, is essential.

Gallstones. Overweight people develop gallstones at a rate higher than normal weight individuals. The occurrence of symptomatic gallstones (pain, diagnosed stones and/or surgery) in individuals 30 percent or more over desirable body weight (50 pounds or more overweight) not undergoing current treatment for obesity is estimated to be 1 in 100 annually, and for individuals who are 20-30 percent overweight, about one-half that rate, or 1 in 200 annually. It is possible to have gallstones and not know it. One study of individuals entering a weight loss program showed that as many as 1 in 10 had "silent" gallstones at the onset. As body weight and age increase, so do the chances of developing gallstones. These chances double for women, women using estrogen, and smokers. Losing weight--especially rapidly--may increase the chances of developing stones or

sludge and/or increasing the size of existing stones within the gallbladder. The most common symptoms of gallstones are fever, nausea and a cramping pain in the right upper abdomen. If you develop any of these symptoms or if you know or suspect that you may already have gallstones, let your physician and healthcare

professional know immediately. Gallbladder problems may require medication or surgery to remove the gallbladder, and, less commonly, may be associated with more serious complications of inflammation of the pancreas or even death. Drugs are currently available that may help prevent gallstone formation during rapid weight loss. You may wish to discuss these drugs with your physician or primary physician.

Pancreatitis. Pancreatitis, or an infection in the bile ducts, may be associated with the presence of gallstones and the development of sludge or obstruction in the bile ducts. The symptoms of pancreatitis include pain in the left upper abdominal area, nausea, and fever. Pancreatitis may be precipitated by binge-eating or consuming a large meal after a period of dieting. Also associated with pancreatitis is long-term abuse of alcohol and the use of certain medications and increased age. Pancreatitis may require surgery and may be associated with more serious complications and death.

Pregnancy. If you become pregnant, report this to your bariatric physician and primary physician immediately. Your diet must be changed promptly to avoid further weight loss because a restricted diet could be damaging for a developing fetus. You must take precautions to avoid becoming pregnant during the course of weight loss.

Binge Eating Disorders. Binge eating disorder is defined as the habitual, uncontrolled consumption of a large amount of food in a short period of time. Participation in a calorically restricted diet has been shown in one study to increase binge eating episodes temporarily. Several other studies have demonstrated reduced episodes of binge eating following a calorie deficit and portion-controlled diet. Extended binge eating episodes are associated with weight gain.

The risk of weight regain...

Obesity is a chronic condition, and the majority of overweight individuals who lose weight have a tendency to regain all or some of it over time. Factors that help to maintain a reduced body weight include regular physical activity, adherence to a restricted calorie, low fat diet, and planning a strategy for coping with weight regain before it occurs. Successful treatment may take months or even years. Medical studies of calorie deficit/ portioned-controlled diets (including modified fasting) have shown varying results for patients who maintain weight loss. Some studies have shown that fewer than 5% of weight loss patients were able to maintain a reduced body weight after five years. Another study showed that after three years, weight loss patients, on average, maintained about one half of their initial weight loss. If you have had fluctuations in your weight in the past, it may be more difficult to maintain the weight you lose during and after this program. A published medical study indicated people whose body weight fluctuates greatly or often have a higher risk of heart disease and death compared with persons of relatively stable body weight, and such weight fluctuations may play a role in the development of other chronic diseases.

Sudden Death. Patients with morbid obesity, particularly those with serious hypertension, coronary artery disease, or diabetes mellitus, have a statistically higher chance of suffering sudden death when compared to normal weight people without such medical problems. Rare instances of sudden death have occurred while obese patients were undergoing medically supervised weight reduction, though no cause and effect relationship with the diet has been established. The possibility cannot be excluded that some undefined or unknown factor in the treatment program could increase this risk in an already medically vulnerable patient.

Your rights and confidentiality...

You have a right to leave treatment at any time without penalty, although you do have a responsibility to make sure your personal practitioner knows you are discontinuing treatment and to verify your practitioner is able to assume medical care for you after you leave treatment.

Resale of Products...

Products purchased through this weight management program, including HEALTHONE®, are intended to be sold through medically supervised weight management programs. By signing this Informed Consent, you agree that you will not resell any products purchased through this weight management program and that you will continue to consult with your treating physician for so long as you are using such products, as it may be hazardous to your health to abruptly abandon the weight loss program without medical supervision.

Disclosure of conflict of interest

I understand that my medical provider has a financial interest in the sale of meal replacements and other products. Treatment is not contingent upon the use of these products.

By signing this Informed Consent, you state:

I understand that the information about my treatment in the weight management program offered by the Your Better Self is shared, from time to time, with obesity researchers, medical scientists, and developers of weight management treatment. In order for the research, science and weight management industry to learn and benefit from my treatment, I give permission for information regarding my treatment to be entered into a national database. I understand that strict confidentiality for the identities and individual records of patients in the database will be maintained. Should the results of my treatment or any aspect of it be published, all reasonable precautions will be taken to protect my anonymity. As part of my continued education, I consent to receive periodic emails from my physician that will contain valuable information and helpful tips to ensure my success in weight loss and maintenance.

I hereby certify that the patient has advised me that they have read and understand the consent form. The patient has had the opportunity to ask questions and have them answered.

_____ _____

Medical Provider/Signature **Date**

I, the undersigned, have read and understand this information and have had an opportunity to ask questions. I will not sign this form unless I've had my questions answered to my satisfaction.

_____ _____

Participant Signature **Date**

I have received a copy of this signed consent form.

_____ _____

Participant's Initials **Date**

Dr. Mark Pinsky's
MEDICAL
WEIGHT LOSS CLINIC
Transforming you to Optimal Health

Photo/Video Release Form

I, _____(please print), grant permission to Dr. Mark Pinsky's Medical Weight Loss Clinic and its agents and employees the irrevocable and unrestricted right to reproduce the photographs and/or video images taken of me, or members of my family, for the purpose of publication, promotion, illustration, advertising, or trade, in any manner or in any medium. I hereby release Dr. Mark Pinsky's Medical Weight Loss Clinic and its legal representatives for all claims and liability relating to said images or video. Furthermore, I grant permission to use my statements that were given during an interview or testimony, with or without my name, for the purpose of advertising and publicity without restriction. I waive my right to any compensation.

Name: _____

Signature: _____ Date: _____

8045 Spyglass Hill Road Suite 101
Melbourne, FL 32940