Las Vegas Bariatric Physicians

Dr. Dana Trippi　　　Dr. Dominic Ricciardi

Patient Name: (Last)______________________________(First)____________________________(MI)___

Name you prefer to be called: ____

Patient Address: ____

City: ____ State: ______________ Zip: ________________

Home Phone: ___________________________________Cellular: __________________________

E-mail Address:______________________________________

Birthdate: _______________________________________Age: _________Sex: M F

Employment Information:

Patient Employer: ________________________________ Occupation: ______________________________

Work phone No: __________________________________Ext. ___________________________________

Social Security: __________________________________Drivers License: _________________________

In Case of Emergency:

Name: ___________________________________Relationship: _______________ Phone: _____________

Patient's Spouse: ____ Phone: _____________

Family Physician: ____ Phone: _____________

Referred by: ____

Financial Policy:

Thank you for selecting **Las Vegas Bariatric Physicians** for your health care needs. We are honored to be of service to you and your family. Please be advised that the **non-refundable** payment of $199.00 will be due at the time of the initial assessment (includes EKG, body composition, labs and initial physician consultation). Follow-up visits are $65.00, and any medications and injections are additional. Since weight-loss is generally not a covered benefit of most insurance, we do not accept insurance at this time. Patients have the option to submit paid in full receipts to their insurance company for reimbursement, but this is the sole responsibility of the patient. For your convenience, we accept Visa, MasterCard , American Express, Discover, cash and checks. Physician paperwork including chart reviews are $25.00. Copies of medical records are $.10 per page. There is a $25.00 charge for all returned checks. A $25.00 fee will apply to missed appointments or rescheduled appointments without a 24 hour notice.

I have read and understand all of the above and have agreed to these statements.

____ ____

Patient's Signature　　　　　　　　　　　　Date

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PATIENT INFORMED CONSENT

I hereby authorize Dr. Dana Trippi and/or Dr. Dominic Ricciardi to assist me in my weight reduction efforts. I understand my treatment may involve, but is not limited to the use of appetite suppressants for more than 12 weeks and when indicated, in higher doses than the dose indicated in the appetite suppressant labeling. I understand that the medication will only be prescribed when the expected benefits are felt to be greater than the risks. I also understand that regular medical visits will be necessary while on the medications and that theses medications must be used with caution and under direct supervision of the provider.

I have read and understand the following physician statement: "Medications including the appetite suppressants have labeling that has been agreed upon by the maker of the medication and the Food and Drug Administration. This labeling contains, among other things suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter-term studies (up to 12 weeks) using the dosage indicated in the labeling. As a medical provider, I have found the appetite suppressant helpful occasionally for periods in excess of 12 weeks and at times in larger doses than suggested by the labeling. As a provider, I am **NOT** required to use medications as the labeling suggests, but I am required to use labeling as a source of information, along with my own clinical experience, the experience of my colleagues, recent longer term studies, and recommendations of university based investigators. Based on this, I may choose when indicated to use the appetite suppressants for longer periods of time, and at times, in increased doses, albeit very rarely. Such usage has not been as systematically studied as the usage 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 provider, I need to weigh the risks and benefits of the appetite suppressant use with the risk of remaining overweight."

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Risk of proposed treatment: I understand this authorization is given with the knowledge that the use of appetite suppressants involves some risk and some hazards. Most appetite suppressants should be used with extreme caution by people who suffer from glaucoma, alcoholism, psychotic illnesses, uncontrolled high blood pressure, advanced arteriosclerosis, thyroid overactivity, people who are on certain other medications, i.e. monoamine oxidase inhibitors (MAOIs), certain serotonin type migraine medications, antimanic agents (lithium), some over the counter decongestants, and any other over the counter or prescription form anorectic agents. The more common side effects of appetite suppressants include, but are not limited to nervousness, diarrhea or constipation, sleeplessness, headache, dry mouth, dizziness, temporary memory loss, weakness, allergic reactions, psychological imbalances, high blood pressure, palpitations and heartbeat irregularities, and gallstones. Although only seen in rare cases, pulmonary hypertension or heart valve disease may develop. These conditions are serious and can be fatal. More studies are currently being done to document this further. I am willing to undergo studies as indicated by my weight loss physician if necessary for the purpose of ruling out underlying disease that may be a contraindication to the use of appetite suppressant.

Patient responsibility: As the patient, I understand it is my responsibility to follow instructions carefully and to report to the doctor treating me for my weight, any significant medical problems that I think may be related to my weight control program as soon as reasonably possible. I agree to notify my weight loss provider of any medical problems that I may have, that they are not aware of, or any results of labs/tests, ordered and reviewed by any other physician. I further acknowledge that I enter into this program in full knowledge and understanding that no physician, provider or staff of the weight loss physician has prior knowledge as to whether I would or would not have adverse effects due to the fact that each individual has a different biological and chemical make-up. 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 the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance. I understand that a balanced calorie counting program without the use of appetite suppressants may likely prove successful if followed, even though I would be hungrier than without the suppressant. I also understand that there are also risks of remaining overweight or obese. I understand that abrupt discontinuation of the appetite suppressant may result in lethargy or depression.

I understand that during the program, medications will be discontinued if:

1) I become pregnant, try to become pregnant, or suspect I am pregnant
2) I develop a contraindication or serious side effect of the medication
3) I do not comply with medical requirements, i.e. visits, med doses, etc.
4) I fail to lose and/or maintain weight appropriately
5) I use another medication that is not compatible
6) I have a planned surgery. Meds are to be stopped at least 2 weeks prior

I understand that occasionally other medications such as antidepressants, diabetic medications, diuretics, and anti-seizure medications are used for the purpose of aiding weight loss. I understand that these are considered off label use for weight loss, but can at times be of significant benefit. I understand that all medications carry a risk of side effects and that I need to weight the risk and benefits of all medications before use.

No guarantee: I understand that much of the success of the program will depend on my effort, and that there is no guarantee that the program will be successful. I understand that I will have to continue with sensible and nutritional eating habits and regular exercise all my life if I am to be successful long term.

Patient consent/waiver: I have read and fully understand this document and authorize and accept the proposed care regardless of risk. I affirm that my questions have been satisfactorily answered at this time. I realize that I should not sign this form if all items are not understood by me or if questions have not been answered to my satisfaction. I hereby release all providers and any and all employees from any liability associated and connected with my participation in this weight loss program. I accept the risks as discussed above, in hopes of obtaining desired beneficial results of weight loss treatment.
Labs/EKG: I understand that it is my sole responsibility to follow up on pending labs and/or EKG results if I chose not to continue with this weight loss program prior to evaluation and interpretation of the labs and/or EKG results. I understand that any pending labs and/or EKG may reflect abnormalities which would need follow through with a primary care physician. I understand it is my responsibility to give Las Vegas Bariatric Physicians the name of a primary care physician where labs and/or EKG can be sent for follow through and interpretation.

(continued on opposite side)

Patient Photographs: I agree/decline (circle one) to allow Las Vegas Bariatric Physicians to use before and after pictures at physicians discretion for purposes of advertising, lectures or research.

Patient signature:__________________________________ Date:_________________

Provider Declaration: I have explained the contents of this document to the patient and have answered all the patient's related questions. To the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies, and the risks concerning an overweight status. After being adequately informed, the patient has consented.

Provider signature:____ Date:_____________________

Medical History Form

Name: ____ Age:_________ Sex: M F

Family Physician: ____ Phone: ____________________

Present Status:

1. Are you in good health at the present time to the best of your knowledge? Yes No

2. Are you under a doctor's care at the present time? Yes No
   If yes, for what? ____

3. Are you taking any medications at the present time? Yes No
   What: _____________________________________ Dosages: __________________
   What:_____________________________________ Dosages: __________________

4. Any allergies to any medications? Yes No
   ____

5. History of High Blood Pressure? Yes No

6. History of Diabetes? Yes No
   At what age: _____________

7. History of Heart Attack or Chest Pain? Yes No

8. History of Swelling Feet Yes No

9. History of Frequent Headaches? Yes No
   Migraines? Yes No Medications for Headaches: ____________________________

10. History of Constipation (difficulty in bowel movements)? Yes No

11. History of Glaucoma? Yes No

12. History of Sleep Apnea? Yes No

13. 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: ____

13. Serious Injuries: Yes No

Specify: ____ Date: ________

14. Any Surgery: Yes No
 Specify: ____ Date: ________
 Specify: ____ Date: ________

15. Family History:

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

Has any blood relative ever had any of the following:

Glaucoma:	Yes	No	Who: ____________
Asthma:	Yes	No	Who: ____________
Epilepsy:	Yes	No	Who: ____________
High Blood Pressure	Yes	No	Who: ____________
Kidney Disease:	Yes	No	Who: ____________
Diabetes:	Yes	No	Who: ____________
Tuberculosis:	Yes	No	Who: ____________
Psychiatric Disorder	Yes	No	Who: ____________
Heart Disease/Stroke	Yes	No	Who: ____________

Past Medical History: (check all that apply)

_______ Polio	_______ Measles	_______ Tonsillitis
_______ Jaundice	_______ Mumps	_______ Pleurisy
_______ Kidneys	_______ Scarlet Fever	_______ Liver Disease
_______ Lung Disease `	_______ Whooping Cough	_______ Chicken Pox
_______ Rheumatic Fever	_______ Bleeding Disorder	_______ Nervous Breakdown
_______ Ulcers	_______ Gout	_______ Thyroid Disease
_______ Anemia	_______ Heart Valve Disorder	_______ Heart Disease
_______ Tuberculosis	_______ Gallbladder Disorder	_______ Psychiatric Illness
_______ Drug Abuse	_______ Eating Disorder	_______ Alcohol Abuse
_______ Pneumonia	_______ Malaria	_______ Typhoid Fever
_______ Cholera	_______ Cancer	_______ Blood Transfusion
_______ Arthritis	_______ Osteoporosis	_______ Other: ______________

Nutrition Evaluation:

1. Present Weight: __________ Height (no shoes): ___________ Desired Weight: _____________

2. In what time frame would you like to be at your desired weight? ______________________________

3. Birth Weight: _____ Weight at 20 years of age: ___________ Weight one year ago: _______________

4. What is the main reason for your decision to lose weight? ___________________________________

5. When did you begin gaining excess weight? (Give reasons, if known): _________________________
6. What has been your maximum lifetime weight (non-pregnant) and when?________________________

7. Previous diets you have followed: Give dates and results of your weight loss:

____ ____

____ ____

8. Is your spouse, fiancee or partner overweight? Yes No

9. By how much is he or she overweight? ____

10. How often do you eat out? ____

11. What restaurants do you frequent?____

12. How often do you eat “fast foods?”____

13. Who plans meals? ______________________ Cooks? ____________________ Shops? ______________

14. Do you use a shopping list? Yes No

15. What time of day and on what day do you shop for groceries? _____________________________

16. Food allergies: ____

17. Food dislikes: ____

18. Food you crave: ____

19. Any specific time of the day or month do you crave food? ______________________________

20. Do you drink coffee or tea? Yes No How much daily? _________________________________

21. Do you drink cola drinks? Yes No How much daily? ___________________________________

22. Do you drink alcohol? Yes No

What? __________________________ How much? _______________________ Weekly? _____________

23. Do you use a sugar substitute? ____________ Butter? ______________ Margarine? _________________

24. Do you awaken hungry during the night? Yes No

What do you do? ____

25. What are your worst food habits? ____

26. Snack Habits:

What? __________________________ How much? _______________________ When? ______________

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

____

____

28. Do you thing you are currently undergoing a stressful situation or an emotional upset? Explain:

____

____

29. Smoking Habits: **(answer only one)**

____ You have never smoked cigarettes, cigars or a pipe.
____ You quit smoking _____ years ago and have not smoked since.
____ You have quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke.
____ You smoke 20 cigarettes per day (1 pack).
____ You smoke 30 cigarettes per day (1-1/2 packs).
____ You smoke 40 cigarettes per day (2 packs).

30.

Typical Breakfast	Typical Lunch	Typical Dinner
________________________	_____________________	____________________________
________________________	_____________________	____________________________
________________________	_____________________	____________________________
________________________	_____________________	____________________________
Time eaten: _____________	Time eaten: __________	Time eaten: ________________
Where: _________________	Where: ______________	Where: _____________________
With whom: _____________	With whom: _________	With whom: ________________

31. Describe your usual energy level: ____

32. 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, jogging, swimming or cycling.
Heavy activity—consistent lifting, stair climbing, heavy construction, etc., or regular participation
in jogging, 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.

33. 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.

34. Please describe your general health goals and improvements you wish to make: __________________

____

____

____

35. Are you interested in appetite control medications? Yes No

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