CONSIGLIO
WELLNESS CENTER

Patient Medical History – Weight Loss Program

Patient Name: _____ DOB: _____

Occupation: _____

Medication Allergies: _____

Environmental/Other Allergies: _____

Primary Care Physician: _____ Gender: Male __ Female __

Phone #_____ Email: _____

Pregnant: Yes ☐ No ☐ Breastfeeding: Yes ☐ No ☐ Last Menstrual Period: _____

Current Medications (prescription, over-the-counter, vitamins, supplements)

Preferred Pharmacy: _____

Medication	Dose/Strength	Medication	Dose/Strength

Past Medical History (make an X next to conditions you currently have or have had in the past)

Condition	Current	Past	Condition	Current	Past
Heart Disease			High Blood Pressure		
High Cholesterol			Liver Disease		
Cancer _____			Anemia/Blood Disorder		
Diabetes			Thyroid Disease		
Stroke			Seizures		
Headaches/Migraine			TB (Tuberculosis)		
Mental Health Disorder			Nerve Impairment		
Spinal Disorder			Sleep Apnea		
Lung Disease (Asthma/COPD)			Chronic Skin Condition		
GI Disorder (Reflux/Heartburn)			Kidney/Bladder Prostate		
Other Conditions:					

CONSIGLIO
WELLNESS CENTER

Patient Name: _____ DOB: _____

Surgical History

Surgery	Approximate Date

Family History

Condition	Mother	Father	Sister	Brother	Daughter	Son	Grand-mother	Grand-father
Heart Disease								
High Cholesterol								
Cancer_____								
Diabetes								
Stroke								
Headaches/Migraine								
Mental Health Disorder								
Spinal Disorder								
Lung Disease (Asthma/COPD)								
GI Disorder (Reflux/Heartburn)								
High Blood Pressure								
Liver Disease								
Anemia/Blood Disorder								
Thyroid Disease								
Seizures								
TB (Tuberculosis)								
Nerve Impairment								
Sleep Apnea								
Chronic Skin Condition								
Kidney/Bladder Prostate								
Deceased/Age at Death								
Other Conditions:								

Social History

Do you:	Current	Past	Never
Smoke Cigarettes			
Chew Tobacco			
Smoke Marijuana			
Use Vaping Device			
Drink Alcoholic Beverages			
Drink Caffeine			

CONSIGLIO
WELLNESS CENTER

Patient Name: _____ **DOB:** _____

Weight Loss Program

Current weight _____

Weight one year ago _____

Ideal weight _____

Family/living Situation – who lives in your home?

Children with age:

_____

_____

_____

Spouse/partner:

_____

Exercise/Recreation – Frequency

_____

_____

_____

What health concerns are you most worried about? How much does this affect your daily life?

_____

_____

_____

How have you dealt with these concerns in the past?

- ☐ Professional medical treatment
- ☐ Self-care

Has this treatment been successful? Explain:

_____

_____

CONSIGLIO
WELLNESS CENTER

Patient Name: _____ **DOB:** _____

List your health practitioners:

Name	Specialty/reason for seeing	Phone Number

In general, describe your diet/eating habits at home:

_____

_____

_____

Which of the following do you consumer regularly?

- ☐ Soda
- ☐ Diet Soda
- ☐ Fast Food
- ☐ Refined Sugar
- ☐ Alcohol
- ☐ Gluten(wheat/rye/barley)
- ☐ Dairy
- ☐ Coffee

Are you on a special diet? Explain:

_____

What percentage of your meals are cooked at home?

_____

Have you had periods of eating junk food, binge eating or dieting? List any known diets (WW, Atkins, Keto etc) that you have been on for a significant amount of time:

_____

_____

Is there anything else we should know about your current diet, history or relationship to food?

_____

_____

_____

CONSIGLIO
WELLNESS CENTER

Patient Name: _____ **DOB:** _____

Have you used or abused alcohol, drugs, meds, tobacco or caffeine? Are you currently? Explain:

_____

_____

How do you handle or deal with stress in your life?

_____

_____

_____

Are you satisfied with your sleep?

_____

How many hours of sleep do you get on average?

☐ 6 or less ☐ 6-8 ☐ more than 8

Do you doze off or nap during the day? Do you fall asleep in less than 30 minutes?

_____ _____

Do you think your family and friends will be supportive of you making health and lifestyle changes to improve your quality of life? If not, explain:

_____

_____

Who in your family or on your healthcare team will be the most supportive of you making dietary changes?

_____

What are your health goals? Why do you want to achieve this?

_____

_____

CONSIGLIO
WELLNESS CENTER

Consent for Medical Weight Loss Treatment

I,_____, (patient) do hereby authorize the providers, staff and Wellness Coordinator of Consiglio Wellness Center to assist me in weight reduction. In order to be successful, I fully understand that this program consists of behavioral lifestyle changes and that my treatment may include the use of appetite suppressants and other supplements. I further understand that in order to continue to receive appetite suppressants, I must show continued weight loss.

Regarding the use of appetite suppressants, I understand that there are potential risks involved. Reported side effects include nervousness, constipation, sleeplessness, headaches, dry mouth, weakness, tiredness, medication allergy, high blood pressure, rapid heartbeat and heart irregularities. I understand that these and other risks could, on occasion, be serious and possibly permanently disabling. _____initial

I understand that if I develop side effects from the medication, I will discontinue taking the medication and notify the staff at Consiglio Wellness Center, as well as my primary care physician, immediately and in the event the problem is severe, I will go to the nearest Emergency room for immediate care. I do not have a history of alcohol abuse, drug abuse, schizophrenia, manic-depressive illness, or eating disorder, as these conditions constitute a contraindication to the use of appetite suppressants. _____initial

I agree not to take any other weight loss medications, other than those prescribed by the providers of the Consiglio Wellness Center and further agree to inform the Consiglio Wellness Center staff of ANY changes in my medication or medical history. _____initial

Female patients – I am not pregnant, nor am I trying to get pregnant. If I become pregnant, I will stop taking the medication, notify the Consiglio Wellness Center and my OB/GYN immediately. I am not breastfeeding. _____initial

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 appetite suppressants would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants. I understand the risk associated with being overweight/obese, which include the possibility of death, high blood pressure, diabetes, heart attack and heart disease, stroke, arthritis of the joints, hips, knees and feet, and gallbladder disease. I also understand that rapid weight loss programs may increase the incidence of symptomatic gallbladder disease. _____initial

There is no guarantee that this program will work for me. I understand that I must follow the program as directed, in order to achieve weight loss. By consenting to treatment, I agree to pay, in full, for all visits and charges incurred at each visit. By signing below I certify that I have read and fully understand this consent form and understand the risks associated with my treatment for weight loss.

Patient:_____ Date:_____

Witness_____