Virginia Weight & Wellness
4439 Cox Road | Glen Allen, Virginia 23060
804-726-1500 | Fax: 804-726-1501 | www.VirginiaWeightLoss.com

WELCOME TO VIRGINIA WEIGHT & WELLNESS

Thank you for choosing Virginia Weight & Wellness for your weight management needs. We sincerely look forward to meeting you and working together to help you achieve your goals.

Our office address is **4439 Cox Road, Glen Allen, Virginia 23060** and we are located in the West End of Richmond, in the Innsbrook area. Our office is at the intersection and stoplight at Cox Road and Waterfront Drive in the office park called "Center Park". Once inside the "Center Park" office complex, our office is located on the corner immediately to the left. Parking is available directly in front of the office.

Please visit **www.VirginiaWeightLoss.com** for driving directions and details about our medical practice.

Here are a few things to know and to have prepared for your first visit:

1) **New Patient Forms.** Please fill out the complete paperwork and forms in advance of your visit. It is **8 pages** and includes your medical history, weight history, consent forms, and a copy of our "Privacy Policy" for your records. **We understand and appreciate that the forms and questionnaires are very detailed and will take about 40 minutes to complete. Please take the time to fill them out completely and accurately as this really helps us learn more about you so that we can better assist you during your visits.**

   If you can, **please fax your new patient forms to our office 3-7 days prior to your visit** as this will allow us time to transfer your information into our electronic medical record and allow us to review your history prior to your visit. You may fax your paperwork to **fax number (804) 726-1501**.

2) **Medication List.** Please make sure to complete the medication section of the New Patient Forms completely listing your medications and their doses so that we may accurately record them in your chart.

3) **Labs.** If you have had blood work drawn in the last 12 months, please bring a copy to your 1st visit, or arrange for a copy to be faxed to our office. If not, once you are seen, we can give you a lab slip which you can take at your convenience to **any lab draw station (i.e. LabCorp)** of your choice or as required by your insurance company. NOTE: Medications cannot be prescribed until your lab results, including thyroid tests, are reviewed.

4) **EKG.** The Virginia Board of Medicine requires that you have an EKG done within the last 90 days if you are considering the use of any appetite suppressant that has any stimulating properties. If you have not had an EKG performed during the last 90 days, then we may perform one during your visit. If you have had an EKG within the last 90 days, please obtain or arrange a copy to be faxed to our office at (804) 726-1501.

5) **Payment.** Please note that full payment is required at the time of service and our office accepts cash, credit cards (Visa & MasterCard) and checks. We do not bill insurance for visits.

6) **Please arrive 30 min prior to your scheduled appointment** so we can register you and start your visit on time.

7) **Fax New Patient Forms**. Again, if possible, please fax your completed New Patient Forms to **(804) 726-1501** in advance of your scheduled appointment.

8) **Prescription Insurance Card and Driver's License.** Please bring your prescription insurance card and driver's license so we can scan a copy into your chart.

Thank you and we look forward to meeting you!

Sincerely,

The Virginia Weight & Wellness Team

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New Patient Demographic Information

Patient Information	**Please print all information clearly with a black pen**
Title	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.
First, Middle, and Last Name	
Preferred / nickname if different from above	
Address Line 1	
City, State, Zip Code	
Phone Number(s) Please star (*) your preferred phone number	Home ( ) Cell ( )
Okay to leave a message on your home phone? **no yes**	Okay to leave a message on cell phone? **no yes**
Email address (only if we may email you)	
by writing your email above, you authorize us to email appointment reminders	
Birthday (mm/dd/yyyy)	Age:
Patient Occupation / Employer Name	/
Marital Status (and spouse name)	
Spouse Occupation / Employer Name	/
Health Insurance (check all that apply)	☐ Commercial Insurance that my family or I purchased ☐ Commercial Insurance provided through my employer ☐ Medicare ☐ Medicaid ☐ Tricare ☐ Veteran's Hospital
Primary Care Provider's Name	PCP:
Names of other Healthcare Providers	
How did you hear about us?	
Pharmacy Information	
Pharmacy Name	
Pharmacy Phone Number	
Pharmacy Address	
Emergency Contact Information	
First and Last Name and Relationship	
Phone Number(s)	
Authorization to Release Healthcare Information	
Please list below the people that you authorize us to discuss your healthcare and health conditions with (optional)	
First & Last Name, Relationship, and Phone #	
First & Last Name, Relationship, and Phone #	

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New Patient Medical History

Medications	
List all prescription medications, doses, & frequencies	**List all Over-The-Counter and Dietary Supplements**
☐ Check here for "no prescription medications"	☐ Check here for "no OTC meds or dietary supplements"
Please include method of birth control (i.e OCPs or IUD)	
Medication Name: Dose: Frequency Taken:	
Allergies to Medications (list drug name and allergic reaction below)	
☐ Check here for "no allergies"	

Medical Conditions and Surgeries			
Have you been diagnosed with any of the following?			**List any OTHER MEDICAL CONDITIONS below:**
High Blood Pressure	**no**	**yes**	☐ Check here if you have no additional medical conditions
High Cholesterol	**no**	**yes**	
Diabetes	**no**	**yes**	
Pre-diabetes (borderline diabetes)	**no**	**yes**	
Personal History of Heart Disease	**no**	**yes**	
Previous heart attack, stent, surgery	**no**	**yes**	
Stroke / TIA	**no**	**yes**	
PCOS (polycystic ovary syndrome)	**no**	**yes**	
Low Thyroid (Hypothyroidism)	**no**	**yes**	
Migraine Headaches	**no**	**yes**	**List any previously SURGERIES below:**
Sleep Apnea	**no**	**yes**	☐ Check here for "no previous surgeries"
If so, do you use a CPAP machine?	**no**	**yes**	
Depression	**no**	**yes**	
Anxiety	**no**	**yes**	
Bipolar Disorder	**no**	**yes**	
Kidney Stones	**no**	**yes**	
Seizure Disorder	**no**	**yes**	
Glaucoma	**no**	**yes**	

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Social History				
Marital Status (please circle)	Single Married Engaged Partnered Divorced Widowed			
Who lives in the household with you?	Live with:			
Your Children's Ages & Names (if applies)	Children:			
Employment or Work Status	☐ Working as (Occupation/Employer):			
	☐ Homemaker			
	☐ Student at:			
Tobacco / Nicotine Smoking History	☐ I have never smoked or vaped			
	☐ I previously smoked or vaped but quit			
	☐ I currently smoke or vape the following amount per day:			
Alcohol Use	☐ I do not drink any alcohol			
	☐ I previously drank but quit History of alcoholism?		**no**	**yes**
	☐ I currently drink alcohol. How many drinks per week?			
Recreational Drugs / Substance Use	Do you use cannabis, marijuana, THC, tinctures, edibles?		**no**	**yes**
	Are you currently using any street / illicit drugs?		**no**	**yes**
	Do you have a history of drug addiction?		**no**	**yes**
Sexual / Reproductive History	Are you sexually active?		**no**	**yes**
	If yes, are you currently trying to become pregnant?			
	If not trying to conceive, what contraceptive method?			
	Is there a possibility that you are pregnant right now?		**no**	**yes**
	Do you have a history of infertility?		**no**	**yes**
	When was your last menstrual cycle?			
	How many menstrual cycles do you have per year?			
Military Service	Have you served in the military? Branch?		**no**	**yes**

Family History (list family members below with each of the following conditions)	
Indicate who in your family have any of the following medical conditions: (e.g. mother, father, brother, sister, children)	Cancer (list types e.g. thyroid):
	Heart Disease:
	Diabetes:
	High Blood Pressure:
	High Cholesterol:
	Obesity:
	Hypothyroidism / Low Thyroid:
	Calcium Disorders:
	Other Family Conditions:

Review of Systems (please circle if you have any of the following)			
General →	Fatigue	Always Cold	Always Hot
Heart →	Chest Pain	Palpitations	Leg Swelling
Abdomen →	Nausea / Vomiting	Constipation	Diarrhea
Women's Health →	Irregular Cycles	No Menstrual Cycles	Post-Menopausal
Mental Health →	Depression	Anxiety	Trouble Sleeping
Skin →	Hair Loss	Acne	Extra Facial Hair
Neurological →	Headaches	Numbness / Tingling	Tremors
☐	**NONE** – I have none of the above symptoms		

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Weight History				
Current height	**Current weight**	**Lowest adult weight** What year?	**Highest weight** What year?	**Goal weight**
How much Weight (in pounds) have you gained or lost over the following most recent time periods?				
6 months	**1 year**	**2 years**	**5 years**	**10 years**

What is the main reason why you are seeking to lose weight?

When did you start gaining extra weight (please provide possible reasons for weight gain if known)?

What do you think is the main cause of your weight gain?

List previous weight loss programs and previous diets you have attempted (include approximate dates and results):

What do you think is the most effective way for you to lose weight?

What do you think your biggest obstacle is that has prevented or might prevent you from losing weight?

Have you ever used any over-the-counter or prescription medications for weight loss (include names dates, results)?

Have you had labs drawn in the last year?	☐	No	☐	Yes - approximately what month?
Have you previously had bariatric surgery?	☐	No	☐	Yes, I previously had weight loss surgery
Do you plan on having bariatric surgery?	☐	No	☐	Yes, I plan on having surgery with Dr.

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Diet and Nutrition Questionnaire (List common foods you eat at the following times of the day)					
Meal	**Main Dishes**	**Side Dishes**	**Desserts**	**Drinks**	**Eating Out / Restaurants**
Breakfast					# breakfasts out/week & where?
Morning Snacks					
Lunch					# lunches out/week & where?
Afternoon Snacks					
Dinner					# dinners out/week & where?
Evening Snacks					

How many breakfasts do you skip per week?		
How many lunches do you skip per week?		
How many dinners do you skip per week?		
How many meals per week do you eat out or take out (including breakfast, lunch, and dinner)?		
Which restaurants do you usually eat out at or take out from?		
Do you frequently eat overnight?	☐ No	☐ Yes, I eat overnight in the middle of the night
Do you consider yourself a stress eater?	☐ No	☐ Yes, I eat when I am stressed
Do you feel hungry all the time?	☐ No	☐ Yes, I am always hungry
Are you interested in using a medication for weight loss?	☐ No	☐ Yes, I am interested in using a medication
If so, the Board of Medicine Guidelines require an EKG within the last 90 days for any medications that are stimulating		
Have you had previous heart testing?	☐ No	☐ Yes – when?
Would you consider a weekly self-injected medication?	☐ No	☐ Yes
The Board of Medicine also requires we review blood tests including thyroid before prescribing weight loss medications		

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Activity and Exercise	
Please select your current activity level (select only one of the options)	☐ Inactive – no regular physical activity with a sit-down, sedentary job ☐ Moderate Activity – i.e. occasionally walk, job, run, bike, golf, tennis ☐ Heavy Activity – regular exercise at least 3x per week ☐ Vigorous Activity – extensive exercise > 60 minutes at least 4x/week
Outside of work and working in the home, please describe what physical activity you do and how often:	
Do you any form of resistance training and if so describe and how often (i.e. lift weights, resistance bands)?	
What limits or prevents you from participating in more physical activity or exercise (i.e. joint problems, arthritis, time)?	
Do you have membership at any gyms or exercise facilities? Which one(s)?	

Stress and Sleep	
Please circle your **STRESS** level:	**1** **2** **3** **4** **5** **6** **7** **8** **9** **10** 1=no stress 5=moderate stress 10=extreme
Please describe major sources of stress in your life and how they affect you:	
Do you have a history of trauma?	☐ No ☐ Yes
Is it pertinent to affecting your weight?	☐ No ☐ Yes
Do you feel comfortable talking about it?	☐ No ☐ Yes
Sleep Hygiene and Sleep Patterns (select all that apply)	* What time do you usually go to sleep? * What time do you usually wake up? * Do you wake up through the night? * Do you wake up and eat overnight?
	☐ I usually sleep 8 hours or more per night ☐ I usually sleep 6-8 hours per night ☐ I usually sleep 4-6 hours per night ☐ I usually sleep < 4 hours per night
	☐ I snore heavily at night ☐ I wake up in the morning still tired ☐ Have you ever had a sleep study? ☐ no ☐ yes ☐ I have sleep apnea; if yes do you use CPAP? ☐ no ☐ yes ☐ I work and liver a night schedule and sleep during the day ☐ My job requires that I work alternating and variable, rotating shifts

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PATIENT INFORMED CONSENT FOR THE USE OF MEDICATIONS FOR WEIGHT MANAGEMENT

1. I authorize Virginia Weight and Wellness to assist me in my weight loss efforts. I understand that weight loss medications may be offered as part of my treatment plan. I understand that the use of medications has been shown to be helpful in losing weight and helpful in keeping the weight off.

   I understand that the use of certain medications may be contraindicated with certain medical conditions or certain medications. I agree to be honest in disclosing this information and will notify my health care provider of changes to my medical history or medications. I understand that failure to do so can be dangerous to my health.

2. I have read and understand the information below regarding medications for weight management:

   Weight loss medications that obtained FDA approval after 2012 are approved for "chronic weight management" meaning they are FDA approved for not just weight loss, but also long-term maintenance.

   Earlier medications originally approved for weight loss in the 1950s and 1960s are still commonly used today to assist with appetite control. In the past, when these become FDA approved, the FDA only required studies as long as 3-6 months in duration, so these medications received the FDA approval and package insert (PI) labeling for "short-term weight loss" and short-term use. However, over the last 6 decades, these medications have been found to be effective with appetite control in durations longer than 3-6 months. Clinicians may prescribe appetite suppressants for periods exceeding 3-6 months and at times at doses larger than those suggested in the package labeling. The use of these medications in such a manner is considered "off-label use" and in such circumstances, we weigh the balance between the potential benefits with risks.

3. I agree to take the medication only as prescribed by Virginia Weight and Wellness. I understand that taking medications in any way other than prescribed can be dangerous to my health. I agree that I will not resell the medication, nor allow anyone to use it other than myself. I agree that I will not visit another doctor for the purpose of obtaining additional or duplicate medications for weight management.

4. I understand that the use of medications it not required to lose weight and it is my choice to use them or not.

By signing below, I acknowledge that I have carefully read, understand, and agree to the above.

PATIENT PRINTED NAME: _____

PATIENT SIGNATURE: _____ **DATE:** _____

ACKNOWLEDGEMENT OF APPETITE SUPPRESSANT REFILL POLICY:

If using medications that have any stimulating properties, I agree to request prescription refills only during regular clinic hours as some appetite suppressants are classified as controlled substances and are regulated by the Drug Enforcement Agency (DEA). I understand that controlled medications are not refilled in advance of the time of refill. Some medications are prescribed initially in one month increments via healthcare provider approval with appropriate evaluation. I understand that missing my appointment may mean being out of medication(s) for a period of time. I understand that Virginia Weight and Wellness is not obligated to replace any medications or prescriptions that are lost or stolen for any reason.

PATIENT SIGNATURE: _____

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES":

By signing below, I acknowledge that I have received a copy of the Virginia Weight and Wellness "Notice of Privacy Practices"

PATIENT SIGNATURE: _____

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NOTICE OF PRIVACY PRACTICES (KEEP THIS PAGE FOR YOUR FILES):

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, and healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected Health Information, or PHI, is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related healthcare.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your healthcare provider, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operations of the healthcare provider's practice, and any other use required by law.

Treatment
We will only use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This may include the coordination or management of your health care with a third party. For example, we could disclose your protected health information, as necessary, to a home health agency that provides care to you or provide it to a physician whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment
Your protected health information may be used as needed to obtain payment for your health care services.

Healthcare Operations
We may use or disclose, as needed, your protected health information to support the business activities of your healthcare provider's practice. These activities include but are not limited to quality assessment, employee review, training of medical students, and licensing. For example, we may call you by name in the waiting room when your healthcare provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments. We may use or disclose your protected health information in the following situations without your authorization: as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, medical examiners, funeral directors, organ and tissue donation, research, criminal activity, military activity, and national security.

Right to Access and or Amend Your Records:
In most cases, you have the right to look at or get a copy of medical information that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing, or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

If you believe that information in your records is incorrect or that important information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information is not maintained by us; or if we determine that your record is accurate. You may submit a written statement of disagreement with a decision by us not to amend a record.

Right to an Accounting:
You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and healthcare operations, circumstances in which you have specifically authorized such disclosure, and certain other exceptions.

To request this list of disclosures, indicate the relevant period, which must be after July 1, 2011. You must submit your request in writing to the Privacy Office listed below.

Right to Request Restrictions:
You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request and work to accommodate it, when possible, but we are not legally required to accept it. We will inform you of our decision on your request. All written requests or appeals should be submitted to the Privacy Office listed below.

Requests for Confidential Communications:
You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.

Right to request a paper copy of this Notice:
You may receive a paper copy of this Notice from us upon request.

Changes to the Terms of this Notice:
We can change the terms of this notice at any time and the changes will apply to all information we have about you. You can receive a copy of the current Notice of Privacy Practices at any time upon request.

Complaints:
If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact the Privacy Office listed below. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Privacy Office
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