WHAT TO EXPECT AT YOUR WEIGHT LOSS VISITS

Initial Visit:

- Medical history review
- Symptom review
- Physical examination including your height and weight.
- Orders for testing. This may include bloodwork, EKG, and/or a sleep study.
- Possible referrals to other providers or services.
- Take home initial treatment plan. This may or may not include medications.

Follow-up visits:

- Repeat physical examination including height and weight.
- Review progress since last visit.
- Discuss any concerns, side-effects, hurdles, etc.
- Review and adjust treatment plan.

What to bring to your appointment:

- **Completed** weight management medical history form.
- **Reviewed** and **signed** consent form.

Steel City Gynecology does not provide primary care. It is strongly recommended that you have a primary care provider for your routine health needs. There are no guarantees made that you will achieve your weight loss goals and results will vary.

WEIGHT MANAGEMENT MEDICAL HISTORY FORM

Name: _____ Date of Birth _____

Date of Visit: _____

How does your weight affect your life and health?

_____

_____

_____

_____

Weight History:

When did you first notice you were gaining weight?

Childhood Teens Adulthood Pregnancy Menopause

Did you ever gain more than 20 pounds in less than 3 months? Y/N If so, when? _____

How much did you weight: one year ago? _____ Five years ago? _____10 years ago? _____

Life events associated with your weight gain (check all that apply):

Marriage Divorce Pregnancy Abuse Illness/Surgery Travel

Shift Work Job change Quitting smoking Periods of general increased stress

Medications (Please list:_____)

Previous weight-loss programs (i.e., Weight Watchers, Nutrisystem, DASH diet, etc):

_____

_____

_____

What was your maximum weight loss? _____

What are your greatest challenges with dieting:

_____

_____

_____

Have you ever taken medication for weight loss? If yes, please list:

_____

What worked? What didn't work? Why or Why not?

_____

_____

Nutritional History:

Do you eat breakfast? _____days per week at ___:___AM

How many times do you eat per day? _____ Do you get up and eat during the night? If so, how many times per week? _____ Food intolerances/restrictions? _____

What beverages do you drink (including alcohol)? _____

Food triggers (check all that apply):

Stress Boredom Anger Insomnia Seeking reward

Parties Holidays Eating out Other:_____

Food cravings (check all that apply):

Salty Chocolate Sweet Fast food High fat Sugar

Starches Crunchy Large portions

Favorite foods: _____

Do you log your total daily caloric intake? Y/N If so, how many calories/day? _____

If so, how do you log? (an app, etc) _____ Have you set a goal for total daily calories? Y/N

If so, how often do you go over this amount per week? _____

Medical History:

Have you ever had any of the following? Please check all that apply:

Heart attack Angina Gallbladder stones High blood pressure

Sleep apnea Stroke Indigestion/reflux Thyroid disease

High cholesterol Diabetes Celiac disease Anxiety

High triglycerides Gout Pancreatitis Depression

Infertility Arthritis PCOS Bipolar d/o

Glaucoma Cancer (type/s):_____

Other:_____

Past surgeries:

Gastric bypass Gastric banding Gastric Sleeve Gallbladder

Heart bypass Other:_____

Medications (list all current medications including over-the-counter medications, supplements, and herbal therapies):

_____

_____

_____

Allergies: _____

Social History/Habits:

Do you exercise? If so, what kind of exercise? _____

Duration: _____hours _____minutes Number of times per week: _____

Does anything limit your ability to exercise? _____

How many hours do you sleep at night? _____ Do you feel rested in the morning? _____

Do you snore? _____ Do you experience any sleep disturbance? _____

Smoking: Never Current smoker (_____packs/day) Past smoker (quit____years ago)

Alcohol: Never Occasional Regularly (_____drinks/day _____drinks/week)

Any prior history of treatment for alcoholism? Y/N For drug use? Y/N

Drugs: Never Current Past Type of drugs: _____

Family History:

Obesity? Check all that apply:

Mother Father Sister(s) Brother(s) Daughter(s) Son(s)

Diabetes? Check all that apply:

Mother Father Sister(s) Brother(s) Daughter(s) Sons(s)

Other? Check all that apply:

High blood pressure Heart disease High cholesterol High triglycerides

Stroke Thyroid disease Anxiety Depression Bipolar d/o Alcoholism

Drug abuse Cancer (Types:_____)

Other: _____

Gynecologic History:

Age periods started: _____ Age periods ended: _____

Periods are: Regular/Irregular Heavy/Normal/Light

Number of pregnancies: _____Number of children: _____

Age of first pregnancy: _____ Age of last pregnancy: _____

System Review:

Check all that apply:

Recent weight loss more than 10 pounds

Recent weight gain more than 10 pounds

Acne Skin rash Cough Acne Shortness of Breath

Chest pain Snoring Difficulty breathing when lying flat

Fainting Palpitations Swelling Abdominal pain Bloating

Constipation Diarrhea Food intolerance Nausea/vomitting

Increased appetite Decreased appetite Heartburn

Urinary frequency/urgency Nighttime urination Blood in stool

Back pain Joint pain Muscle aches Dizziness Depression

Headaches Seizures Dizziness Weakness Insomnia Anxiety

Low libido Cold intolerance Heat intolerance/hot flashes Hair loss

Abnormal hair growth Fatigue Absence of periods Abnormal periods

Additional

Comments/Concerns:_____

_____

_____

_____

_____

OBESITY PROGRAM CONSENT FORM

NOTE: SIGNING THIS FORM DOES NOT GUARANTEE THAT YOUR PROVIDERS(S) AT STEEL CITY GYNECOLOGY WILL FIND YOU TO BE AN APPROPRIATE CANDIDATE FOR ANTI-OBESITY MEDICATIONS, BUT ONLY THAT YOU HAVE READ, UNDERSTOOD, AND AGREE TO THE TERMS OF MEDICATION USAGE SHOULD YOU AND YOUR PROVIDER(S) DECIDE UPON THEIR USAGE NOW OR IN THE FUTURE.

I, _____ , authorize Steel City Gynecology and associated providers to help me in my weight-reduction efforts. I understand that my program may consist of dietary modification, increase in physical activity, instruction on behavior modification, the use of anti-obesity medications and/or referrals to other specialists.

I understand that any medical treatment may involve risks as well as benefits. I also understand that there are certain health risks associated with having excess weight for obesity. Risks associated with obesity management programs are usually temporary, reversible, and may include but are not limited to nervousness, anxiety, or other mood changes, sleeplessness, headaches, electrolyte abnormalities,dry mouth gastrointestinal disturbances, weakness, fatigue, pancreatitis, psychological problems, gallstones, high blood pressure, rapid or slowing of the heartbeat and other heart irregularities, and risk of weight regain. These and other possible risks could on occasion, be serious or even fatal. Risks associated with having obesity may include, but are not limited to, high blood pressure, diabetes, heart attack, heart disease, cancer, arthritis of the joints, sleep apnea, and sudden death. I understand that these risks may increase with additional weight gain.

Some anti-obesity medications are considered "controlled substances". By law, a controlled substance can only be prescribed from one facility at a time; therefore I agree that only Steel City Gynecology will prescribe anti-obesity medications for me. I agree that it is my responsibility to inform my provider(s) at Steel City Gynecology and any other providers from whom I receive treatment of all medications prescribed to me. I understand that the use of anti-obesity medications is contraindicated with certain medical histories, allergies, and/or other medication use. I agree that I will be honest in disclosing all of this information and will notify my provider(s) at Steel City Gynecology of any changes to my medical history or medication usage. I understand that failure to do so can be dangerous to my health.

I agree to take the medication only as prescribed and directed by my provider(s). I understand that taking medications in any way other than as directed and prescribed could affect my health and be dangerous. I understand that I am to report any side effects or adverse reactions of my medications to my provider(s) at Steel City Gynecology.

I understand that it is my responsibility to follow the instructions carefully and that the purpose of this treatment is to assist me in my desire to decrease my body weight for improvement of health and to maintain weight loss. I understand that the purpose of medications for weight loss

is to be used as an adjunct to a program that includes nutrition and/or physical activity and/or behavior modifications.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees in the medical treatment of the disease of obesity. I also understand that I will have to continue monitoring my weight after active weight loss. I understand that obesity is a chronic, lifelong condition that will require permanent changes in eating habits, activity level, and behavior to be effective.

Patient Signature: _____

Patient Name (printed): _____

Date: _____

Witness: _____