Nutrition and Weight Loss

Dr. CJ Wolinski MD

Patient Information and Health History

First Name:	Last Name:			Middle Initial:
Date of Birth:	Age:	Sex:	Marital Status:	
Street Address:	City:		State:	Zip
Home Phone:	Cell Phone:		Work Phone:	
SSN:	Employer:		Occupation:	
How did you hear about us?			Email:	

Patient History (please check all that apply)

General	Head/Ears/Nose/Throat	Pulmonary	
☐ Unplanned Weight Change	☐ Visual Problems	☐ Cough	☐ Fall Asleep at Wheel
☐ Fevers	☐ Glasses/Contacts	☐ Wheezing	☐ Asthma
☐ Chills	☐ Cataracts	☐ Shortness of Breath	☐ Never feel rested
☐ Sweats	☐ Hearing Problems	☐ Positive TB Test	☐ Sleep Study Done
☐ Loss of Energy	☐ Sore Throat	☐ Snoring	☐ Results: _____
☐ Fatigue	☐ Sinus Infection	☐ Headache upon Waking	☐ Insomnia

Cardiac	Gastrointestinal		Genitourinary
☐ Chest Pain with Exertion	☐ Abdominal Pain	☐ Diarrhea	☐ Blood in urine
☐ Chest Pressure	☐ Trouble Swallowing	☐ Constipation	☐ Hesitancy
☐ Irregular Heartbeat	☐ Nausea	☐ Bright Red Blood in Stool	☐ Kidney Stones
☐ Palpitations	☐ Vomiting	☐ Hemorrhoids	☐ Frequent Urination
☐ Congestive Heart Failure	☐ Dark/Black Stool	☐ Stomach Ulcers	☐ Prostate Problems
☐ Rheumatic Fever	☐ Yellow/Jaundiced	☐ Heartburn or Reflux	☐ Discomfort-Urination

Metabolic	Hematological	Neurological
☐ High Blood Pressure	☐ Abnormal Bleeding	☐ Severe headaches
☐ Diabetes	☐ Easy Bruising	☐ Chronic Headaches
☐ High Cholesterol	☐ Blood Clots in legs/lungs	☐ Migraines
☐ Thyroid Problems	☐ HIV/AIDS	☐ Dizziness
☐ Other_____	☐ Nose Bleeds	☐ Passing Out
	☐ Hepatitis C	☐ Seizure/Epilepsy
	☐ Hepatitis B	☐ Stroke

Musculoskeletal	Psychological	Gynecologic/Other
☐ Joint Pain	☐ Depression	☐ Breast Pain
☐ Swelling of Extremities	☐ Anxiety	☐ Breast Lumps
☐ Back Pain	☐ Shaking	☐ Breast Discharge
☐ Pain in Legs	☐ Emotional Upsets	☐ Menopause
☐ Leg Ulcers	☐ Ever Received Psychiatric/Psychological	☐ Irregular Cycle
☐ Varicose Veins	treatment? _____	☐ Last Cycle _____
☐ Leg Cramps		

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List ALL prescriptions AND over-the-counter medications you are currently using		
Name of Medication	Strength	Prescribing Physician

List ALL Prior Surgeries

List ALL Drug Allergies

Current level of Exercise? (Please check one that applies)

- ☐ None
- ☐ Light exercise (1-3 times per week, easy pace, stretching, walking, etc.)
- ☐ Moderate exercise (2-3 times per week, moderate pace, some weights, etc.)
- ☐ Heavy Exercise (3-4 times per week, vigorous pace, weights, fast running, etc.)

Do you:			
☐ eat breakfast?	☐ eat lunch?	☐ eat dinner?	
☐ eat when stressed?	☐ eat at night?	☐ eat between meals?	

On average, which of the following reflects your daily eating habits? (Please check all that apply)

☐ 3 meals with healthy snacks	☐ 3 meals	☐ 2 meals or less	☐ Skip breakfast or other meals
☐ Generally, eat on the run	☐ No regular eating pattern	☐ Often crave sweets/carbs	☐ Graze; small, frequent meals

Patient's Signature Date:	Physician's Signature Date:
Your signature indicates that the above information is complete and true.	

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Please initial each statement and sign.

Financial Policy

_____ Payment is due at time of service.

_____ Payment methods include cash, credit card, check, HSA, Care Credit

_____ We do not bill insurance.

_____ Dr Wolinski will discuss your recommended tier during consultation.

_____ Fees will be adjusted per visit if you opt to change tiers.

_____ _____

Patient Signature Date

Nutrition and Weight Loss

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Program Consent Form

I, _____, authorize Dr. CJ Wolinski MD and associated health care providers, to help me in my weight-reduction efforts. I understand that my program may consist of a balanced-deficit diet, a regular exercise program, instruction on behavior modification techniques, and may involve the use of anti-obesity medications. Other treatment options may include a very low-calorie diet or a protein-supplemented diet. I further understand that if medications are used, they have been used safely and successfully in private medical practices with experienced obesity medicine specialists as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with having excess weight or obesity. Risks of this program are usually temporary, reversible, and may include but are not limited to nervousness, sleeplessness, headaches, electrolyte abnormalities, dry mouth, gastrointestinal disturbances, weakness, fatigue, pancreatitis, psychological problems, gallstones, high blood pressure, rapid or slowing of the heartbeat and heart irregularities, and risk of weight regain. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints, including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight but will increase with additional weight gain over time.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees that the program will be successful. I also understand that obesity is a chronic, lifelong condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and it has been fully explained to me. My questions have been answered to my complete satisfaction.

_____ _____

Patient's Name (Printed) Witness

_____ _____

Patient Signature Date

(Or signature of person with authority to consent for patient)

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Rules for Use of Anti-Obesity Control Medication

Note: Signing this form does not guarantee that your provider at Nutrition and Weight Loss at Clinics of North Texas will find you to be an appropriate candidate for ani-obesity medications, but only that you have read, understood, and agree to the terms of medication usage should you and Dr. Wolinski decide upon their usage now or in the future.

Many anti-obesity medications are considered "controlled medications." By law, a controlled medication can only be prescribed from one facility at a time; therefore, I agree that only Nutrition and Weight Loss at Clinics of North Texas will prescribe anti-obesity medications for me. I agree that it is my responsibility to inform my physician(s) at Nutrition and Weight Loss at Clinics of North Texas 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, or other medication use.** I agree that I will be completely honest in disclosing this information and will notify my physician (s) at Nutrition and Weight Loss at Clinics of North Texas 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 Dr. CJ Wolinski MD. I understand that taking medications in any way other than as directed and prescribed could affect my health and be dangerous. I also understand that medications are typically considered after a trial of failed weight loss with only nutrition/behavior modifications. If I am deemed a candidate for the medication program at Nutrition and Weight Loss at Clinics of North Texas, I am aware that the lowest effective dosage will be tried prior to increasing dosages.

I understand that medication prescriptions can be filled at a pharmacy of my choice. I agree to use only one pharmacy at a time to fill any scheduled anti-obesity prescriptions, and I give my permission for Nutrition and Weight Loss at Clinics of North Texas to notify area pharmacies of the terms of this agreement.

I will not share, sell, or trade my medication with anyone. I understand that doing so is illegal and will result in my discharge from the care of Nutrition and Weight Loss at Clinics of North Texas.

I understand that the use of some of the anti-obesity medications beyond 12 weeks is considered "off label" or not initially approved by the U.S. Food and Drug Administration (FDA). I understand that my physician(s) at Nutrition and Weight Loss at Clinics of North Texas are experienced specialist(s) in obesity medicine who will, at times, elect/choose, when indicated, to use the anti-obesity medication(s) for longer periods of time as deemed appropriate for my individual treatment.

I understand that I am to report any side effects or adverse reactions of my medications to the physician(s) at Nutrition and Weight Loss at Clinics of North Texas.

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 modification.

I agree that my physician at Nutrition and Weight Loss at Clinics of North Texas may sometimes taper and/or stop my medication to evaluate its effect on my weight loss and/or hunger and health.

I understand that much of the success of the program will depend on my efforts and that there are NO GUARENTEES in medical treatment in the disease of obesity. I also understand that I will have to continue monitoring my weight after active weight loss.

Patient Signature_____ Date _____