METROLINA MEDICAL CLINIC

CARDIOMETABOLIC MEDICINE & WEIGHT HEALTH

1510 Orchard Lake Drive, Suite A
Charlotte, NC 28270
Ph 980-339-3133 : Fax 980-245-8066
www.metrolinamedicalclinic.com

Thank you for choosing Metrolina Medical Clinic for your cardio-metabolic health and weight management needs. We sincerely look forward to meeting you and working together to help you achieve your goals.

Our office address is **1510 Orchard Lake Drive, Suite A, Charlotte, NC 28270** and we are located off Monroe Road

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

Here are a few things to know and 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 **10 pages** and includes your medical history, weight history and consent forms. **We understand and appreciate that the forms and questionnaires are very detailed and will take about 20 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 chart prior to your visit. You may fax your paperwork to **fax number (980) 245-8066**.

2) **Medication List.** If you have not already filled out the paperwork prior to your visit, please make sure to bring a complete list of all of your medications and their doses so that we may accurately record them in our chart.

3) **Labs.** If you have had blood work drawn in the last 6 months, please bring a copy to your 1st visit, or arrange a copy to be faxed to our office. If not, **we can draw fasting labs in our office at your visit (if you are fasting)**, **or** we can give you a lab slip which you can take at your convenience to **any Labcorp site** throughout the Greater Charlotte area as well. Labs drawn at Labcorp are billed by Labcorp through your insurance.

4) **EKG.** If you are considering the use of an appetite suppressant, we request that you have an EKG done within the last 90 days. If you have not had an EKG performed during the last 90 days, then we will 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 (980) 245-8066.

5) **Payment.** Please note that full payment is required at the time of service. Your new patient visit for the self pay weight loss program is $300 and follow up monthly visits is $100. Our office accepts cash, credit cards (Visa & MasterCard) and checks.

6) **Please arrive 20 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 **(980) 245-8066** in advance of your scheduled appointment.

Thank you and we look forward to meeting you!

Sincerely,

MMC Weight & Cardiometabolic Team

MMC WEIGHT and HEALTH
New Patient Demographic Info

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	
Address Line 2	
City, State, Zip Code	
Phone Number(s) please star (*) your preferred phone number	Home ( )
	Cell ( )
	Work ( )
Okay to leave a message on home phone?	**no** **yes** Okay to leave a message on cell phone? **no** **yes**
E-mail address (only if we may email you)	
by writing your email above, you authorize us to email you an appt reminder 7 days and 2 days prior to your appt	
Birthday (mm/dd/yyyy)	Age:
Social Security # (optional)	
Your Occupation and Employer Name	**Your occupation:**
Marital Status (& spouse name)	
Spouse's Occupation and Employer Name	Spouse:
Primary Care Provider's Name	PCP:
Names of your other Physicians	Your other doctors:
How didyou hear about us?	
Pharmacy Information	
Pharmacy Name	
Pharmacy Phone Number	
Pharmacy Street Address (or street name)	
Pharmacy City / Town	

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)	
Name, Relationship, and Phone #	
Name, Relationship, and Phone #	
Name, Relationship, and Phone #	

MMC WEIGHT and HEALTH New Patient Medical History

Medications	
List all prescription medications & doses below	**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)	

Allergies to Medications (list drug name and allergic reaction below)	
☐ check here for "no allergies"	

Medical Conditions and Surgeries

Do have a history of any of the following conditions?			List any OTHER MEDICAL CONDITIONS below:
High Blood Pressure	**no**	**yes**	
High Cholesterol	**no**	**yes**	
Diabetes	**no**	**yes**	
Personal history of Heart Disease	**no**	**yes**	
Previous heart attack or stent?	**no**	**yes**	
Previous heart surgery (bypass?)	**no**	**yes**	
Stroke / TIA	**no**	**yes**	
PCOS (polycystic ovary syndrome)	**no**	**yes**	
Low Thyroid (Hypothyroidism)	**no**	**yes**	
Migraine Headaches	**no**	**yes**	**List any previous 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**	
Asthma / Emphysema / COPD	**no**	**yes**	
Eating Disorder (anorexia / bulimia)	**no**	**yes**	
Glaucoma	**no**	**yes**	

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 applicable)	Children:
Employment or Work Status	☐ Working as (Occupation/Employer):
	☐ Homemaker
	☐ Student at:
Smoking History	☐ I've never smoked
	☐ I previously smoked but quit

	☐ I currently smoke the following # of packs 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?
Drugs / Illicit Substances	Have you ever given yourself street drugs with a needle? **no** **yes**
	Do you have a history of any drug addition? **no** **yes**
	Are you currently using any street/illicit drugs? **no** **yes**
Sexual / Reproductive History	Are you sexually active? **no** **yes**
	If yes, are you currently trying to become pregnant? **no** **yes**
	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?

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, cousins, uncles, aunts, grandparents)	Cancer (list types):
	Diabetes:
	Heart Disease:
	High Blood Pressure:
	High Cholesterol:
	Hypothyroidism/Low Thyroid:
	Sudden Death (age < 40):
	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
Lungs	→	Shortness of Breath	Coughing	Wheezing
Abdomen	→	Nausea / Vomiting	Constipation	Diarrhea
Menstrual	→	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

Weight History

Current Height	Current weight	Lowest adult weight	Highest weight	Goal weight
		what year?	what year?	

How much Weight (lbs) have you gained 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 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?
Interested in using all meal replacements?	No	☐	Yes, I'd like to use bars/shakes to replace ALL my meals
Interested in using some meal replacements?	No	☐	Yes, I'd like to use bars/shakes to replace SOME meals
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.

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?	Why?
How many lunches do you skip per week?	Why?
How many dinners do you skip per week?	Why?
How many meals per week do you eat out or take out (Including breakfast, lunch, and dinner)?	
Which restaurants do you usually eat out or take out at?	
Do you frequently eat overnight?	☐ No ☐ Yes, I eat overnight
Do you consider yourself a stress eater?	☐ No ☐ Yes, I eat when I'm stressed
Do you feel hungry all the time?	☐ No ☐ Yes, I'm always hungry
Are you interested in using an appetite suppressant?	☐ No ☐ Yes, I'm interested in an appetite suppressant

If so, we require an EKG within the last 90 days based on the recommendations by Medical organizations
Do you need an EKG? (we'll perform as part of your visit) ☐ No ☐ Yes, I need an EKG
Have you had previous heart testing? (stress test, echo?) ☐ No ☐ Yes, I've had previous heart testing

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, jog, run, bike, golf, tennis ☐ Heavy Activity - regular exercise at least 3x per week ☐ Vigorous Activity - extensive exercise > 60 min at least 4x/week
Outside of work and working in the home, please describe what physical activity you do and how often:	
Do you do 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 (e.g. joint problems, arthritis, time)?	
Do you have membership at any gyms or exercise facilities? Which one(s)?	
Behavior Styles, Stress, and Sleep Hygiene	
Behavior Style (select only one of the options)	☐ You are calm and easygoing ☐ You are sometimes calm but frequently impatient ☐ You are seldom calm and have overwhelming drive for ambition ☐ You are hard driving and can never relax
Please circle your **STRESS** level:	**0 1 2 3 4 5 6 7 8 9 10** 0=no stress 5=moderate stress 10=extreme stress
Please describe major sources of stress in your life and how they affect you:	
Sleep Hygiene and Sleep Patterns	* What time do you usually go to sleep? * What time do you usually wake up? * Do you wake up through the night? ☐ no ☐ yes * Do you wake up and eat overnight? no yes
	☐ I usually sleep 8 or more hours per night ☐ I usually sleep 6 - 8 hours per night

(select all that apply)	☐ 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 live a night schedule and sleep during the day

PATIENT INFORMED CONSENT FOR THE USE OF APPETITE SUPPRESSANTS

I. Procedures and Alternatives

1. I authorize MMC Weight and Health to assist me in my weight loss efforts. I understand that my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks, and when indicated, in higher doses than the dose in the appetite suppressant Food and Drug Administration (FDA) labeling.

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

I understand that the use of appetite suppressants is completely voluntary and is not required to be used during my weight reduction program at MMC Weight and health.

2. I have read and understand my healthcare provider's statements that follow:

"*Medications, including appetite suppressants, have labeling worked out between the makers 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 the shorter term studies (up to 12 weeks) using the dosages indicated in the labeling.”*

"In the field of weight loss medicine, appetite suppressants have been found helpful for periods exceeding 12 weeks, and at times in larger doses than those suggested in the labeling. As a physician / healthcare provider, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, and studies and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses."

"Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted below)."

"I believe the probability of such side effects may be outweighed in certain individuals, by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses. However, you must decide if you are willing to accept the risks of the side effects, even if they might be serious, for the possible help the appetite suppressants being used in this manner may give."

3. I understand it is my responsibility to follow the instructions carefully and to report any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.

4. I agree to take the medication only as prescribed by MMC Weight and Health. 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 ever share it with a family member or friend whatsoever. I agree that I will not visit another doctor for the purpose of obtaining additional or duplicate medication of the same type.

5. I agree to arrange for prescription refills for scheduled medications from MMC Weight and Health only during regular clinic hours as some appetite suppressants are classified as controlled substances and are regulated by the Drug Enforcement Agency. I understand that controlled medications are not refilled in advance of the time of refill. Medications are typically refilled in one month increments and only via physician or provider during appointments with appropriate evaluation. I understand that missing my appointment may mean being out of the medications for a short period of time as controlled medications are not refilled via phone. I understand that MMC Weight and Health is not obligated to replace any medications or prescriptions that are lost or stolen for any reason.

6. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain weight loss. I understand my continuing to receive the appetite suppressant will be dependent on progress in weight reduction and weight maintenance.

7. I understand that medication prescriptions can be filled at pharmacy of my choice. I agree to use only one pharmacy to fill any weight loss scheduled prescriptions and I give my permission for MMC Weight and Health to notify area pharmacies of the terms of this agreement.

8. I understand there are other methods and programs that can assist me in decreasing my body weight and to maintain weight loss. In particular, a balanced calorie counting program or/ and exchange eating program without the use of the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

II. Risks of Proposed Treatment

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks and in doses higher than indicated on the labeling involves some risks. The more common adverse effects are nervousness, sleeplessness, headaches, dry mouth, weakness, psychological problems, medication allergies, high blood pressure, increased heart rate, and heart irregularities. Less common, but more serious risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

III. Risks of Being Obese or Overweight

I am aware that there are certain risks associated with remaining overweight or obese. Among them are increased risk for high blood pressure, cholesterol, pre-diabetes, diabetes, heart disease, stroke, kidney disease, sleep apnea, certain cancers, joint pain and arthritis and many others. I understand these risks may be modest if I am not very much overweight but that these risks increase the more overweight I am.

IV. No Guarantees

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue watching my weight all of my life if I am to be successful.

V. Patient's Consent

I have read and fully understand this consent form and I realize I should not sign this form if I have any unanswered questions or concerns that have not been answered to my complete satisfaction. I have taken all the

time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

PATIENT PRINTED NAME: ____

PATIENT SIGNATURE: ____ **DATE:** ____________

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WEIGHT-LOSS CONSUMER BILL OF RIGHTS:

WARNING: Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1 ½ pounds to 2 pounds per week, or weight loss of more than 1 percent of body weight per week after the second week of participation in a weight-loss program. Only permanent lifestyle changes, such as making healthy food choices and increasing physical activity, promote long term weight loss. Qualifications of this provider are available upon request. You as the patient have the right to:

Ask questions about the potential health risks of this program and its nutritional content, psychological support, and educational components; receive an itemized statement of the actual or estimated price of the weight-loss program, including extra products, services, supplements, examinations, and laboratory tests; know the actual or estimated time of the program; know the name, address, qualifications of the physician or provider who has reviewed and approved weight-loss program.

I have read and understand the above:

PATIENT PRINTED NAME: ____

PATIENT SIGNATURE: ____ **DATE:** ____________

ACKNOWLEDGEMENT OF APPETITE SUPPRESSANT REFILL POLICY:

I agree to arrange for prescription refills for scheduled medications from MMC Weight and Health 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. Medications are typically dispensed only in one month increments and only via physician or provider approval during appointments with appropriate evaluation. I understand that missing my appointment may mean being out of the medications for a short period of time as controlled medications are not refilled via phone.

PATIENT SIGNATURE: ____

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES" (HIPAA):

By signing this form, I acknowledge that I have received a copy of the "Notice of Privacy Practices" of MMC Weight and Health, which explains how your health information will be handled in various situations.

PATIENT SIGNATURE: ____