Ea Medical Weight Loss Services
Solutions for permanent weight loss

PATIENT HISTORY

Name:______________________________________Age:_________Date: ____________________

When did you first become overweight? (Your age then)__________ or Year _____________
____

How did your weight gain start? Describe any circumstances:
____
____
____

What do you think is the cause of your weight problem?
____
____
____

Your present weight:____________________Your weight goal: ___________________

What was your highest weight? ____________________________

What was your lowest weight? ____________________________

Have you ever stayed the same weight for 10 years or more? Yes / No

Have you attempted to lose weight before?_____________Pounds lost: __________

How long did it take? ____

Describe previous methods of weight loss (e.g. diets, pills, injections, hypnosis, and acupuncture):
____
____

Where and when do you do most of your overeating?
____
____

Please make any comments that you think might be helpful:
____
____

Do you currently have any medical concerns? Please List:

____

____

Past History: (Please check if you have or have had any of the following)

☐ Breast Cancer
☐ Adrenal Gland Tumor
☐ Fever
☐ Asthma
☐ Chickenpox
☐ Blood Clot
☐ Uterine Cancer
☐ Diabetes
☐ Pituitary Tumor
☐ Kidney Disease
☐Heart Disease
☐Ovarian Cysts
☐ Hypothyroidism
☐Epilepsy
☐ Primary Ovarian Failure
☐ PCOS
☐ Scarlet Fever
☐ Cancer, Type: ____
☐ Other Diseases ____

Operations: (dates)

____

____

Current Medications (vitamins, birth control pills):

____

____

Allergies to medicines, foods, etc.

____

____

Family History:

Father: Healthy_____________Age_______Deceased_____at age__________Cause ___________________
Mother: Healthy_____________Age_______Deceased_____at age__________Cause ___________________
# of siblings: __________ # Living:_______# Deceased: _______________
Cause ____

Family Diseases: Check diseases known in your blood relatives (not yourself):

☐ High blood pressure
☐ Migraine
☐ Strokes
☐ Kidney disease
☐ Arthritis
☐ Allergy
☐ Bleeding
☐ Diabetes
☐ Syphilis
☐ Other ____
☐ Heart trouble
☐ Cancer
☐ Nervous breakdown
☐ Suicide
☐ Anemia
☐ Epilepsy
☐ Fever
☐ Obesity

Prior Examinations:

Date of last physical examination: ____
____

Hospitalizations: ____
____

Laboratory tests: ____
____

Do you now have or have had any of the following?

- ☐ Eczema
- ☐ Limitation of motion
- ☐ Goiter
- ☐ Asthma
- ☐ Emphysema/Bronchitis
- ☐ Shortness of breath
- ☐ Tire easily
- ☐ Diarrhea
- ☐ Abdominal pain
- ☐ Jaundice
- ☐ Kidney disease
- ☐ Painful urination
- ☐ Albumin or sugar in urine
- ☐ Depressed
- ☐ Fainting
- ☐ Hives
- ☐ Backache
- ☐ Leg pains
- ☐ Varicose veins
- ☐ Heart trouble
- ☐ Palpitations
- ☐ Swelling
- ☐ Hemorrhoids
- ☐ Gas or bloating
- ☐ Rectal Bleeding
- ☐ Bladder disease
- ☐ Headaches
- ☐ Insomnia
- ☐ Paralysis
- ☐ Convulsions
- ☐ Nerve pain
- ☐ Loss of consciousness

Are you on any hormones? ____

Females: Menstrual History ___________ How many days ___ Cycle ____________Regular ________________

Last GYN exam : Normal ________ Abnormal with ____

I have read and understand all of the above and have agreed to these statements.

____ ____
Patient's Signature Date

PATIENT DEMOGRAPHICS

Patient Name: (Last)________________________(First)__________________(MI)________

Name you prefer to be called:______________________E-mail:______________________________

Patient Address: __________________________City_________________State_______Zip____________

Home Phone:_____________________________Cellular: __________________________________

Birth date:_______________________________Age:_____________Sex: M F

Education: (circle highest level achieved)
Elementary High School/Technical School 2-yr College 4-yr College Graduate School

Employment Information:

Patient Employer:______________________________Occupation: ______________________________

Employer Address: _________________________City:_____________State:_______ Zip: ______________

Work Phone:_____________________________Ext. ____

Social Security:____________________________Drivers License: _________________________________

In Case of Emergency:

Name:_____________________________Relationship: ______________________

Phone: ____

Patient's Spouse:______________________________________Phone: _____________________

Family Physician:______________________________________Phone: _____________________

Referred by:____

FINANCIAL POLICY

Thank you for selecting Ea Medical Weight Loss Services for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy.

Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made.

Patient:

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

My fee for each visit is $_________ Plus the cost of (vitamins, supplements, foods and Tests etc)

My fee for _____ weeks of program is $ _________ Plus the cost of (vitamins, supplements, foods etc)

If I am given payment arrangement, I understand that my fee starts from today and is for continuous

Number of days/weeks/months and also I am responsible for the entire amount even if I fail to return.

Other special terms ____

I have read and understand all of the above and have agreed to these statements.

____ ____

Patient's Signature Date

INFORMED CONSENT FOR HCG WEIGHT LOSS PROGRAM

Being overweight is associated with several health problems, including development of Type 2 diabetes, elevated blood pressure, heart disease, elevated cholesterol, gallbladder disease, some forms of cancer, metabolic syndrome, and low self-esteem and depression.

Losing weight also has health risks, which sometimes include side effects such as bad breath, lightheadedness, dizziness, constipation, nausea, reversible hair loss, muscle cramps and other risks described below. Usually, side effects are temporary and are attributable to the body adjusting to metabolizing fat instead of glucose. Diet, exercise, diet pills, Injectables and certain vitamins/supplements are part of the weight loss program. The use of any medications has sometimes been associated with an allergic reaction, a reversible rash, injection site soreness, bruising, tingling and the like. Furthermore, rapid weight loss may result in gallstones in approximately 5% of patients that experience such rapid weight loss.

As a medically supervised program, it is important that you advise the staff of any medical issues or conditions that you are currently experiencing. The weight loss program does not replace your comprehensive health care program or primary care physician/family doctor. We will assume that you have fully advised the staff of your medical issues and conditions, and that the medical questionnaire that you have completed is accurate. If you believe that you may have any condition that would be adversely affected by diet, exercise, diet pills or certain vitamin/supplements, it is your responsibility to advise the staff/doctor. It is also your responsibility to advise your primary care physician/family doctor of the fact that you are in a weight loss program that has diet pills, vitamins and supplements.

Other drugs may interact with diet pills, vitamins and supplements. You must tell the attending Doctor, staff and in writing, about all of the prescription and over-the- counter medications that you are taking. This includes vitamins, minerals, herbal products as well as drugs prescribed by other physicians. Medications that you are currently taking may require adjustment or discontinuance during the weight loss program. Do not start using a new medication without telling The Doctor and staff.

Allergic responses may occur as a result of using the diet pills, vitamins and supplements for weight loss program. You should stop using diet pills, vitamins and supplements and immediately report your allergic response to the Doctor and staff if you experience hives, difficulty breathing, and swelling of your face, lips, tongue, or throat, or any other indication of an allergic reaction. In addition, prior to treatment, you must advise the doctor and staff if you have any of the following conditions:

- thyroid or adrenal gland disorder
- ovarian cyst
- cancer or a tumor of the breast, ovary, uterus, prostate, hypothalamus, or pituitary gland
- undiagnosed uterine bleeding

- heart disease
- kidney disease
- epilepsy
- migraines
- asthma
- blood clotting disorder

During your participation in the weight loss program, you may experience side effects as a result of changes in your dietary patterns, and until the blood sugar levels stabilize over a period of time with high protein intake. These side effects may include:

- headache
- restlessness or irritability
- mild swelling or water weight gain
- depression
- breast tenderness or swelling
- pain, swelling, or irritation where the injection is given

It is not known whether a medication passes into breast milk. Therefore, if you are breast-feeding a baby, do not use medications without first consulting with the doctors and staff. While many patients have experienced significant weight loss using the weight loss program, the Food and Drug Administration requires the following disclaimer: “This weight reduction treatment includes the use of diet pill, a drug which has not been approved by the Food and Drug Administration as safe and effective in the treatment of obesity or weight control. There is no substantial evidence that diet pills increases weight loss beyond that resulting from caloric restriction, that it causes a more attractive or "normal" distribution of fat, or that it decreases the hunger and discomfort associated with calorie restricted diets.” There is no guarantee that you will experience significant weight loss using the diet pills in weight loss program, as individual results may vary. Your participation and adherence to the plan is essential to your success.

HIPAA Compliance: Ea weight Loss Services and its staff uphold the standards of the HIPAA laws. As a patient, you should know the following:

- We respect the privacy of your personal medical records and will take all reasonable steps that we can to secure and protect that privacy.
- When it is appropriate and necessary, we provide the minimum necessary information only to those we believe are in need of your health care information, for purposes of patient treatment or payment of health care services.
- You may refuse to consent to the use or disclosure of your personal health information, but this refusal must be provided to us in writing.
- Under the provisions of this law, we have the right to refuse to treat you should you refuse to disclose your personal health information. This information is critical to us in making appropriate medical decisions.

If you have any questions regarding this Informed Consent, please speak with the appropriate member of our staff.

____
Signature of Patient

____
Signature of Witness

____
Date