3903 Fair Ridge Drive, Suite 209, Fairfax, VA 22033

44121 Harry Byrd Hwy, Suite 285, Ashburn, VA 220147

NOVA PHYSICIAN WELLNESS CENTER

**How did you hear about our program? _____

IF YOUR INSURANCE REQUIRES A REFERRAL, PLEASE MAKE SURE YOU BRING YOUR REFERRAL AT THE TIME OF YOUR APPOINTMENT.

Patient History

Patient Name: First _____ Middle: _____ Last: _____

Address: _____

City: _____ State: _____ Zipcode: _____

Home Phone: _____ Cell Phone: _____

Birthdate: _____ Age: _____ Sex: M F

Email Address: _____

Emergency Information

Name: _____ Relationship: _____ Phone: _____

Family Physician _____ Phone: _____

Referred By: _____

Medical History

Are you in good health at the present time to the best of your knowledge? Yes No

Are you taking any medications at the present time? Yes No

Medication Name: _____ Reason: _____

Medication Name: _____ Reason: _____

Medication Name: _____ Reason: _____

Medication Name: _____ Reason: _____

Medication Name: _____ Reason: _____

Medication Name: _____ Reason: _____

Medication Name: _____ Reason: _____

Medication Name: _____ Reason: _____

Any allergies to any medications? Yes No

History of High Blood Pressure? Yes No

History of Diabetes? Yes No

At what age:

History of Heart Attack or Chest Pain? Yes No

History of Swelling Feet: Yes No

History of Frequent Headaches: Yes No

Migraines? Yes No

History of Constipation (difficulty in bowel movements)? Yes No

History of Glaucoma? Yes No

History of Epilepsy? Yes No

Gynecologic History:

Last Menstrual Period:

Are they regular? Yes No

Surgical History? Please List

Specify: Date::

Specify: Date::

Specify: Date::

Do you have a pacemaker? Yes No

Family History: (if blood relative has suffered the following, please indicate relationship):

- Heart Attack
- Cancer
- Hypertension
- Stroke
- Epilepsy
- Psychiatric Disorder
- Arthritis
- Diabetes
- Obesity
- Glaucoma
- Asthma
- Other

Have you ever been hospitalized?

Year: Illness or Operation:

Year: Illness or Operation:

Year: Illness or Operation:

Year: Illness or Operation:

Past Medical History: (Please check all that apply)

- Glaucoma
- Asthma
- Tuberculosis
- Heart Murmur
- Palpitations
- Irregular Pulse
- Swollen Ankles
- Chest Pain
- Eating Disorder
- Stomach Ulcers
- Diarrhea
- Constipation
- Bloody Stools
- Gall Bladder Issues
- Sudden Weight Loss
- Liver Disorder
- Joint Pains
- Fainting Spells
- Insomnia
- Depression
- Schizophrenia
- Bipolar Disorder
- Kidney Disorder
- Headaches
- Fatigue
- Anemia
- Immune Disorders
- Alcohol Abuse
- Drug Abuse
- Hypertension
- Heart Disease
- Thyroid Disease
- Cancer
- Diabetes
- Stroke
- Gout
- Jaundice
- Arthritis
- Are you pregnant? _____
- Are you planning to become pregnant? _____
- Are you breastfeeding? _____

Assessing Readiness for Change

On a scale of 1-10, with 10 being 100% ready to take action, how ready are you to lose weight?

_____

What is your attitude towards physical activity?

_____

Are you supported by family and friends?

_____

What are the potential barriers in your efforts to lose weight?

_____

Thank you for your time and patience in completing these forms.
This information will help us to assist you better in achieving your weight loss and wellness goals.

Weight History

How long have you been trying to lose weight? _____

_____

What is the main reason behind your being overweight? _____

_____

What is the main motivation for your decision to lose weight? _____

_____

Have you ever participated in a structured weight loss program? When?

Name of program:

Result:

Dietary Behavioral Factors

Do you "portion control" your sizes? Yes No

Frequency of eating:

Night-Eating:

Binge-Eating:

What is your daily consumption of caffeine (tea, coffee, cola, energy drinks)?

How many cups per day?

Do you drink alcohol?

- Daily
- Weekly
- Monthly

How much is your consumption in a sitting?

How often do you watch TV in a day?

- 1 Hour
- 2 Hours
- 3 Hours
- More

Physical Activity Assessment

1. Current Activity Level: (circle one)

   Sedentary (no exercise, gardening or housework)

   Moderately active (3-5 x/week ,20-30 minutes at a time)

   Active (3-5x/week, 45-60 minutes at a time)

   Very active (3-5x/week, 90 minutes at a time)

   Extremely active (5 or more/week, 60-90 minutes at a time)

2. Do you have physical limitations we should be aware of?

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Rules for Use of Anti-Obesity Control Medications

NOTE: SIGNING THIS FORM DOES NOT GUARANTEE THAT YOUR PROVIDER(S) AT NOVA PHYSICIAN WELLNESS CENTER 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 MEDICAL PROVIDER 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 Nova Physician Wellness Center will prescribe anti-obesity medications for me. I agree that it is my responsibility to inform my physician(s) at Nova Physician Wellness Center 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 contra-indicated 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 Nova Physician Wellness Center 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 the medical provider. 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 nutritional/behavior modifications. If I am deemed a candidate for the medication program at Nova Physician Wellness Center, 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 Nova Physician Wellness Center 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 Nova Physician Wellness Center.

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 Nova Physician Wellness Center 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 Nova Physician Wellness Center.

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(s) at Nova Physician Wellness Center 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 GUARANTEES** 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: ____/____/_____

NOVA PHYSICIAN WELLNESS CENTER

Weight Loss Program Consent Form

I, _____, authorize Nova Physician Wellness Center 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)

NOVA PHYSICIAN WELLNESS CENTER

CANCELLATION POLICY

We regret the need to implement the policy below, but we have had an increasing number of patients who fail to keep their scheduled appointments. As a courtesy, we agree to confirm your appointment by a reminder call to your primary phone number two days before your scheduled appointment. You will at that time have the opportunity to cancel, confirm, or submit a request to have someone from the office contact you to reschedule. If you have scheduled your appointment within 24 hours, you will not receive a confirmation call. The result of patients not canceling their scheduled appointments is that the physician is then unable to accommodate those patients with sudden medical problems that require medical intervention.

I hereby acknowledge that I am aware and accept the financial responsibility for fees assessed to my account for failing to provide a 24 hour cancellation notice of any scheduled appointment at NOVA Physician Wellness Center.

The fee will be $25.00 for an office visit payable by statement or at my next scheduled visit. I understand that this fee is not reimbursable by my insurance carrier.

_____

Patient Signature

_____ _____

Patient Name *Date*