De Silva Medical Weight Loss

623 West Avenue Q, Suite A, Palmdale, CA. 93551
Phone (661) 726-6255

Bariatric Patient Questionnaire

Today's Date:_____.Patient Name:_____.DOB:_____.
Weight Gain
Onset_Gradual ( ) Sudden ( )
Time Period: Childhood ( ) Puberty ( ) Pregnancy ( ) Peri-menopausal ( )
Life changes: College ( ) Career/Work ( ) Marriage ( ) Divorce ( ) Death ( )

Anorectic Use:

Have you used an Anorectic drug in the past? Yes No Medication:_____.
Problems with medications in the past?_____.

Psychiatric History:

Depression / Dysthymia
Anxiety / Adjustment disorder / Stress: Yes No
Binge eating disorder / Binge eating patterns
Bulimia / Purging patterns
Anorexia nervosa

Dietary History:

Do you keep a food diary (When and what is eaten daily)

Eating Patterns Direct potential treatment options:

Night time eater ( ) No hunger until evening ( )
Stress eater ( ) Cravings ( ) Binges ( )
Volume eater (Yes) (No)
Snack habits:_____. Food Allergies:_____.

Exercise History:

Current level of activity what_____. Frequency_____. Duration_____.

Past Medical History:

High Cholesterol	Neuropathy	Heart Disease	High blood pressure
Heart burn	Varicosities	Lung Disease	Sleep Apnea
Cellulitis	Diabetes	Hernias	Arthritis
Lower back pain	Polycystic ovaries		

Other: _____
Surgery History:_____.
Last menstrual period:_____.

Psychiatric History:

Depression ( ) Eating disorder ( ) Alcoholism ( )
Allergies:_____.

Family History:

Obesity (Yes) (No)	Diabetes (Yes) (No)	Cardio vascular disease (Yes) (No)
Hyperlipidemia (Yes) (No)	Hypertension (Yes) (No)	Psychiatric (Yes) (No)

Social History:

Smoker (Yes) (No)_____.
Alcohol History:_____.
Current Medications:_____.
_____.
_____.

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(661)726-6255 Fax (855)451-0552

Appointment Cancellation Policy

As a result of not having any available appointments in our schedule and in order to best serve our patients, the following policy is necessary.

Please be aware that De Silva Medical Weight Loss will charge $50 fee for failed appointments NOT cancelled 24 hours prior to the scheduled appointment date.

Payment in full is necessary prior to any treatments being rendered. The payment is non-refundable and non-transferable. In the event that you are unable to complete a pre-paid treatment regimen you could finish the treatment at a later date. (Up to one year from your last appointment)

By signing below I agree that I was informed of this office policy.

X_____

_____

(Patient Name)

Date _____/_____/_____

De Silva Medical, Inc
INT. MEDICINE • BARIATRIC • AESTHETICS
PAMELA DESILVA, M.D.

623 West Ave Q, Suite A
Palmdale, CA 93551
Ph: (661) 726-6255 Fax: (855) 451-0552

Today's Date: _____

Name: _____
Last First Middle

Address: _____
Street Apt # City Zip Code

Home Phone: (___) _____ Work Phone: (___) _____

Date of Birth: _____ Male/Female Weight____ Height____ Age ____

Marital Status: Single___ Married___ Separated___ Divorced___ Widowed ____

Occupation: _____ **Employer:** _____

Referred By: _____

Present Illness: _____

_____ **Date of onset:** _____

Duration: _____

Any other Complaints _____

_____

_____

Past Illnesses:

_____

_____

Past Surgeries: _____

_____

Do you: Smoke____ Drink Alcohol____ Abuse Drugs____
If you, how much?____ If yes, how much?____ If you, how much?____

Allergies (to medication of food):

1) _____ 2) _____ 3) _____ 4) _____

5) _____ 6) _____ 7) _____ 8) _____

Medications You are taking NOW:

1) _____ 2) _____ 3) _____ 4) _____

5) _____ 6) _____ 7) _____ 8) _____

Have any relatives had any of the following:

Cancer	Y	N	Convulsions	Y	N
Tuberculosis	Y	N	Bleeding Disorder	Y	N
Diabetes	Y	N	Kidney Disease	Y	N
Heart Trouble	Y	N	Psychiatric Problems	Y	N
High Blood Pressure	Y	N	Pulmonary Problems	Y	N
Stroke	Y	N	Arthritis	Y	N

GENERAL			Hemorrhoids or piles?	Y	N
Recent Weight change?	Y	N	Frequent diarrhea?	Y	N
Fever of Chills?	Y	N	Heartburn?	Y	N
Hives, Eczema, or rash?	Y	N	Pain in abdomen?	Y	N
Frequent infection or boils?	Y	N	Food sticking in throat?	Y	N
Abnormal pigmentation?	Y	N	Constipation?	Y	N
HANDS, EYES, EARS, NOSE & THROAT			**NECK**		
Eye Disease or injury?	Y	N	Stiffness?	Y	N
Do you wear glasses?	Y	N	Thyroid Trouble?	Y	N
Double Vision?	Y	N	Enlarged Glands?	Y	N
Glaucoma?	Y	N	**RESPIRATORY**		
Allergies?	Y	N	Spitting up blood?	Y	N
Chronic Sinus Trouble?	Y	N	Chronic or frequent cough?	Y	N
Ear Disease?	Y	N	Asthma or wheezing?	Y	N
Impaired hearing?	Y	N	Difficulty breathing?	Y	N
NEUROPSYCHRIATRIC			**RHEUMATOLOGICAL**		
Blurring or vision?	Y	N	Joint pain?	Y	N
Headache?	Y	N	Change in color of hands on exposure to cold?	Y	N
Psychiatric problems?	Y	N	Back pain?	Y	N
Head Injury/loss of consciousness?	Y	N	Pain in calves on walking reviewed by rest?	Y	N
Convulsions?	Y	N	Pain in buttocks on walking reviewed by rest?	Y	N
Numbness, tingling, and or weakness of muscle?	Y	N	**GENITOURONARY**	Y	N
Speech Trouble?	Y	N	Loss of urine?	Y	N
Memory loss?	Y	N	Frequent or night time urination?	Y	N
HEMATOLOGICAL			Burning or painful urination?	Y	N
Blood Disease?	Y	N	Blood in urine?	Y	N
Anemia?	Y	N	Kidney Trouble?	Y	N
Phlebitis or Blood clots?	Y	N	Kidney Stones?	Y	N
Abnormal bruising or bleeding?	Y	N	**GYN HISTORY (WOMEN ONLY)**		
ENDOCRINE			Date of last menstrual cycle?		
Thyroid Disease?	Y	N	Regular___ Irregular___ Spotting___		
Hormone Therapy?	Y	N	Age period started?		
Change in hair growth?	Y	N	Any Pain?	Y	N
CARDIOVASCULAR			Number of Pregnancies?		
Dizzy Spells?	Y	N	Number of Miscarriages?		
Chest Pains or Angina Pectoris?	Y	N	**PREVENTATIVE MEDICINE**		
Shortness of breath?	Y	N	Last Physical Exam?		
Hearth trouble or Heart Attack?	Y	N	Sigmoidoscopy / Colonoscopy?		
High Blood Pressure?	Y	N	Date: Results:		
Swelling of Hands, feet, or ankles?	Y	N	Rectal Exam? Date:		
Heart Murmur?	Y	N	Last Eye Exam?		
Palpitations?	Y	N	**WOMEN ONLY!**		
Pain in calf / thigh?	Y	N	Last Pap/Pelvic Exam?		
Is it relieved by rest?	Y	N	Last Mammogram?		
GASTROINTESTINAL			**MEN ONLY!**		
Ulcers, stomach or duodenal?	Y	N	Last Prostate Exam?		
Vomiting food or blood?	Y	N	PSA?		
Gallbladder Disease?	Y	N			
Liver Trouble?	Y	N			
Bleeding with bowel movement?	Y	N	**REVIEWED BY M.D.:**		

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Patient Name: _____ DOB _____

List Allergies: _____

_____

Medication List

Medication	Dose	Frequency (How Often You Take The Medications)	Frequency (How Often You Take The Medications)

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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 1½ 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. Consult your personal physician before starting any weight-loss program. Only permanent lifestyle changes, such as making healthful food choices and increasing physical activity, promote long-term weight loss. Qualifications of this provider are available upon request. You have a 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 duration of the program; know the name, address and qualifications of the dietitian or nutritionist who has reviewed and approved the weight-loss program.

I have read the above:

_____ _____

Patient's Signature Date

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Weight Loss Program Consent Form

I _____ authorize the Los Angeles Center for Medical Weight Loss and whomever they designate as their assistants, 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 in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices 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 remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to 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.

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 obesity may be a chronic, life-long 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 I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Date: _____ **Time:** _____

Witness: _____ **Patient:** _____
(Or person with authority to consent for patient)

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Patient Informed Consent for Appetite Suppressants

I. Procedure And Alternatives:

1. I,_____ (patient or patient's guardian) authorize the Los Angeles Center for Medical Weight Loss to assist me in my weight reduction efforts. I understand 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 indicated in the appetite suppressant labeling.

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

> "Medications, including the 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 shorter term studies (up to 12 weeks) using the dosages indicated in the labeling.
>
> "As a bariatric physician, I have found the appetite suppressants helpful for periods far in excess of 12 weeks, and at times in larger doses than those suggested in the labeling. As a physician, 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, recent longer term 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).
>
> "As a bariatric physician, I believe the probability of such side effects is outweighed 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 side effects, even if they might be serious, for the possible help the appetite suppressants use in this manner may give."

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

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

5. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an 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 higher doses than the dose indicated in the labeling involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heart beat 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 Associated with Being Overweight or Obese:

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly 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 all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take 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.

WARNING

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK YOUR DOCTOR NOW BEFORE SIGNING THIS CONSENT FORM.

DATE:_____ **TIME:**_____

PATIENT:_____ **WITNESS:**_____

(or person with authority to consent for patient)

VI. PHYSICIAN DECLARATION:

I have explained the contents of this document to the patient and have answered all the patient's related questions, and, to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies and the risks of continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving the appetite suppressants in the manner indicated above.

_____

Physician's Signature