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?_____

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: _____

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? _____

_____

Describe your activity level:

- ○ No physical activity (sedentary)
- ○ Moderate Activity
- ○ Limited Activity
- ○ Very Active

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

Smoking Habits:

- ○ Do not smoke
- ○ Have quit smoking
- ○ One pack a day
- ○ More than one pack a day
- ○ Cigars
- ○ Other: _____

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

Hustory of Swelling Feet: Yes No

History of Frequent Headaches: Yes No

Migraines? Yes No

Medications for Headaches: Yes No

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

History of Glaucoma? Yes No

History of Epilepsy? Yes No

Gynecologic History:

Pregnancies: Number: Dates:

Natural Delivery or C-Section (specify):

Last Menstrual Period:

Duration: _____

Are they regular?: Yes No

Pain Associated? Yes No

Contraception Method: _____

If Menopausal, when was last menstrual period? _____

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):

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

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

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Informed Consent for Prescription of Weight Loss Enhancers

(A) PROCEDURE AND ALETERNATIVES:

1. I, _____ (patient or patient's guardian) authorizes Nova Physician Wellness Center and its associates to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of weight loss enhancers including prescriptions for medications such as appetite suppressants, synthetic compounds, nutritional supplements, or herbal treatments. I also understand that amino acids, synthetic compounds, nutritional supplements and herbal treatments are over the counter nutritional supplements not approved by FDA for weight loss. I agree that prior to receiving any weight loss enhancers I have met with a Nova Physician Wellness Center healthcare provider who has answered any questions I might have about the potential benefits and risks of such treatments.

2. I have read and understand the following statements:
   The healthcare providers at Nova Physician Wellness Center may prescribe appetite suppressants approved by the Food and Drug Administration or other weight loss enhancers in dosages higher than those suggested by the pharmaceutical manufacturer in its package insert or for periods of time longer than the twelve (12) week frequently referenced in the insert – These patterns of usage are sometimes referred to as "off label" usage of the medication. Such off label usage may not have been as systematically studied in clinical trials as the doses and prescription periods described in the package insert. There is a lack of scientific data regarding the potential danger of long term use of combination weight loss treatments. As with most other medications, there could be serious side effects (as noted below) from all the use of all weight loss enhancers. By signing below you agree to accept the risks of side effects of the use of weight loss enhancers as prescribed.
   For female patients, it is important to note the following regarding some of the appetite suppressants which may be prescribed.

"Given potential risks to a fetus, it is contraindicated to be on Phentermine or Qsymia while pregnant or trying to become pregnant. For this reason, all women of childbearing age must be on a reliable form of contraception. This includes:
a) Partner vasectomy
b) Oral contraceptive pills
c) Nexplanon
d) IUD
e) Depo Provera injection
f) Condom usage 100% of the time
g) Tubal ligation

Women who have gone through menopause (12 months without any vaginal bleeding) or have undergone a hysterectomy are considered to have a reliable form of pregnancy prevention. If while on one of the aforementioned medications (Phentermine, Qsymia), you feel you may be pregnant, stop the medication immediately and call the office."

3. It is my responsibility to follow carefully the instructions provided to me by Nova Physician Wellness Center including returning to the Center for all follow-up appointments. I will report any medical problems that I think may be related to my weight control program as soon as reasonably possible, to the healthcare provider treating me for my weight loss.

4. The purpose of this treatment is to assist me in my desire to decrease my body weight and to maintaining this weight loss. I understand that continuing the prescription of the appetite suppressant will be dependent on my compliance with the Center's total weight loss program.

Dietary intervention and physical exercise are part of any weight loss regimen. I acknowledge that these and other ways or programs might 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.

I have reviewed the Informed Consent for Weight Loss.

(B) RISKS OF PROPOSED TREATMENTS:

I acknowledge the use of the appetite suppressants or other weight loss enhancers involves potential risks and hazards. The more common side effects from the use of appetite suppressants include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heartbeat and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could be serious or fatal.

(C) RISKS ASSOCIATED WITH BEING OVERWEIGHT OR OBESE:

I am aware that there are certain risks associated with remaining overweight or obese. Among those are tendencies of high blood pressure, diabetes, heart attack and heart disease, and 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.

(D) NO GUARENTEES:

I acknowledge 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.

(E) PATIENT'S CONSENT:

I have read and fully understood 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 healthcare providers 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 healthcare provider **NOW BEFORE SIGNING THIS**

CONSENT FORM. By signing this form, I acknowledge the receipt of the information contained herein, my understanding of the risks and benefits of the weight loss program, my willingness to comply with the program's requirements, and my consent to the use of appetite suppressants and other weight loss enhancers associated with the weight loss program prescribed by Nova Physician Wellness Center.

PRINT NAME:_____ DATE:_____

PATIENT SIGNATURE:_____

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Informed Consent for Weight Loss

WARNING: Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1 1/2 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:

PRINT NAME:_____ DATE:_____

PATIENT SIGNATURE:_____