Current or past history of illnesses or injuries?

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

List any medications you are currently taking:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Any history of substance abuse?**

**Y / N**

Any allergies to drugs?

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Any surgeries?

Reason/Type and Date: \_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Have you ever taken medication to lose weight before? Y / N

If yes, have you ever had negative symptoms?

Y / N

Explain:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Any trouble with your heart or

Blood pressure? Y / N

Do you smoke cigarettes? Y / N

If yes, how many daily? \_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? Y / N

Socially / Daily / Rarely

Water intake?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the following? Check all that apply

* Sweet cravings
* Bread cravings
* Cheese cravings
* Alcohol cravings
* Salt cravings
* Night hunger
* Soda cravings

Are you hungry all the time? Y / N

Exercise: \_\_\_\_\_ x/week for \_\_\_\_\_/min per session

Patient Comments:

**Patient Information**

Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

City / State**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** ZIP **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date of Birth **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Phone #:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Occupation **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Home / Work Phone **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Email: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

How did you hear about us? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Emergency Contact**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Relationship **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Phone Number **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

WHITTIER MEDICAL WEIGHT CONTROL

Patient Medical History Form

How many times have you tried to lose weight before? **\_\_\_\_\_\_\_**

Do you have trouble losing weight? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you hold water? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family and Medical History**

Circle One

**Self Family**

Female Organ Problems…………………..Y/N…….Y/N

Cancer…………………………………….Y/N….….Y/N

Diabetes…………………………………..Y/N….….Y/N

Kidney Trouble…………………………...Y/N….….Y/N

High Blood Pressure……………………...Y/N….….Y/N

Low Blood Pressure………………………Y/N……..Y/N

**Female Patients:**

Are you pregnant?

Are you breastfeeding?

**Do you suffer from any of the following?**

Check all that apply

* Anxiety
* Depression
* Chest Pains
* Indigestion
* Headaches
* Dizziness
* Insomnia
* Easy Fatigue
* Leg Cramps
* Irregular Menstruation
* Eating disorders
* Labored Breathing
* Swelling of the hands or feet
* Bowel movement problems
* Blood pressure problems
* Glaucoma

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Check**

B/P**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Heart / Rhythm**\_\_\_\_\_\_\_\_\_\_\_**

Weight**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Height **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Lungs**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Thyroid **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Other **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Doctor's Comments:**

**Head & Neck Diagnosis:**

**H & L**

**Abd**

**S & E**

**Nenro**

Patient Consent: I have read and understand the above and do hereby agree to the treatment administered to me, including medications for weight control.

Notice: All patients may receive medications dispensed by Whittier Medical Weight Control or receive a written prescription to take to a pharmacy of choice, for a fee. If you suspect you are pregnant discontinue medication. Pregnant or nursing mothers should not be taking this medication

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date Patient Printed Name

\*If patient is under the age of 18 years, a parent or legal guardian must sign above.

NOTICE OF PRIVACY PRACTICES & CONTROLLED SUBSTANCE AGREEMENT

This notice is effective June 1, 2019

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

WE ARE REQUIRED BY LAW TO PROTECT MEDICAL INFORMATION ABOUT YOU

We are required by law to protect the privacy of medical information about you and that identifies you. This medical information may be information about health care we provide to you or payment for health care provided to you. It may also be the information about your past, present, or future medical condition. We are also required by law to provide you with our Notice of Privacy Practices explaining our legal duties and privacy practices with respect to medical information. We are legally required to follow the terms of the Notice. In other words, we are only allowed to use and disclose medical information in the way that we have described in the Notice.

We may change the terms of the Notice in the future. We reserve the right to make changes and to make the new Notice effective for all medical information that we maintain.

Any changes will be posted on our website www.wm-weightcontrol.com and a copy can be made available to you upon request by calling our office at (562)943-2395.

The Notice of Privacy Practices discusses how we may use and disclose medical information about, explains your rights with respect to medical information about you, describes how and where you may file a privacy related complaint. If at any time, you have questions about information in the Notice or about our privacy policies, procedures or practices, you can contact WMWC (562)943-2395.

WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU IN SEVERAL CIRCUMSTANCES

**CONTROLLED SUBSTANCE AGREEMENT**

I understand that prescription appetite suppressants are controlled substances. As such, I acknowledge and agree to the following if I am prescribed an appetite suppressant:

• I cannot share my controlled substance prescription with anyone else

• I cannot take anyone else’s appetite suppressant medication prescribed to them

• I cannot obtain this medication/medication class from more than one clinic at the same time

• This medication must always be kept in the original labeled childproof bottle and must be kept securely away from children and animals for their protection

• I must lose an average of at least 4 pounds per month for the benefits to outweigh the risks of this medication and for continued prescribing/dispensing

I have read the NOTICE OF PRIVACY PRACTICES and agreed to the CONTROLLED SUBSTANCE AGREEMENT.

Furthermore, I hereby acknowledge that I have received a copy of the Guide to Self-Administration of Intramuscular Injections and that I’ll be given a chance to ask further questions, if any, during my appointment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Guardian Relationship to Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient’s Name and Legal Guardian’s Name, if applicable Date

**PHYSICIAN-PATIENT ARBITRATION AGREEMENT**

Article l: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

Article 2: **All Claims Must Be Arbitrated**: It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant the term "patient" shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against a Physician, including any fee dispute, whether or not the subject of any existing court action shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law**: A demand arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing-the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator who was previously a California Superior Court Judge to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: **Retroactive Effect:** The patient intends this agreement to cover all services rendered by physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Severability Provision:** In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed there from and the of the Agreement enforced in accordance with California and federal law.

I understan that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician or Duly Authorized Date Patient’s Signature Date

Representative Signature

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print or Stamp Name of Physician, Print Patient’s Name

Medical Group or Association Name

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Translator Date Patient’s Representative’s Signature Date

(if applicable)