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| **David P Willett MD PA  Carlin R Willett DNP FNP-C**  **2-B Owens Lane Mauldin, SC 29662** |
| **ANNUAL PATIENT INFORMATION SHEET**  **FULL LEGAL NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Sex**: M /  F  **MARITAL STATUS**:  M  S  D  W  **ADDRESS**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **CITY**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **STATE** \_\_\_\_\_\_\_ **ZIP** \_\_\_\_\_\_\_\_  **DOB**:\_\_\_/\_\_\_\_/\_\_\_\_\_\_  **SSN**: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ **Phone/Text number**: (­\_\_­\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_  **EMAIL**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **LIVING WILL**:  Y / N  **EMPLOYER** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **HIPAA APPROVED EMERGENCY CONTACT’S NAME** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **CONTACT’S #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **RELATIONSHIP** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   I understand that I have the right to revoke this authorization at any time.  I must do so in writing and present the written revocation, in person.  This authorization will remain in effect until a written revoke is on file. **INITIAL** \_\_\_\_\_\_\_\_\_\_\_   We are required by law to maintain your privacy and provide you with this notice of our legal duties and privacy practices with respect to protecting health information.  Medical records, which must be requested by you in person, will be released to another physician’s office when transferring records or referral to a specialist.  If you have any objections to this form, please ask to speak with our office staff regarding HIPAA compliance.  I am aware the HIPAA Privacy Notice is displayed in the office for my review and a copy can be provided to me, if requested. **INITIAL** \_\_\_\_\_\_\_\_\_\_\_\_  By law, Dr. Willett, MD PA must inform you that they ARE NOT a Medicare / Medicaid provider.  It is your responsibility to inform our office if you are covered by Medicare or Medicaid because they WILL NOT reimburse for any services rendered by David P. Willett, MD PA and Associates.  You CANNOT file your own claim to Medicare / Medicaid  **Initial that you have READ the above, regardless of Medicare/Medicaid status**.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                \_\_\_\_\_\_\_\_\_\_   **Initial** if covered by Medicare? \_\_\_\_\_\_\_\_\_ **Initial** if covered by Medicaid |

Due to contraindications between some weight loss medications & Attention Deficit (ADD) medications/Stimulants, our providers WILL NOT prescribe weight loss medications if you are taking ADD / Other Stimulant medications.

A Lost, stolen, or unfilled (unused) Bariatric Medication Prescription cannot be written before 28-30 days from the original date of the prescription.  No paid money for your office visit will be refunded.

 ● You *must* have a BMI of greater than 25. No Exceptions ● Appointments must be consistent. ● You must have a Valid South Carolina Driver's License ( WE DO NOT ACCEPT ANY IDs.  NO EXCEPTIONS! ) ● You must be compliant with our recommendations and consistently lose weight.

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|  | |  | | --- | | **AUTOMATIC DISMISSAL FROM THE WEIGHT LOSS PROGRAM FOR THE FOLLOWING REASONS:** |   ●At age 65,  due to a potential increase in health risks  from taking an Appetite Suppressant/Stimulant |  |
|  | ● Failure to disclose ALL medications prescribed by ANY provider. Taking multiple medications can increase risk of interactions and possible contraindications that can be dangerous to your health. It is illegal to see multiple doctors for ANY controlled medications within the same 30 day period of time |  |
|  | ● Any drug related charges brought to our attention will lead to automatic termination. This would include examples such as selling, distributing, sharing, or abusing medications. |  |
| ● If there is any suspected misuse of controlled substance medication outside of the intended purpose, you will be immediately terminated from the program.  ● Consistently not showing up for scheduled appointments or calling within 3 hours of appt. to cancel.  Per SC regulations, We are required by law to notify Drug Enforcement Control of any illegal use of controlled substances.  I have read and understand all of the information and requirements stated above for the weight loss program. I authorize treatment for myself by David P. Willett, MD PA & Associates. | | |
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**Signature of Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date -\_\_\_\_\_\_\_\_\_\_\_**

**NEW PATIENT MEDICAL HISTORY FORM**

**Name: (First) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Last) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ Primary Care Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical History**

*Current or Past Personal medical history (check all that apply):*

o Heart attack                    o Angina                 o Gall bladder stones                     o Sleep apnea

o High blood pressure        o Stroke                 o Indigestion/reflux arthritis            o Thyroid

o High cholesterol              o Diabetes              o Celiac disease                            o Anxiety

o High triglycerides            o Gout                    o Pancreatitis                                 o Depression

o ADD/ADHD/Narcolepsy o PCOS                 o Suboxone/Methadone ***Past* or *Present* Use**

Other Medical Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

o Cancer (type/s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been diagnosed with an eating disorder? Y / N If yes, which one? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Past surgical history (check all that apply):*

o Gastric bypass    o Gastric banding  o Gastric sleeve     o Gall bladder o Heart bypass o Appendectomy

o Hysterectomy     o C-Section            o Ortho. Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

o Other Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications** (list ***ALL*** medications/supplements/birth control with dosages):

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

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

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

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

**Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Reaction: \_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

Smoking:     o Never      o Current smoker (\_\_\_\_\_ packs/day) o Past smoker (quit \_\_\_\_\_ years ago)

Alcohol:   o Never      o Occasional/Weekly                         o Daily (\_\_\_\_\_ drinks per day)

*Any treatment for alcoholism?  Y / N Any treatment for Opiate Use? Y / N*

Drug Use: o Never        o Current    o Past         o Type of drugs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

Obesity (check all that apply):        o Mother    o Father     o Sister       o Brother

Diabetes (check all that apply):          o Mother   o Father o Sister   o Brother

Other (check all that apply):       o High blood pressure           o Heart disease

o High cholesterol           o High triglycerides            o Stroke     o Thyroid problems

o Anxiety                            o Depression                 o Alcoholism

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Women’s History Only***

Are you pregnant currently? Y / N              If no, have you had a child in the last 12 weeks? Y / N

Are you currently breastfeeding? Y / N      History of Infertility? Y / N

o Absence of period          o Abnormal/excessive menstruation         o Facial hair

**LAST NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Weight History**

When did you become overweight?

o Childhood o Teens      o Adulthood o Pregnancy  o Menopause

Did you ever gain more than 20 pounds in less than 3 months? Y / N     If so, how long ago? \_\_\_\_\_\_\_\_\_

As best you can remember, how much did you weigh one year ago? \_\_\_\_\_\_\_\_\_\_\_\_\_

Triggers for your weight gain/overeating (check all that apply):

o Stress o Marriage  o Divorce o Illness o Medication abuse   o Travel   o Injury   o Parties

o Nightshift work  o Insomnia   o Boredom   o Anger o Seeking Reward o Eating Out

o Quitting (circle all that apply): Smoking / Alcohol / Illicit Drugs

Previous weight-loss programs (check all that apply):

o Weight Watchers o Nutrisystem        o Jenny Craig                    o LA Weight Loss   o Atkins/Keto

o South Beach   o Zone diet             o Medifast              o Dash diet             o Paleo diet

o HCG diet             o Mediterranean diet  o Optifast   o Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your greatest challenges with dieting? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever taken Prescription Medication to lose weight (Not all meds listed are only used for weight loss)? Check all that apply:

o Phentermine (Adipex)    o Meridia    o Xenecal/Alli         o Phen/Fen

o Phendimetrazine (Bontril)   o Topamax o Fastin/Suprenza  o Diethylpropion

o Bupropion (Wellbutrin)    o Belviq      o Qsymia               o Contrave

o Didrex                             o HCG       o Metformin           o Injection: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What worked? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What didn’t work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nutritional/Exercise History**

How often do you eat breakfast? \_\_\_\_\_\_\_\_\_ days per week

Number of times you eat per day: \_\_\_\_\_\_\_\_\_

Do you get up at night to eat? Y  /  N If so, how often? \_\_\_\_\_ times per week

Daily servings of: Vegetables \_\_\_\_\_ Fruits \_\_\_\_\_ Meat \_\_\_\_\_ Dairy \_\_\_\_\_

Sweet beverages (check all that apply):

o Soda       o Juice       o Sweet tea o Coffee/tea   If so, how many times per day? \_\_\_\_\_

Number of times per week you eat fast food: Breakfast \_\_\_\_\_ Lunch \_\_\_\_\_ Dinner \_\_\_\_\_

Favorite foods: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Food cravings:

o Sugar      o Chocolate   o Starches o Salty   o High Fat o Large Portions

Exercise type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration: \_\_\_\_\_ hours \_\_\_\_\_ minutes Number of times per week: \_\_\_\_\_

What prevents you from exercising? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours do you sleep per night? \_\_\_\_\_ How many times do you get up during the night? \_\_\_\_\_