GLORY

Patient Name____
First Middle Initial Last

Street Address____

City__________________________ State______________ Zip Code__________________________________

Phone Numbers: **Cell** ______________________________ Email___________________________________

Home____ Work ___________________________________

Social Security Number________________________ Marital Status______________________________

Date Admitted_____/_____/________ Date of Birth _____/_____/_______ Sex __________

Occupation____

Nearest Relative______________________________________ Phone_____________________________

Allergies?________ If so please list ____

____

Are you on any medications?_________ If so please list ______________________________________

____

Referred by:

Phone Book______________________________________ Walk-in/Sign

Patient/Person______________________________________ Letter/Card

Magazine/Newspaper Ad______________________________ TV____________________

Internet____ Radio__________________

Pharmacy/Doctor/Employee____

GLORY

CURRENT MEDICAL HISTORY

PATIENT NAME____ DATE______________________

Please circle all that apply

Thyroid Disease	Depression	Hepatitis	Heart Disease
Glaucoma/Cataracts	Chest Pain	Heartburn	Cancer / type____________________
Asthma	Diabetes	High blood Pressure	Heart Murmur
Emphysema	Seizures	Ulcer	Prostate Disease

Other____

MEDICATIONS

Name of drugs	Strength & Frequency		Name of drugs	Strength & Frequency
1.________________________			6.________________________	
2.________________________			7.________________________	
3.________________________			8.________________________	
4.________________________			9.________________________	
5.________________________			10.________________________	

DRUG ALLERGIES (please list reactions)

1.____
2.____
3.____
4.____
5.____

PAST SURGERIES(type and dates)

1.________________________	6.________________________
2.________________________	7.________________________
3.________________________	8.________________________
4.________________________	9.________________________
5.________________________	10.________________________

SOCIAL HISTORY

Do you currently smoke? __Yes __No # packs per day?________ How many years________
If you quit smoking, how long ago?____
Do you now or have you ever taken any illicit drugs? __Yes __No
Please list:____
Do you drink alcohol? __Yes __No # drinks per week?_______________
Do you drink caffeine? __Yes __No # drinks per day? _______________
How many times a week do you exercise? ____

FAMILY HISTORY

1.____
2.____
3.____
4.____

Date of last menstrual period? __________________________ Age of menopause:____________________
Any concerns or history of domestic or sexual violence? __Yes __No

PREGNANCY HISTORY

Year	Sex	Complications
1.________		
2.________		
3.________		
4.________		

IMMUNIZATIONS(please list year)

Influenza:______________________
Pneumovax:______________________
Tetanus:______________________
Hepatitis B:______________________
Other______________________

Doctor Signature________________________________ Patient Signature________________________________

REVIEW OF SYSTEM

Patient Name____Date__________________________

Circle Yes or No

Respiratory	Now	Past	Comments
Wheezing	Y N	Y N	
Frequent Cough	Y N	Y N	
Shortness of Breath	Y N	Y N	
Other	Y N	Y N	

Cardiovascular	Now	Past	Comments
Chest Pain	Y N	Y N	
Irregular Heartbeats	Y N	Y N	
Swelling in Ankles	Y N	Y N	
Other	Y N	Y N	

Neurological	Now	Past	Comments
Tremors	Y N	Y N	
Dizzy Spells	Y N	Y N	
Numbness/Tingling	Y N	Y N	
Other	Y N	Y N	

Endocrine	Now	Past	Comments
Excessive thirst	Y N	Y N	
Too hot/cold	Y N	Y N	
Tired/sluggish	Y N	Y N	
Other	Y N	Y N	

Gastrointestinal	Now	Past	Comments
Abdominal Pain	Y N	Y N	
Nausea/Vomiting	Y N	Y N	
Indigestion/heartburn	Y N	Y N	
Other	Y N	Y N	

Musculoskeletal	Now	Past	Comments
Bone Pain	Y N	Y N	
Muscle Pain	Y N	Y N	
Joint Pain	Y N	Y N	
Other	Y N	Y N	

Integumentary	Now	Past	Comment
Rush	Y N	Y N	
Lumps or bumps	Y N	Y N	
Moles, skin tags	Y N	Y N	
Other	Y N	Y N	

Eyes	Now	Past	Comment
Double Vision	Y N	Y N	
Glaucoma	Y N	Y N	
Cataracts	Y N	Y N	
Other	Y N	Y N	

Psychological	Now	Past	Comment
Are you generally happy	Y N	Y N	
Do you feel depressed	Y N	Y N	
Do you feel anxious	Y N	Y N	
Do you feel safe at home	Y N	Y N	

Allergic	Now	Past	Comment
Hay Fever	Y N	Y N	
Drug Allergies	Y N	Y N	
Food	Y N	Y N	
Other	Y N	Y N	

Genitourinary	Now	Past	Comment
Change in Stream	Y N	Y N	
Nocturia	Y N	Y N	
Urinate frequently	Y N	Y N	
Other	Y N	Y N	

Ear/Nose/Throat	Now	Past	Comment
Hearing Change	Y N	Y N	
Sore Throat	Y N	Y N	
Sinus Problems	Y N	Y N	
Other	Y N	Y N	

Hematologic/Lymphatic	Now	Past	Comment
Swollen Glands	Y N	Y N	
Blood clotting problem	Y N	Y N	
Bruising	Y N	Y N	
Other	Y N	Y N	

Sexual History	Now	Past	Comment
Change in Sex Drive	Y N	Y N	
Blood clotting problem	Y N	Y N	
Satisfactory?	Y N	Y N	
Other (i.e. sexual trauma)	Y N	Y N	

Constitutional Symptom	Now	Past	Comment
Weight Change	Y N	Y N	
Chills	Y N	Y N	
Sleep Disorder	Y N	Y N	
Other	Y N	Y N	

Living Will? YES OR NO

Last Exams or Lab **Please enter date**

Dental:____________________ Eye:________________

Pelvic:____________________ PAP:________________

Mammogram:________________ PSA:________________

Colonoscopy:_______________ Stool:_______________

Prostate:__________________ Bone Density:________

Doctor Signature______________________________________

Patient Signature_________________________________

GLORY

CAUTIONARY STATEMENT
PEOPLE WHO SHOULD NOT USE DIET PILLS
(PHENTERMINE, PHENDIMETRIZINE, DIETHYLPROPION AND BENZPHETAMINE, MERIDIA)

HEART DISEASE	People with cardiovascular disease should not use the above medications.
HYPERTENSION	People with elevated blood pressure should not use any of the above medications.
GLAUCOMA	People with glaucoma (elevated pressure in the eye) should not use these medications.
EXTRAPYRAMIDAL DISORDERS	People with extrapyramidal disorder (diseases characterized involuntary movement changes in muscle tone and abnormal posture) should not use these medications. Extrapyramidal disorders include: Tarrdive dyskinesia, Chorea, Athetosis and Parkinson's Disease.
THYROID DISEASE	People with hyperthyroidism (overactive thyroid) should not take these medications.
EASILY OVER-EXCITED	These people should not use these medications.
HISTORY OF DRUG ABUSE OR ALCOHOLISM	These people should not use these types of medications.
PREGNANT WOMEN	Pregnant women should not use these medications.
BREAST – FEEDING MOTHERS	Breast-feeding mothers should not use these medications.
AGE REQUIREMENT	Patients must be between 18 and 60 years of age.
ANTI-DEPRESSANTS	Are counter indicated and should not be used with appetite suppressant unless the physician makes an exception.

I have been offered the opportunity to ask questions regarding these medications from the medical assistant and also the facility's physician. I fully understand the counter indications noted and also medical complications that can be caused by these medications. I also understand that if I do take these medications, that they may over-sedation or drowsiness and if this occurs, I should not drive. I also understand that these medications should not be taken with tranquilizer, barbiturates, alcohol or antidepressants.

Patient Signature______________________________ Date____________________

Doctor/MA Signature____________________________ Date____________________

GLORY

AKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Version of Notice of Privacy Practices Provided: April 14th, 2004

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how my health information may be used and/or disclosed, and how I may obtain access to and control this information.

______________________________ ______________

Signature of Patient (or Authorized Personal Representative) **Date**

______________________________ ______________

Signature of Patient (or Authorized Personal Representative) **Authority of Personal Representative (e.g., parent, legal guardian, health care surrogate)**

DOCUMENTATION OF GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

The patient presented for his/her services on this date and was provided a copy of the Notice Regarding Privacy Of Health Information pamphlet. A good faith effort was made to obtain a written acknowledgement of receipt of this notice. However, an acknowledgement of receipt was not obtained because of the following reason (s):

___ Patient refused to sign the Acknowledgement of Receipt.
___ Patient was unable to sign or initial the Acknowledge of Receipt.
___ There was a medical emergency, and a attempt will to obtain an Acknowledgement of Receipt at the next available opportunity.

______________________________ ______________

Signature of Employee completing form Date

____

Print Name of Employee

GLORY
WEIGHT-LOSS CONSUMER BILL OF RIGHTS

<u>WARNING:</u> Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1 ½ 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 the right to: ask questions about the potential health risk 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 according to s.468-505(1)(j), Florida Statutes.

Required to be posted by section 501.0575 of Florida Statutes.

You have the right to fill your prescription(s) at our office or any other location.

I have read the above:

______________________________ Patient's Signature

____________________ Date

<u>OUR STRICT POLICY – A MUST READ! A MUST READ!</u>

***If** a patient is on Appetite Suppressant, **EKG** must be done before the start of his/her 2nd monthly plan and will be done **yearly** afterwards, price is **$60**.

*A **$170** laboratory fee is due within the 1st month or before the start of the 2nd month. If initial $60 is paid for laboratory fee for 2 blood tests, the balance of $60 for the remaining 3 test must be paid before the start of the 3rd month. The laboratory fee of **$170** is **NON-REFUNDABLE** after the blood is drawn. Patients may bring their recent labs result, BUT MUST have the 5 tests required and MUST have been done within the last 3 months. **NO EXCEPTION to the 3 months rule. Thanks.**

*Initial Consultation is **FREE** ***as long as*** you start a monthly plan **or your 1st payment** towards a plan is at least **$99.** ***Otherwise, you will be charged $100 for Initial Consultation with the Doctor***. You m*ay ask for more details.* Your monthly plan comes with **ONE FREE** doctor visit. At any other time, doctor's visit is **$45.**

*Every 6 months, there is a MANDATORY **(If BMI < 27 & on Appetite Suppressant)** for **BCA (Body Composition Analysis) or Fat% measurement.**

*Every 6 months, there is a MANDATORY Lab Fee of **$35** for **Comprehensive Metabolic Panel OR** BRING YOUR OWN LABS TESTS RESULTS.

*If a patient cancels before completing a monthly program, the value of products and services received by the patient will be deducted from the monthly payment, and the balance will be refunded.

I have read and clearly understand the above strict policy, and that the price may change in future without prior notice:

______________________________ Patient's Signature

____________________ Date

Weight Loss Program Consent Form

I ______________________________________ authorize Glory 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)

Glory

Patient Informed Consent for Appetite Suppressants

I. Procedure and Alternatives:

1. I,____ (patient or patient's guardian) authorize Glory 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 heartbeat 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 <u>NOW BEFORE SIGNING THIS CONSENT FORM</u>.

DATE:______________________________ **TIME:**______________________________

PATIENT:____________________________**WITNESS:**___________________________
(or person with authority to consent for patient)

VI. <u>PHYSICIAN DECLARATION</u>:

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