Name_____Date of Birth_____

NORTON HEALTHCARE

MEDICAL WEIGHT MANAGEMENT PATIENT PACKET

Name_____Date of Birth_____

Welcome to Norton Weight Management Services. Our goal is to provide comprehensive services to assist in your weight loss journey. Norton recognized the step to move forward with a weight loss program is not always easy to make. Norton Weight Management has a multidisciplinary team to assist in your weight loss journey. It is imperative patients take an active role during their weight loss journey. Your engagement will ensure your process moves as efficiently as possible.

To provide you with the best possible service, please provide the following information. You may use this sheet as a checklist for your items. Norton does reserve the right to cancel any appointments should all the required documentation not be provided.

- **The Medical Weight Management Patient Packet**: Complete all forms and provide all necessary information to take the next step in the program.
- **Lab Values**: If you have had any lab tests by your primary care provider within the last six months, please include the results with your packet.

We look forward to assisting you as our patient.

Send Completed information to:

Norton Weight Management Center

Attn: Medical Weight Management

1000 Dupont Rd.

Louisville, KY 40207

502-899-6500 Phone

502-895-2675 Fax

Email: WeightManagement@nortonhealthcare.org

Name_____Date of Birth_____

DEMOGRAPHIC INFORMATION

PATIENT NAME:	**SSN:**	**SEX:**	**DOB:**
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
HOME PHONE:	**WORK PHONE:**	**MOBILE PHONE:**	
NEEDS INTERPRETOR?:		**LANGUAGE:**	
MARITAL STATUS:		**RELIGION:**	
EITHNICITY:	**RACE:**	**BIRTH STATE:**	

EMPLOYMENT INFORMATION

EMPLOYER: **EMPLOYMENT STATUS:**
ADDRESS: **CITY:** **STATE:** **ZIP:**

PATIENT CONTACTS - PRIMARY

NAME: **HOME NUMBER:** **OTHER PHONE:**
ADDRESS: **CITY:** **STATE:** **ZIP:**
RELATIONSHIP TO PATIENT:

PATIENT CONTACTS – SECONDARY

NAME: **HOME NUMBER:** **OTHER PHONE:**
ADDRESS: **CITY:** **STATE:** **ZIP:**
RELATIONSHIP TO PATIENT:

GUARANTOR INFORMATION

NAME: **GUARANTOR TYPE:** **HOME PHONE:**
ADDRESS: **CITY:** **STATE:** **ZIP:**
EMPLOYER: **EMPLOYMENT STATUS:** **EMPLOYER PHONE:**

PRIMARY CARE PROVIDER

NAME: **PHONE:**
ADDRESS: **CITY:** **STATE:** **ZIP:**

REFERRING PROVIDER

NAME: **PHONE:**
ADDRESS: **CITY:** **STATE:** **ZIP:**

Name_____Date of Birth_____

NORTON HEALTH & WEIGHT MANAGEMENT SPECIALISTS

Weight Loss Program Consent Form

I_____authorize Dr. Thompson and/or Dr. McIntyre 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 behavioral modification techniques, and may involve the use of medications including appetite suppressants. Other treatment options may include a very low calorie diet or a protein supplemented diet. I further understand medications with appetite suppressants may be used for durations exceeding those recommended in the medication package insert. Some medications may be used that have been approved for uses other than weight loss, but found in studies to be useful for weight loss purpose. It has been explained to me that these medications have been used in private bariatric practices as well as in academic centers for period exceeding those recommended in the product literature and at dosages that may differ from those recommended in the medication package insert.

I understand any medical treatment may involve risks as well as the proposed benefits. I also understand there are certain health risks associated with remaining overweight or obese. Risks of the Medical Weight management program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, fatigue, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. Serious heart and lung problems have been reported with other appetite suppressant medications and may occur. These and other possible risks could, on occasion, be serious or even fatal.

Risks associated with remaining overweight may include high blood pressure, high cholesterol, diabetes, heart attack and heart disease such as congestive heart failure, arthritis of the joints including hips, knees, feet, and back, sleep apnea, increased risk of severe vein disease, increase risk of many types of cancers and sudden death. I understand these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand much of the success of the program will depend on my efforts. I understand there is no guarantees or assurances the medical weight management program will be successful. I also understand obesity is a chronic life-long condition requiring changes in eating habits and permanent changes in behavior to be treated successfully.

I agree that following instructions for medication use, follow up appointments, labs, and other recommendations from the physician are critical to the success and safety of the program.

I agree to use medications only as directed and realize sharing or selling these medications is dangerous and illegal.

I have read and fully understand this consent form. 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 needed to read and understand this form.

Date_____ Time_____

Patient signature_____
Patient name_____

Name_____Date of Birth_____

Past Medical History: Check box if you have been diagnosed with any:

○	Asthma	○	Emphysema	○	Pancreatitis	○	
○	Angina	○	Epilepsy	○	Poor Blood clotting	○	
○	Anemia	○	Gall Stones	○	Positive TB Test	○	
○	Arthritis	○	Glaucoma	○	Rheumatic Fever	○	
○	Blood Transfusion	○	Fractures	○	Sleep Apnea	○	
○	Cancer	○	Heart Murmur	○	Stroke	○	
○	Chronic Bronchitis	○	Heart Attack	○	Thrombophlebitis	○	
○	Cirrhosis	○	High Blood Pressure	○	Tuberculosis	○	
○	Colitis	○	Hepatitis	○	Thyroid disease	○	
○	Diabetes/Prediabetes	○	Kidney Infection	○	Ulcers	○	
○	Diverticulosis	○	Kidney Stones	○		○	

Contraception if applicable_____

Bariatric Medical Questionnaire

Weight Loss History:
When did your weight problem begin?_____ Approximate age when starting dieting?_____

Minimum weight in the past 5 yrs?_____ Maximum lifetime weight (non-pregnant)_____

Diets and Diet Programs: please indicate any diet plans or programs you have tried.

Previous Diets	Date(s)	Duration	Weight Loss	Long-term results

Weight Loss Medications: Please indicate if you have taken any of the following medications for weight loss.

Medication	Yes/No	Dates	Duration	MD Prescribed?	Maximum Loss
Amphetamines					
Phentermine					
Qsymia					
Phen-Fen					
Saxenda					
Contrave					
Belviq					
Redux					
Xenical					
Meridia					
Alli					

Name_____Date of Birth_____

When have you had the most success at weight loss and why do you think it was successful?_____
_____
_____
_____

Why do you think you have gained weight?_____
_____
_____
_____

Do you or have you purged? Yes No If yes, how recent?_____

Sleep quality and amount per night/day?_____

Exercise History Type_____Amount_____
Type_____Amount_____

Dietary History

How often do you eat out?_____

Who cooks and grocery shops for your household?_____

Who lives in your household?_____

Do any other members of your household have a weight problem?_____

Do you eat more in response to stress?_____

What food types are you more likely to overeat?_____

Are you currently in a stressful situation?_____

What do you usually consume for:

Breakfast_____
_____

Lunch_____
_____

Dinner_____
_____

Sodas_____Type_____How many per day_____

Alcohol____Type_____Amount_____How often_____
Type_____Amount_____How often_____

Other beverages Type_____Amount_____How often_____
Type_____Amount_____How often_____

Snacks Type_____Amount_____How often_____
Type_____Amount_____How often_____

_____ _____

Name_____Date of Birth_____

Patient Signature

Physician Signature