Date: _____

Name: _____ E-mail: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone number: _____ May we contact you at home? YES ☐ NO ☐

Sex: M ☐ F ☐ DL#: _____ Birthday: _____ Age: _____

How did you hear about us? _____

Family Physician: _____

Current Medication: _____

_____

Drug Allergies: _____

Do you have:	YES	NO		YES	NO
Heart Disease	☐	☐	Fibromyalgia	☐	☐
High Blood Pressure	☐	☐	Chronic Fatigue	☐	☐
Depression	☐	☐	Diabetes	☐	☐
Thyroid Disorder	☐	☐	Other _____		
Hypoglycemia	☐	☐			

Date of last EKG or Stress Test: _____ Normal ☐ Abnormal ☐

Surgeries: _____

What is your goal weight? (The weight you are happiest at) _____

Estimate current exercise level: None ☐ Low ☐ Medium ☐ High ☐

How many hours of TV or Computer activity each day? _____

How many meals do you eat each day? _____

How often do you eat out? _____ (times a week). I rarely eat out ☐

How many 12 oz. cans of sodas (or equivalent) do you drink in a day? Diet _____ Regular _____

How many glasses of SWEETENED tea AND OR cups of SWEETENED coffee do you drink per day? _____

How many 8oz. glasses of water per day? _____

Do you eat when you are bored? YES ☐ NO ☐ , if (yes) what do you eat _____

Do you binge eat (feel compelled to eat because of stress)? YES ☐ NO ☐

Have you ever used laxatives, diuretics or vomiting for weight control ? YES ☐ NO ☐

Have you ever tried prescription medication for weight loss? YES ☐ NO ☐

If yes, when was the last time? _____

If yes, which of the following medications :

Phentermine (Adipex, Fastin, Ionamin)	Benzphetamine (Didrex)
Diethylopropion (Tenuate)	Phendimetrizine (Bontril)
Silbutramine (Meridia)	Phen-Fen
Belviq	Contrave

Other _____

HAYES CLINIC
520 NORTH COLLEGIATE DRIVE
PARIS, TEXAS 75460
LICENSE NUMBER H 9983

Effective date: April 1, 2003

NOTICE OF PRIVACY PRACTICES

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our office strives to protect your privacy in all phases of care we provide for you. Your records can only be released to another party if you have given our office written permission for us to do so. This protection covers release of information to pharmacies, other doctors, and insurance companies. We must have your written permission on file before we can release your information.

On file in our office, we have a complete copy of the NOTICE OF PRIVACY PRACTICES/HIPPA FORMS and you are entitled to a copy of this notice upon request. Please contact the receptionist if you would like a copy.

By signing below, you show that you have been advised of our privacy practices.

SIGNATURE _____ DATE _____

HAYES CLINIC

Patient Informed Consent for Appetite Suppressants/Nutritional Meal Planning

Copy Available Upon Request

I. PROCEDURE AND ALTERNATIVES:

1) I, _____ (patient or patient's guardian) authorize Dr. Gaylen G. Hayes, D.O. to assist me in my weight reduction efforts. I understand my treatment may involve, but not 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 follows:
"Medications, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This 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 required to use the medication as the labeling. As a physician, I am not required to use the medication as the labeling suggest, 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 used 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 the 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 balance 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, 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. RISK 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, and other diseases. 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 QUESTION AS TO THE RISK OR HARZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTION WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS. ASK YOUR DOCTOR NOW BEFORE SIGNING THIS CONSENT FORM.

DATE: _____ TIME: _____
PATIENT: _____
(or person with authority to consent for patient)
WITNESS: _____

VI. PHYSICIAN DECLARATION:

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 risk 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: _____
Gaylen Hayes, D.O.