Personal Information

Today's Date:_______/_______/2018

First Name:___________________________________ Last Name:_______________________________

Email Address:__________________________@__________________

Date Of Birth:_______/_______/_______

Street Address:____

Home Phone: (________)_________________________

Cell Phone: (_______)____________________________

Sex You Identify As: ◯ **M** ◯ **F**

Height:____________

Weight:___________

BMI:______________

How Much Weight Would You Like To Loose?:______________________

Marital Status

◯ **Married** ◯ **Single** ◯ **Domestic Partnership** ◯ **Divorced** ◯ **Separated** ◯ **Widowed**

Spouse Name:_________________________________Contact #: (_______)______________________

Emergency Contact Name:_______________________________________

Relationship:____

Contact Phone: (_______)_______________________________________

General Health Status Information

1. How is your weight distributed?

   ○ Central (abdomen, hips, buttocks) ○ General (all over, carries weight well)

2. Challenges maintaining weight loss even with exercise?

   ○ Yes ○ No

3. Sleep/Energy

   ○ Yes ○ No

4. Wakes refreshed, energized?

   ○ Yes ○ No

5. Uses caffeine to get going in the morning?

   ○ Yes ○ No

6. Energy low all day, Fatigue?

   ● Yes ○ No

7. Energy crash mid-afternoon (2, 3, 4pm)?

   ○ Yes ○ No

8. Wired at night (night owl, insomnia)?

   ○ Yes ○ No

General

1. Women: Any; Hot flashes, night sweats, insomnia?

   ○ Yes ○ No

2. Low libido, decreased sex drive?

   ○ Yes ○ No

3. Depression, mood swings?

   ○ Yes ○ No

4. Muscle weakness, decreased muscle tone?

   ○ Yes ○ No

5. High stress (emotional, financial, physical etc)?

   ○ Yes ○ No

6. Hair loss, feeling cold frequently, constipation?

   ○ Yes ○ No

Do you have any special needs? If so please explain:

Present Health: ○ Great ○ Good ○ Fair ○ Poor

What are your health Concerns:

Who is your primary care provider:______________________________________

Contact #: (________)___________

Please list any allergies that you may have:

____

Please list any medications you are currently taking:

___________________________________ ________________________________

___________________________________ ________________________________

___________________________________ _______________________________

Previous Weight Loss History

Have you previously tried other Programs? (Weight Watchers, Jenny Craig, LA Weight Loss, etc)

Yes No

Name of Program:____

Length of weeks you participated:________________

Amount of weight Lost:________________

Did you keep the weight off? Yes No

Describe your current exercise regimen:

Kindly provide us information about whether you take some of following if yes then mention the quantity.

Cigarettes Yes No

Cigarettes Quantity

Coffee Yes No

Coffee Quantity

Soda Yes No

Cola Quantity

Water Yes No

Water Quantity

Alcohol Yes No

Alcohol Quantity

Tea ○ Yes ○ No

Tea Quantity ______

Rec drugs ○ Yes ○ No

Rec drugs Quantity ______

Other ○ Yes ○ No

Other Quantity ______

Personal History

List hospitalizations or surgeries have you had with corresponding dates.

____

____

____

____

____

Have you been diagnosed with any diseases or disorders Any prior or current diagnosis of cancer?

○ Yes ○ No

Any prior or current diagnosis of type I diabetes? ○ Yes ○ No

Any prior or current kidney disease? ○ Yes ○ No

Any prior or current liver disease? ○ Yes ○ No

Any surgery within the last 4 weeks? ○ Yes ○ No

Any surgery scheduled in the next 3 months? ○ Yes ○ No

Date of most recent full physical exam:________/________/__________

Date of most recent blood work.:____________/________/________

Any abnormalities noted:

______

Review of Symptom

Weight ______

Weight 1 yr. ago ______

Y= a condition you have **Now** **N**= Conditions You Have **Never** had **P**= a condition you have had in **Past**

Eczema Y N P
Hives Y N P
Acne Y N P
Lumps Y N P
Night Sweats Y N P
Headaches Y N P
Head Injury Y N P
Glaucoma Y N P
Cataracts Y N P
Constipation Y N P
Frequent Colds Y N P
Sinusitis Y N P
Postnasal Drip Y N P
Dizziness Y N P
Nose Bleeds Y N P
Joint Pain/Stiffness Y N P
High Blood Pressure Y N P
Heart Murmur Y N P
Palpitations Y N P
Edema Y N P
Diarrhea Y N P
Blood in Stool Y N P
Gas/Bloating Y N P
Broken Bones Y N P
Muscle Spasms Y N P
Deep Leg Pain Y N P
Cold Hands and Feet Y N P
Varicose Veins Y N P
Mood Swings Y N P
Eating Disorder Y N P
Drug/Alcohol Abuse Y N P
Difficulty Sleeping Y N

Change in Taste Y N P
Goiter Y N P
Neck Pain Y N P
Wheezing Y N P
Asthma Y N P
Difficulty Breathing Y N P
Shortness of Breath Y N P
Anemia Y N P
Gall Bladder Disease Y N P
Heartburn Y N
Fainting Y N P
Numbness/Tingling Y N P
Anxiety Y N P
Thyroid Problem Y N P

Female:

Spotting Y N P
Irregular Cycles Y N P
Pain with Intercourse Y N P
Painful Menses Y N P
Birth Control Y N P
Breast Lumps Y N P
Breast Pain Y N P
STD Y N P
Menopausal Symptoms
Y N P

Age your Periods Started:_____
Age your Period Ended:______
Average Length Of Cycle:______
Number of Pregnancies:_______
Number of Births:_______

Tuberculosis
Y N P
Heart Disease
Y N P
Jaundice
Y N P
Indigestion
Y N P
Hemorrhoids
Y N P
Abdominal Pain
Y N P
Peptic Ulcer
Y N P
Frequent Kidney Infection
Y N P
Arthritis
Y N P
Excessive Thirst
Y N P
Excessive Hunger
Y N P

Males:
Hernias
Y N P
Testicular Masses
Y N P
Testicular Pain
Y N P
Sexual Difficulties
Y N P
STD
Y N P
Prostate Disease
Y N P

Hudes Concierge Medicine

Consent For Diet Clinic Treatment

I_______________________________________authorize the Dr. Brian K. Hudes and Hudes Concierge Medicine to use the following to facilitate my diagnosis and treatment:

Use of Nutrition: Vitamin B and Vitamin D intramuscular vitamin injections:______(initials)

Prescription Medications: ________(Initials

Physical Medicine: JuVa Shape Ultrasound and Radio Frequency Therapy _______(Initials)

Lifestyle Counseling: (Diet therapy, promotion of wellness including recommendations for exercise, sleep and stress.)

I recognize the potential risks and benefits of these procedures as described below:

Potential Benefits: Restoration of health and the body's maximum functional capacity without the use of surgery, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Potential Risks: Allergic reactions to prescribed medications, herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipunctures or procedures, tenderness/soreness or bruising from physical treatments. Please note, you will be obtaining the written prescription and filling at a pharmacy of your choice.

Side Effects: Phentermine side effects to keep an eye out for include the onset of headaches, irritability, restlessness, slight water retention, tenderness of breast tissue, swelling of the injection site, and depression. There are some rare, severe side effects as well which include the development of ovarian hyper stimulation in females. The latter condition requires immediate medical treatment and is accompanied by the following symptoms: tremendous pain in the region of the pelvis, the swelling of feet, legs, and hands, abdominal pain, abdominal swelling, difficulty breathing, diarrhea, vomiting, nausea, a diminishing of urination, and weight gain. If a user ofphentermine products notes any side effects it is recommended that he or she cease using the products immediately and that he or she seek out the assistance of a physician.

Notice to all pregnant women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to pregnancy. There are no therapies at Diet Doc that are acceptable for pregnant woman. ___________(Initials)

I understand that a record will be kept of the health services provided to me. This record will be kept confidential, and will not be released to others unless so directed by myself, my representative, or unless law requires. I understand that I may look at my medical record and can request a copy of my record by my paying

the appropriate fee. I understand that my medical record will be kept no more than ten years after the date of my last treatment.

I understand that the doctor will answer any questions that I might have.

With this knowledge, I voluntarily consent to the above Weight Loss Regimen. I realize that neither the doctor nor any personnel of Hudes Concierge Medicine has made any absolute guarantees to me regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and discontinue participation in these procedures at any time. I waive my right to future litigation regarding my present health condition by signing this agreement. ___________(Initials)

Printed Name:_____________________________________

Signature:____ Date:_____/_____/_____

Acknowledgement of Receipt of Statement of Privacy Practices & Patients Rights

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office Hudes Concirege Medicine. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Hudes Concierge Medicine reserves the right to change the privacy practices that are describes in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority:

In addition to the allowable disclosure described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

Name:_______________________________________ Relationship:____________________

Name:_______________________________________ Relationship:____________________

Name:_______________________________________ Relationship:____________________

Statement of Privacy Practices:

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information:

We use and disclose the information we collect from you only as allowed by the Health Insurance Probability and Accountability Act and the state of Washington. This personal health information will never be otherwise given to anyone- even family members- without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information:

We will only request personal information needed to provide our standard of quality care, implement payment activities, conduct normal practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, ECT. Perfect Health Technologies retains full ownership of all documentation collected, and reserves the right to duplicate it for treatment purposes. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information:

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental official under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including utilizing phone auto dialers to remind you of missed consults, follow-up to your diet, doctor renewals, etc., voicemail/answering machine messages, postcards, newsletters and special events.

Patient Rights:

You have the right to request copies of your healthcare information; to request copies in various formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for used other than stated above. All such requests must be in writing. We may charge you for copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

Signature:___________________________________ Date:______/______/_______

Weight Loss Guarantee

Hudes Concierge Medicine Weight Loss Program is a unique medically, supervised weight loss program which personalizes a diet for each person. In order to lose the weight desired, it's important that the overall program is followed specifically according the weight loss doctor and nurse recommendation. If weight loss ceases or slows down by half, it's necessary to call or email Hudes Concierge Medicine as we are experts at reversing weight loss plateaus.

Patient Acknowledges Guarantee: * ☐

If patient is seeking health care reimbursement, Hudes Concierge Medicine will provide documents and receipts for patient to submit to insurance company for reimbursement, but Hudes Concierge does not make claims or promises that the individual's health insurance will reimburse.

This treatment is 100% the patients responsibility.

Patient Acknowledges Health Care Reimbursement: * ☐

My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand. By signing this form, I certify: · That I have read or had this form read and/or had this form explained to me · That I fully understand its contents including the risks and benefits of the telemedicine consultation(s). · That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

____ Date:________/________/________

Patient's Signature

____

Printed Name