Application for MD Weight Management

Today's Date _____

Name _____ Home Phone_____

Address_____ Work Phone_____

Cell Phone_____Date of Birth _____

□ Male □ Female E-Mail Address_____

Emergency Contact _____Phone Number _____

How did you hear about MDWM/who referred you?_____

Demographics

Ethnicity: □ Hispanic or Latin □ Non-Hispanic or Latino □ Asian □ Decline to state

Race: □ American Indian/Alaska Native □ Black or African American
□ Native Hawaiian or Pacific Islander □White □ Other □ Decline to state

Primary Language: _____

Weight History

To the best of your recollection, what is your:

Height: _____ Current Weight:_____

Minimum Adult Weight: _____ Maximum Adult Weight: _____

Number of Years Overweight: _____

What methods of weight reduction have you tried previously?

Diet Alone _____ Shots_____ Pills _____ Programs_____

Full Meal Replacement ("Fasting")_____ Other _____

Have you participated in this program previously? If so, what year(s) did you participate?

_____

Insurance

Type of Insurance: _____

There are several insurance plans that are contracted with our program. To find out if your insurance will cover the program, please call the customer service number listed on the back of your insurance card and ask if your plan covers 'medical weight loss.' To receive a list of service codes, contact our office. Due to the vast diversity of plans, we are not able to reliably predict the rate at which plans will cover the program. If you have questions regarding your out of pocket costs for the program while using your insurance, please contact your carrier directly.

MD Weight Management
2340 Clay St. 6th Floor
San Francisco, CA 94115
P (415) 674-5200
F (415) 600-3705
www.mdweightmanagement.com

Medical History: To be completed by the Patient

Have you ever experienced, been told you have, or been treated for any of the following disorders?

	Yes	No		Yes	No
Alcoholism	__	__	Gout	__	__
Anemia	__	__	Heart Attack	__	__
Angina	__	__	Hepatitis	__	__
Anorexia	__	__	High Blood Pressure	__	__
Anxiety	__	__	Hyperlipidemia	__	__
Arthritis	__	__	Hyperthyroidism	__	__
Back Pain	__	__	Hypothyroidism	__	__
Bleeding Gums	__	__	Insomnia	__	__
Bipolar Disorder	__	__	Joint Pain	__	__
Binge Eating	__	__	Kidney Disease	__	__
Bowel Disease	__	__	Kidney Stones	__	__
Bulimia	__	__	Leg Swelling	__	__
Celiac Disease	__	__	Liver Disease	__	__
Chest Pain	__	__	Missing Menstrual Periods	__	__
Coronary Artery Disease	__	__	Obstructive Sleep Apnea	__	__
Current or Recent Pregnancy	__	__	Pre-Diabetes	__	__
Daytime Sleepiness	__	__	Psychiatric Illness/Hospitalization	__	__
Dental Issues	__	__	Rapid or Irregular Heart Rate	__	__
Depression	__	__	Shortness of Breath	__	__
Drug Addiction	__	__	Snoring	__	__
Diabetes	__	__	Stroke	__	__
Eating Disorder	__	__	Taking Insulin	__	__
Elevated Blood Sugar	__	__	Ulcer Disease	__	__
Falling Asleep at Odd Times	__	__	Urinary Frequency/Incontinence	__	__
Fainting	__	__	**Please list any additional medical problems or illnesses:**		
Fatty Liver	__	__	_____		
Gall Bladder Disease or Stones	__	__	_____		
GERD/Reflux/Heartburn	__	__	_____		
Gallbladder removal surgery?	__	__	_____		
			_____		
			_____		

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Allergies:

Medication Allergies: ○Yes ○No List:_____

Food Allergies: ○Yes ○No List:_____

Family History

If positive: indicate father, mother, sibling, child, maternal and paternal grandparents

Obesity:_____ Diabetes:_____

High Blood Pressure:_____ Gall Bladder Removal:_____

Stroke:_____ Gall Stones:_____

High Cholesterol: _____ Alcohol or Drug Abuse: _____

Heart Disease:_____ Other: _____

Current Medications: **Please Include All Vitamins, Supplements, and Herbal Medications.**

IMPORTANT: Failure to disclose ALL medications, herbal supplements, and over-the-counter treatments can result in discharge from the program.

Name	Purpose	Dose	Frequency

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Personal History

Marital Status:_____

Present Occupation: _____

Children:_____

Coffee Consumed: _____

Smoking:

___ Current Smoker, occasional
___ Current Smoker, every day
___ Former Smoker
___Never a Smoker

Do you drink alcohol? _ Yes _ No
If yes, how many drinks per week?_____
(One drink equals 5 oz wine, 12 oz beer or 1.5 oz hard liquor)

Exercise Habits: _____

Comments:_____

_____

_____

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<u>Physician Approval Form</u>: To Be Completed by your treating Physician

We'd like to make you aware that your patient_______, has applied for participation in MD Weight Management. Our medically managed program is dedicated to help with weight reduction through meal replacement fasting as well as nutritional education and planned physical activity. Any additional medical problems will be referred back to you, the primary physician. All laboratory data from this Program will be sent to you periodically.

The following are contraindications to the use of total meal replacement fasting, due to diuresis and hemodynamic changes:

- History of active liver disease
- Type I diabetes
- Myocardial infarction, recent
- Cerebral vascular accident within the past 6 months
- Accelerated angina
- Multifocal premature beats
- History of alcohol or drug addiction
- Ischemic disease
- Pregnancy or lactation
- Active ulcer disease
- Recent treatment for acute psychiatric illness

Does your patient have any of these conditions?

Indications for treatment with this program include Body Mass Index (BMI) in excess of 27, hypertension, adult onset diabetes mellitus, cardiovascular disease, sleep apnea, weight reduction prior to surgery and orthopedic problems aggravated by excess weight. Please provide any relevant medical information about your patient.

Please provide physician's name phone number and address:

_____

_____

_____

Physician's signature:_____

Patient Release:

I, _____, hereby authorize my personal physician, Dr._____, to release any information contained in my medical records to MD Weight Management, or to insurance companies who may be processing claims made by me.

_____

Patient's signature Date

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