Nutritional Health Center

Spartanburg Location
1463 East Main Street, Suite C, Spartanburg, SC 29307
Phone (864)585-6400

Greenville Location
2082 Woodruff Road, Greenville, SC 29607
Phone (864)254-9930 Fax (864)254-9929

CONFIDENTIAL HEALTH RISK QUESTIONAIRE

NAME: _____ _____ ____ DATE OF BIRTH: ___/___/____
LAST FIRST MI

ADDRESS: _____CITY_____ST_____ZIP_____

HOME PHONE: (____) _____ CHECK HERE IF YOU DO NOT WANT US TO CONTACT YOU AT THIS NUMBER

MOBILE PHONE: (____) _____ CHECK HERE IF YOU DO NOT WANT US TO CONTACT YOU AT THIS NUMBER

EMAIL:_____ (ALL PATIENT INFORMATION IS CONFIDENTIAL)

DRIVER LICENSE#: _____ MARITAL STATUS: _____ GENDER: M F

EMPLOYMENT: _____ _____
COMPANY JOB TITLE

PRIMARY CARE PHYSICIAN (PCP): _____ PHONE #: (____) _____

A. WHAT IS YOUR PERSONAL ASSESSMENT OF YOUR GENERAL HEALTH? GOOD AVERAGE POOR
WHAT CURRENTLY CONCERNS YOU THE MOST ABOUT YOUR HEALTH? _____

B. ARE YOU ALLERGIC TO ANY MEDICATIONS? (PLEASE LIST) _____
_____

C: DO YOU SMOKE? _____ HOW MUCH? _____

D: DO YOU DRINK ALCOHOL? _____ HOW MANY DAYS PER WEEK? _____ WHEN YOU DO DRINK HOW MUCH DO YOU DRINK? (5 OZ OF WINE, 12 OZ OF BEER OR 1 OZ OF LIQUOR EQUALS ONE DRINK) _____

E. DO YOU CURRENTLY TAKE ANY NON-PRESCRIPTION MEDICATION? (PLEASE LIST) _____
_____

F. DO YOU TAKE ASPIRIN? _____ HOW MANY DAYS PER WEEK? _____ HOW MANY ASPIRIN? _____

G. DO YOU CURRENTLY TAKE ANY HERBAL PREPARATIONS? (PLEASE LIST) _____
_____

H. DO YOU CURRENTLY TAKE ANY PRESCRIPTION MEDICATIONS? (PLEASE LIST) _____
_____

I. HAVE YOU EVER HAD SURGERY? (PLEASE LIST ALONG WITH THE YEAR PERFORMED) _____
_____

J. DO YOU HAVE ANY CHRONIC (MORE THAN A YEAR) ILLNESSES? (PLEASE LIST) _____
_____

K. PLEASE INDICATE WHICH IMMUNIZATIONS YOU HAVE HAD: DIPTHERIA AND TETANUS WITHIN THE PAST TEN YEARS? _____ MEASLES, MUMPS, RUBELLA IF BORN AFTER 1956? _____ HEPATITIS B? _____
PNEUMOCOCCUS? _____ INFLUENZA? _____ DATE GIVEN:_____

L. FAMILY HISTORY. PLEASE INDICATE WHETHER ANY MEMBERS OF YOUR IMMEDIATE FAMILY (PARENTS, GRANDPARENTS AND SIBLINGS) HAVE BEEN DIAGNOSED WITH: DIABETES _____ STROKE _____
CANCER _____ HIGH CHOLESTEROL _____ HIGH BLOOD PRESSURE _____ HEART DISEASE _____
OBESITY _____ THYROID DISORDER _____

M. WEIGHT HISTORY: AT WHAT WEIGHT ARE YOU MOST COMFORTABLE? _____
WHEN DID YOUR WEIGHT BECOME A PROBLEM? _____
WHAT WAS YOUR LOWEST WEIGHT AS AN ADULT? _____ WHEN WAS THAT? _____
WHAT IS YOUR HIGHEST NON-PREGNANT WEIGHT AS AN ADULT? _____ WHEN WAS THAT? _____
HOW MANY TIMES HAVE YOU TRIED TO LOSE WEIGHT IN THE LAST FIVE YEARS? _____
WHAT WEIGHT LOSS PROGRAMS HAVE YOU TRIED? _____
LIST ANY PRESCRIPTION OR NON-PRESCRIPTION APPETITE SUPPRESSANTS YOU HAVE TAKEN: _____
_____
DID THEY CAUSE YOU ANY DIFFICULTY? _____ DID THEY HELP YOU LOSE WEIGHT? _____

N. PHYSICAL REVIEW

CHECK ✓ IF YOU HAVE SYMPTOMS OR HISTORY AS LISTED

1. RESPIRATORY:

- ❑ SHORTNESS OF BREATH AT REST
- ❑ SHORTNESS OF BREATH AFTER CLIMBING ONE FLIGHT OF STAIRS
- ❑ PNEUMONIA
- ❑ ASTHMA
- ❑ PRODUCTIVE COUGH (PURULENT YELLOW OR GREEN SPUTUM)
- ❑ PRODUCTIVE COUGH WITH BLOOD
- ❑ PULMONARY EMBOLI (BLOOD CLOTS IN THE LUNGS)
- ❑ EMPHYSEMA BY PHYSICIAN DIAGNOSIS
- ❑ TUBERCULOSIS – HAVE YOU HAD A SKIN TEST IN THE LAST FIVE YEARS? _____

2. CARDIOVASCULAR:

- ❑ CHEST PAIN
- ❑ HEART ATTACK BY PHYSICIAN DIAGNOSIS
- ❑ HEART FAILURE BY PHYSICIAN DIAGNOSIS
- ❑ HIGH BLOOD PRESSURE
- ❑ EDEMA (SWELLING DUE TO FLUID IN THE ANKLES OR LEGS)
- ❑ HEART MURMUR
- ❑ PERIPHERAL VASCULAR DISEASE (POOR CIRCULATION)

3. ENDOCRINE

- ❑ ABNORMAL THYROID FUNCTION
- ❑ DIABETES
- ❑ GOUT

4. GASTROINTESTINAL

- ❑ ABDOMINAL PAIN
- ❑ HEARTBURN
- ❑ HIATAL HERNIA
- ❑ VOMITING
- ❑ RECTAL BLEEDING (BLACK STOOLS)
- ❑ HEMORRHOIDS
- ❑ GALLSTONES
- ❑ DIARRHEA

BELCHING
ULCER DISEASE
ACID REFLUX
EXCESSIVE GAS
NAUSEA
CONSTIPATION
COLITIS
SEVERE HEARTBURN

HAVE YOUR STOOLS BEEN TESTED FOR BLOOD IN THE LAST TWO YEARS?_____

5. PSYCHOLOGICAL

- ❑ DEPRESSION OR BIPOLAR DISORDER
- ❑ SCHIZOPHRENIA
- ❑ CHRONIC ANXIETY
- ❑ PANIC ATTACKS
- ❑ HISTORY OF ANY EATING DISORDERS

6. NEUROLOGICAL

- ❑ HEADACHES
- ❑ FAINTING
- ❑ SEIZURE DISORDER
- ❑ NUMBNESS
- ❑ DIZZINESS

7. MUSCULOSKELETAL

- ❑ ACHING JOINTS
- ❑ LIMITATIONS ON MOBILITY
- ❑ LOW BACK PAIN
- ❑ ARTHRITIS
- ❑ MUSCLE CRAMPS

8. EARS, EYES, NOSE AND THROAT

- ❑ SEASONAL ALLERGIES
- ❑ SIGNIFICANT HEARING LOSS
- ❑ DIFFICULTY SWALLOWING
- ❑ GLAUCOMA
- ❑ GLASSES OR CONTACTS
- ❑ CATARACTS

9. GENITOURINARY

- ❑ FREQUENT NIGHTTIME URINATION (2+ TIMES PER NIGHT)
- ❑ RECURRENT URINARY INFECTIONS (1+ PER YEAR)
- ❑ BLOODY URINE
- ❑ DIFFICULTY URINATING
- ❑ SUDDEN URGE TO URINATE (8+ TIMES PER DAY)
- ❑ BURNING URINATION

MEN ONLY:

HAS YOUR PSA BEEN DETERMINED IN THE PAST YEAR? ____
DO YOU ROUTINELY EXAMINE YOUR TESTICLES? _____

10. SKIN

DO YOU HAVE YOUR SKIN EXAMINED REGULARLY?____
DO YOU PROTECT YOURSELF IN THE SUN:
WITH CLOTHING? _____
WITH SUNSCREEN? _____
WITH SUNGLASSES? _____

11. DENTAL

DO YOU VISIT THE DENTIST EVERY SIX MONTHS FOR ROUTINE CHECKS AND CLEANING? _____
DO YOU FLOSS REGULARLY? _____

12. WOMEN ONLY:

ARE YOUR MENSTRUAL PERIODS REGULAR?____
ARE YOU POST-MENOPAUSAL?____
DO YOU HAVE HEAVY MENSTRUAL FLOW? ____
HAVE YOU BEEN DIAGNOSED ANEMIC? ____
HAVE YOU BEEN PREGNANT? ____
BIRTH WEIGHT OF YOUR HEAVIEST BABY? _____
HAVE YOU EVER HAD A DIFFICULT PREGNANCY?_____
EXCESSIVE EDEMA ____ HYPERTENSION ____ GESTATIONAL DIABETES ____
DID YOU BREASTFEED? _____
DO YOU ROUTINELY EXAMINE YOUR BREASTS? ____
DO YOU HAVE ANNUAL BREAST AND PELVIC EXAMS AND PAP SMEARS? ____
DO YOU HAVE ANNUAL MAMMOGRAMS? ____
DO YOU TAKE HORMONE REPLACEMENT? ____

Nutrition & Exercise History

Do you normally drink more or less than 2 quarts of water a day? _____
What other beverages do you drink? _____
Do you eat breakfast regularly? _____
Do you eat cereal regularly? _____ Do you use Milk?_____
What time of day you most notice your appetite? ○ Morning ○ Afternoon ○ Evening
If you snack, when do you snack? ○ Morning ○ Afternoon ○ Evening
What is your typical snack food? _____
How often do you eat fish? _____

For the next questions: ½ cup of most vegetables and beans and 1 cup of leafy green vegetables and fruit = 1 serving.

How often do you eat vegetables? _____ How much?_____
What vegetables do you prefer? _____
How often do you eat fruit? _____ How Much?_____
What fruits do you prefer? _____
Do you eat or drink dairy products?_____ Which ones?_____
_____
Do you eat margarine? _____
Do you eat packaged bakery goods? _____ Which ones?_____
_____

What nutritional supplements do you take? _____
_____

Do you climb stairs on a regular basis? ____ How many flights? _____
Are you physically active at your job? _____
Do you do your own housework? _____
Do you do your own yardwork? _____
How many times a week do you exercise? _____
Typical exercise: _____for_____minutes
Do you do any strength training? _____
Do you stretch regularly? _____
Have you participated in organized sports? _____
What sport and When?_____

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Patient Informed Consent for Controlled Medications
(including phentermine, phendimetrazine, diethylpropion and furosemide)

I. PROCEDURE AND ALTERNATIVES.

1) I hereby authorize the physicians and staff of Nutritional Health Center to assist me in my weight reduction and maintenance efforts. I understand that my treatment will likely involve the use of medications.
2) I UNDERSTAND THAT IT IS ILLEGAL AND POTENTIALLY DANGEROUS TO GET DUPLICATE PRESCRIPTIONS FROM MORE THAN ONE DOCTOR.
3) I understand that there are risks of side effects from the use of these medications and that some of these side effects may be serious.
4) I understand that it is my responsibility to carefully follow the instructions I have been given and to report any significant medical problem to the physician as soon as is reasonably possible, REGARDLESS OF WHETHER THE PROBLEM MAY BE DUE TO THE TREATMENT I AM RECEIVING HERE.
5) I understand that the purpose of this treatment is to assist me in achieving my goal of reducing my body weight and maintaining this weight loss. I understand that my continuing to receive medications will be dependent on my progress in weight reduction and weight maintenance.
6) I understand that for effective weight loss it is essential to participate in a controlled diet combined with a regular exercise program even if I am taking an appetite suppressant. I UNDERSTAND THAT GOOD HEALTH REQUIRES GOOD FOOD. I WILL NOT USE APPETITE SUPPRESSANTS TO STARVE MYSELF.

II. RISKS OF PROPOSED TREATMENT.

I understand my consent is given with the knowledge that the use of any medication involves some risks and hazards. The more common ones I should be aware of include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, allergic reactions to the medication, high blood pressure, rapid heartbeat and other heart irregularities. These and other possible risks could become serious.

III. RISKS ASSOCIATED WITH BEING OVERWEIGHT OR OBESE.

I am aware that there are certain risks associated with remaining overweight or obese. Among these are the tendencies to high blood pressure, diabetes, heart attack (and other heart diseases) and arthritis. I understand that these risks may be modest if I am not very overweight but increase the more overweight I am.

IV. NO GUARANTEE.

I understand that much of the success of this program depends on my own efforts and therefore there can be no guarantee that the program will be successful for me. I also understand that I will have to continue watching my weight and maintaining a healthy lifestyle for the rest of my life to be successful.

V. CONSENT.

I have read this consent and I realize I should not sign it if I do not fully understand it or if any questions I have concerning any aspect of it have not been answered to my satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with the physician regarding the risks associated with appetite suppressants.

_____ _____

Signature Date

FINANCIAL POLICY AND PAYMENT RESPONSIBILITY

Payment is expected at the time service and is the responsibility of the patient or, in the case of a minor, the signed responsible party. OUR OFFICES DO NOT FILE FOR ANY INSURANCE BENEFITS. It is the patient's responsibility to file all claims with his or her insurance company. This office will, upon request, provide an itemized bill at the time of the visit which indicates a diagnosis code and, where applicable, CPT codes to aid the patient in seeking reimbursement. Other than this itemized bill, THIS OFFICE IS UNABLE TO PROVIDE ANY FURTHER ASSISTANCE IN SEEKING REIMBURSEMENT. In our experience, we have found that MOST INSURANCE WILL NOT COVER ANY EXPENSES FOR MEDICAL WEIGHT LOSS PROGRAMS.

HOWEVER, the new health care law may change this. We encourage all patients to submit their charges for reimbursement. The worst outcome is that you do not get reimbursed which we are telling you to expect anyway. If you do submit charges for reimbursement please let us know about the outcome.

Acceptable methods of payment are: CASH, CHECK, VISA, MASTERCARD and DISCOVER. We charge a $25 fee for dishonored checks.

MEDICARE NOTICE

The rules for Medicare have recently changed to include coverage for weight loss and nutritional services. Because we are not a participating Medicare provider, we are legally prohibited from providing these goods and services to people covered by Medicare.

By signing below you are accepting financial responsibility for all charges incurred and affirming that you are not currently covered by Medicare. You further acknowledge that you understand that not everyone who is eligible for Medicare is covered and therefore it is your responsibility to inform us if your Medicare coverage status changes for any reason.

_____ _____

Signature Date