Greetings From Dr. Horowitz

Welcome to The New Start Wellness and Weight Loss Center. The program at New Start will be your foundation to a better life, both physically and mentally. Our program is unique in that although we will address the physical nature of being overweight and unhealthy, we will also offer you unique lifestyle guidance that will give you lasting tools for continued success. The decision to change does not come easily and you are to be congratulated on choosing a new path to unlock the potential of your life. At New Start, we are committed to positive change in all phases of your life, not just your weight and the number on a scale. Our mind, body, and spiritual approach to weight loss will be your ticket to a new life. This decision to improve your health and well-being will reap benefits for years to come.

At New Start, your personalized program will not only include a medically supervised weight management program but also a framework for you to incorporate daily lifestyle principles to increase your chances of long term success. There will be ups and downs along the way, but we will be with you at each step. In our society, we are all under a constant barrage that promotes unhealthy living and eating. There will be challenges to your ability to stay committed to the program and to yourself. The food industry values profits not your health. If you fall prey to those lies, your chances of healthy, meaningful living is slim. Think of our program as a protection against those forces. At New Start, you will not merely begin a weight loss program; you will begin a new way to live and we will be your partners along this amazing journey.

As the founder and Medical Director of New Start Wellness and Weight Loss, I am one of you. I understand first hand the difficulties that arise out of a body that is fed unhealthy quantities and types of food. I understand the pain, isolation, and medical problems that come from a body plagued by too much weight. Personally, my weight caused severe medical problems that if left untreated would have certainly shortened my life. For so long, I had no way out because I had no connection to a program that could help me. At New Start, we believe support and connection is the only way to stay on the path to a new you. Our commitment is that you won't have to go it alone any longer.

Congratulations on choosing to partner with us to reach your full potential. Our passion is helping you achieve your better life. Now is the time to choose you, let's get started!

Dr. John D. Horowitz, MD, FACS
American Society of Bariatric Physicians

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NEWSTART
WELLNESS AND WEIGHT LOSS CENTER

Ocoee Orlando/MetroWest Kissimmee The Villages
(407) 802-3533 (352) 561-2820
www.newstartwellness.com

Date: _____

Patient Name (First-Initial-Last) _____

Address _____ City_____ St _____ Zip _____

Home Phone _____ Cell Phone _____ Alternate Phone _____

Place of Employment _____ Work Phone _____

Occupation _____

Email Address _____

Birth date (Month-Day-Year) _____ Age _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Ethnicity: ☐ Latino/Hispanic ☐ Other ☐ Prefer not to disclose

Race: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ Native American ☐ Subcontinent Asian American
☐ Pacific Islander ☐ Asian Pacific American ☐ Native Hawaiian ☐ American Indian or Alaskan Native
☐ Black Non-Hispanic ☐ White Non-Hispanic ☐ Other Race or Ethnicity

Name of Spouse: _____ Phone _____

Nearest Relative not living with you: _____ Phone _____

Emergency Contact _____ Phone _____

Primary Care Physician: _____

Referred by: ☐ Self ☐ Internet ☐ Television ☐ Family ☐ Friend ☐ Other
☐ Physician (First-Last) _____

I authorize the Physicians and Physician's associates of New Start Wellness and Weight Loss Center to render medical care to the above named patient. I acknowledge that all information listed above is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges. This signed agreement will act as a valid facsimile of the original.

Patient's Signature _____ Date _____

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PRIVACY PRACTICE ACKNOWLEDGEMENT

I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW THE NOTICE OF PRIVACY PRACTICES AND MAY ALSO REQUEST A COPY TO KEEP FOR MYSELF IF I SO CHOOSE.

NAME _____

BIRTHDATE _____

SIGNATURE _____

TODAY'S DATE _____

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NOTICE OF PRIVACY PRACTICES

NEWSTART
WELLNESS AND WEIGHT LOSS CENTER

10000 W COLONIAL DR, STE 495
OCOEE, FL 34761

•

3302 GREENWALD WAY N
KISSIMMEE, FL 34741

•

6200 METROWEST BLVD, STE 106
ORLANDO, FL 32835

407.802.3533

1503 BUENOS AIRES BLVD, BLDG 123
THE VILLAGES, FL 32159

352.561.2820

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

WE ARE REQUIRED BY LAW TO PROTECT MEDICAL INFORMATION ABOUT YOU

We are required by law to protect the privacy of medical information about you and that identifies you. We are also required by law to provide you with this Notice of Privacy Practices (NPP) that explains our legal duties with regard to your medical information and how we may use and disclose your protected health information (PHI) for treatment, payment, and health care operations, as well as other purposes that are permitted or required by law. We reserve the right to make changes to the terms of the NPP in the future. If we make changes to the NPP, we will post the new NPP in our reception area and have copies available upon request. You have certain rights regarding the privacy of your PHI which will be described in this notice.

Ways in Which We May Use and Disclose Your Protected Health Information

The following paragraphs describe different ways that we use and disclose your PHI. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your health information fall within one of these categories.

Treatment. We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally, we may from time to time, disclose your health information to another physician who we have requested to be involved in your care. *For example* – we would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

Payment. We will use and disclose your PHI to obtain payment for the health care services we provide you. *For example* – we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Health Care Operations. We will use and disclose your PHI to support the business activities of our practice. *For example* – we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription services for our practice.

Other Ways We May Use and Disclose Your Protected Health Information

Appointment Reminders. We will use and disclose your PHI to contact you as a reminder about scheduled appointments or treatment.

Treatment Alternatives. We will use and disclose your PHI to tell you about or to recommend possible alternative treatments or options that may be of interest to you.

Others Involved in Your Care. We will use and disclose your PHI to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment for care. We may also use or disclose PHI about you to a disaster relief organization (i.e. Red Cross) if we need to notify someone about your location or condition.

Required by Law. We will use and disclose your PHI when required to do so by federal, state, or local law.

National Priority Uses and Disclosures. When permitted by law, we may use or disclose PHI about you without your permission for various activities that are recognized as "national priorities." When permitted to do so by law we will disclose your PHI as below:

- **Threat to health or safety:** if we believe it is necessary to prevent or lessen a serious threat.
- **Public health activities**: for investigating diseases, reporting abuse, communicable diseases, etc.
- **Abuse, neglect or domestic violence**: if we reasonable believe you may be a victim.
- **Health oversight activities**: agency responsible for overseeing the healthcare system or certain government programs.
- **Court proceedings**: if a judge would order us to do so.
- **Law enforcement**: for specific law enforcement purposes such as in order to help find or identify a missing person.
- **Coroners and others**: to assist with organ, eye and tissue transplants.
- **Workers' compensation**: in order to comply with workers' compensation laws.
- **Research organizations**: if the organization has satisfied certain conditions about protecting your PHI.
- **Certain government functions**: includes military and veterans' activities, national security and intelligence activities, and in some circumstances to a correctional institution.

Authorizations. Other than the uses and disclosures described above, we will not use or disclose medical information about you without the "authorization" – or signed permission – of you or your personal representative.

If you sign a written authorization allowing us to disclose medical information about you, you may later revoke (or cancel) your authorization in writing (except in very limited circumstances related to obtaining insurance coverage). If you would like to revoke your authorization, you may write us a letter revoking your authorization or fill out an Authorization Revocation Form. Authorization Revocation Forms are available from our Privacy Officer. If you revoke your authorization, we will follow your instructions except to the extent that we have already relied upon your authorization and taken some action.

YOU HAVE RIGHTS WITH RESPECT TO MEDICAL INFORMATION ABOUT YOU

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

Right to a Copy of This Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

Right of Access to Inspect and Copy. You have the right to inspect and copy the protected health information that we maintain in certain groups of records. If we maintain your medical records in an Electronic Health Record (EHR) system, you may obtain an electronic copy of your medical records. You may also instruct us in writing to send an electronic copy of your medical records to a third party.

If you wish to inspect or receive a copy of your medical information, you must provide us a request in writing. You may mail in your request, or bring it to our office. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. We will also inform you, you have the right to have our decision reviewed by another person.

Right to Have Medical Information Amended. You have the right to request that we amend your medical information we maintain in certain groups of records if you feel that it is incomplete or inaccurate. You must make this request in writing to our Privacy Officer, stating exactly what information is to be amended and your reasoning that supports your request.

We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. You will have the opportunity to send us a statement explaining why you disagree with our decision to deny your amendment request and we will share your statement whenever we disclose the information in the future.

Right to Request Restrictions on Uses and Disclosures. You have the right to request that we limit the use and disclosure of medical information about you for treatment, payment and healthcare operations. Under federal law, we must agree to your request and comply with your requested restriction(s) if:

1. Except as otherwise required by law, the disclosure is to a health plan for purpose of carrying out payment of healthcare operations (and is not for purposes of carrying out treatment); and,
2. The medical information pertains solely to a healthcare item or service for which the healthcare provided involved has been paid out-of-pocket in full.

Once we agree to your request, we must follow your restrictions (except if the information is necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

You also have the right to request that we restrict disclosures of your medical information to a health plan or other party, when that information relates solely to a healthcare item or service for which you have paid us for in full. Once you have requested such restriction(s), and your payment in full has been received, we must follow your restriction(s).

Right to an Accounting of Disclosures We Have Made. You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made for the previous six (6) years. If you would like to receive an accounting, you may send us a letter requesting an accounting or fill out an **Accounting Request Form.** Accounting Request Forms are available from our Privacy Officer.

The accounting will not include several types of disclosures, including disclosures for treatment, payment or healthcare operations. If we maintain your medical records in an Electronic Health Record (EHR) system, you may request that include disclosures for treatment, payment or healthcare operations. The accounting will also not include disclosures made prior to April 14, 2003.

Right to Request an Alternative Method of Contact. You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address.

We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, you must provide us with a request in writing. You may write us a letter or fill out an **Alternative Contact Request Form**. Alternative Contact Request Forms are available from our Privacy Officer.

Right to Notification if a Breach of Your Medical Information Occurs. You also have the right to be notified in the event of a breach of medical information about you. If a breach of your medical information occurs, and if that information is unsecured (not encrypted), we will notify you promptly.

YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you believe that your privacy rights have been violated or if you are dissatisfied with our privacy policies or procedures, you may file a written complaint either with us or with the federal government.

We will not take any action against you or change our treatment of you in any way if you file a complaint.

To file a written complaint with us, you may bring your complaint directly to our Privacy Officer, or you may mail it to the following address: Privacy Officer, c/o New Start Wellness & Weight Loss Center, 10000 W. Colonial Drive, Suite 495, Ocoee, FL 34761.

To file a written complaint with the federal government, please use the following contact information:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Toll-Free Phone: 1-(877) 696-6775

Website:
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

Email: OCRComplaint@hhs.gov

This notice is effective September 18, 2014

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS AND COMMUNICATION WITH FAMILY AND FRIENDS

The patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") and patient medical record information by New Start Wellness and Weight Loss Center (the "Center") in order to carry out treatment, payment, or health care operations.

Patient retains the right to request that the Center further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Center is not required to agree to such requested restrictions; however, if the Center does agree to Patient's requested restriction(s), such restrictions are then binding on the Center.

Family and Friends. It is the office policy of New Start Wellness and Weight Loss Center not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers, please indicate that below, so that we may best serve you. If you do not list anyone below, your medical information will not be released except as stated in this signed Consent. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing.)

Spouse: _____ Parent: _____

Other: _____ Other: _____

Other: _____ Other: _____

At all times, Patient retains the right to revoke this consent. Such revocation must be submitted to the Center in writing. The revocation shall be effective except to the extent that the Center has already taken action in reliance on the Consent.

The Center may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form. If Patient (or authorized representative) signs this Consent and then revokes it, the Practice has the right to refuse to provide further treatment to the Patient as of the time of revocation (except to the extent that the Center is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEIVED A COPY OF THIS CONSENT, AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

_____	_____	_____
Please Print Name	Signature of Patient (Authorized Representative*)	Date

*Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of the Patient (Proof of authorization must be provided):

_____

_____

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COMMUNICATIONS AGREEMENT

In order to keep pace with electronic communications and comply with governmental regulations, please let us know how you would like us to communicate with you.

PLEASE CHECK APPROPRIATE BOXES BELOW & INDICATE PRIORITY (1st, 2nd or 3rd) OF NUMBERS

_____ Priority

HOME Telephone: _____ - _____ - _____

- ❑ OK to leave **voice** message with detailed information.
- ❑ Leave message with call back number **ONLY**.

_____ Priority

CELLULAR Telephone: _____ - _____ - _____

- ❑ OK to leave **voice** message with detailed information.
- ❑ Leave message with call back number **ONLY**.
- ❑ OK to send text message (Opt In) Cell Phone Carrier_____

_____ Priority

WORK Telephone: _____ - _____ - _____

- ❑ OK to leave **voice** message with detailed information.
- ❑ Leave message with call back number **ONLY**.

EMAIL ADDRESS: _____

- ❑ Ok to send message with detailed information.

WRITTEN COMMUNICATION

Mail will be sent to the home address provided.

I agree and consent to New Start Wellness and Weight Loss Center releasing information to myself in the above manners.

At all times, I retain the right to revoke this consent. Such revocation must be submitted to **New Start Wellness and Weight Loss Center** in writing. The revocation shall be effective *except* to the extent that **New Start Wellness & Weight Loss Center** has already taken action in reliance on the Consent.

Patient Name: _____ Date: _____

Signature: _____

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Patient Commitment Form

Commitment

Realizing that losing weight will require a great deal of time and effort on my part, I _____ _____ wish to participate in the New Start Wellness Program, a medically monitored program for weight loss and weight management of my health I must maintain my weight loss once I reach my goal. Therefore, I am making the commitment to understand and practice the lifestyle changes presented in this program. If I find myself having difficulty, I will not hesitate to contact _____ for assistance.

Involvement/Product

I agree to adhere to the program by being actively involved in the weekly office visits. I also agree to purchase and consume the amount of nutritional products prescribed to me. I also understand that once I have purchased the products they may not be returnable.

I understand that the Program requires the following services to make my weight loss effective and safe:

- Medical and psychological screening before I enter the program.
- Routine visits with a physician
- Weekly office visits that include information on behavior modification, nutrition education and exercise.
- I will follow prescribed meal plan and consume daily requirement of nutritional products.
- I agree to purchase all of my weekly-prescribed protein product from your facility.
- Individual consultation about program-related issues that may be initiated by the staff or by me.
- Weekly medical monitoring of my weight, blood pressure and weekly compliance to the program.
- Periodic blood tests and EKG monitoring at regular weight loss intervals.

I have read all the above statements and understand their meaning. It is my wish to participate in the **New Start Wellness Program** under the conditions described.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

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Medical Weight Management Program Treatment Consent Form

Authorization for Examination and Treatment

1. Having been explained the risks and benefits of the **New Start Wellness Program** a medically monitored program for safe* weight loss and complete education to help manage weight. I knowingly and voluntarily desire to participate in the **New Start Wellness Program**.
2. I am aware that I must meet medical and psychological screening criteria established by the Medical team before entering the **New Start Wellness Program**.
3. I hereby authorize and consent to have the **New Start Wellness** physicians perform complete physical and diagnostic procedures including blood test and electrocardiogram (EKG) for evaluation purposes. I have had the opportunity to ask questions regarding the diagnostic procedures.
4. As part of the **New Start Wellness Program**, continuous medical monitoring is mandatory. Consequently, upon acceptance to the program, I willingly agree to have this monitoring performed (blood tests, periodic EKG, and other tests as indicated).
5. I am aware during the weight loss period possible side effects may occur from ketosis. Ketosis is an increased amount of fat by-products (ketone bodies) in the body due to altered nutrient composition of the diet (low carbohydrate). These side effects include dizziness and fruity breath. Less common, but possible side effects are fatigue, leg cramps, missed or late menstrual periods, dry skin, temporary hair loss, sensitivity to cold, diarrhea and constipation.
6. If medical complications unrelated to weight loss arise during the New Start Wellness Program, I am fully aware I will be referred back to my private physician for treatment and evaluation.
7. I recognize that if I should become pregnant my participation in the **New Start Wellness Program** must be terminated.
8. I understand that I will pay for my products and program services on a weekly basis. I understand that it is my responsibility to pay for these services.
9. The physician/nurse practitioner team of weight management professionals has answered my questions regarding this program and possible side effects.

Patient Signature: _____ Date: _____

Staff Signature: _____Date: _____

**Physician monitoring is required to help minimize the potential for health risks.*

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FINANCIAL POLICY

Thank you for selecting Dr. John Horowitz and the staff at the **New Start Wellness and Weight Loss Center** for your health care needs. This notice is to inform you of our billing requirements and our financial policy. Please be advised that payment is due when services are rendered unless prior arrangements have been made. For your convenience, we accept *Visa, MasterCard, Discover, and Care Credit*.

I _____ agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all costs associated with said collection, including reasonable attorney's fees and necessary court costs.

I have read and understand all of the above and have agreed to these statements.

Patient Signature: _____ Date: _____

PHOTOGRAPH CONSENT

I _____ authorize **New Start Wellness and Weight Loss Center** to take my photograph during the initial consultation and when I reach my weight loss goal. I understand that these photographs are for office use and will be kept in my medical and electronic chart and all times.

Patient Signature:_____ Date:_____

I consent to my pictures being placed on the New Start Wellness Success Board. _____ (initial)

I consent to my pictures being used on the New Start Wellness Website. _____ (initial)

I consent to my pictures being used in any New Start Wellness Email Publications. _____ (initial)

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DISCLOSURE OF FINANCIAL INTEREST

As part of our open communication to our patients and pursuant to Florida Statutes §456.052 (2014), this Disclosure of Financial Interest statement is being provided. Please be advised that should you receive a referral to New Start Wellness and Weight Loss Center, LLC, (10000 West Colonial Drive, Suite 495, Ocoee, FL 34761) that Dr. John D. Horowitz, M.D. has a financial interest in that business.

You are free to receive your wellness and weight loss services from an entity of your choice:

Two other alternatives where Dr. John Horowitz has no financial interest are as follows:

1. Transformation Medical Weight Loss Center
   920 Lee Rd, Orlando, FL 32810 (407) 278-1115

2. Physicians Weight Loss Center
   6735 Conroy Windermere Rd #110, Orlando, FL 32835 (407) 313-0070

Should you have any questions regarding this, please feel free to ask us. We appreciate the opportunity to provide you with open communication regarding your health care.

Patient Signature _____ Date: _____

Staff Signature _____ Date: _____

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Medical Program Diet History and Lifestyle Questionnaire

CONFIDENTIAL

Patient Name: _____ **Date:** _____

NOTE: This form must be completed before you can be enrolled in the **New Start Wellness Program**. Please answer every question. Please print, type or write clearly.

Weight History

Indicate ages during which you were overweight:

☐ Childhood (Age 2-11 yrs) ☐ Adolescence (Ages 12-19 yrs) ☐ Ages 20-29 yrs ☐ Ages 30-40 yrs ☐ Over 40 yrs

Present weight (lbs) _____ Present height (feet, inches) _____

What is your goal weight? _____ When did you last weigh this amount? _____

How much weight do you expect to lose during this program? _____ lbs.

Which weight loss methods have you tried in the past? Please be as specific as possible (e.g. NutriSystem, Jenny Craig, Starvation,

Protein Formula, Medications, Spa, Hypnosis, Weight Watchers, Psychotherapy, Etc.):

_____

_____

Which weight loss method do you consider your most successful? _____

What accounted for that success? _____

Please explain the reasons why you want to take the steps necessary to lose weight: _____

_____

_____

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Patient Name:_____

Diet History

- ☐ ??
- ☐ Current diet is high in fat content
  - Current diet high in fat includes:
    - ☐ fatty meats
    - ☐ high fat snacks
    - ☐ frequent 'fast foods'
    - ☐ fried foods
- Current diet is:
  - ☐ high in fiber
  - ☐ low in fat content
  - ☐ high in cholesterol
  - ☐ high in salt
  - ☐ high in salt from processed foods
  - ☐ high in salt added to food
  - ☐ low in iron
- ☐ Current diet is high in sugar
  - Current diet high in sugar includes:
    - ☐ sweet snacks
    - ☐ sweetened breakfast food
    - ☐ high sugar beverages
- ☐ Inappropriate diet & eating habits
- ☐ Current diet needs:
  - ☐ improvement
  - ☐ reduction of caloric intake
  - ☐ elimination of junk food
- ☐ Food & nutrition-related knowledge deficit
- ☐ Vegetarian Diet Vegan
- ☐ Vegetarian Diet
  - ☐ including eggs
  - ☐ including milk products
  - ☐ including eggs, milk products
  - ☐ including eggs, milk products, chicken
  - ☐ including fish
- ☐ Dietary excesses
- ☐ Dietary excesses snacking
- ☐ Frequent high carbohydrate meals
- ☐ Carbohydrate intake is excessive

Daily water intake _____ oz.

Exercise Habits

- ☐ Exercise habits
- ☐ Exercise regularly
  - ☐ Walking
  - ☐ Biking
  - ☐ Swimming
  - ☐ Aerobics
  - ☐ Other
- ☐ Exercise frequency (times/week)
  - ☐ Daily
  - ☐ Weekly
  - ☐ Biweekly
  - ☐ Other _____
- ☐ Lack of exercise
- ☐ Discomfort with activity
- ☐ Location _____
- ☐ Recent decrease in exercise activity
- ☐ Weight control – serious attempts to lose weight
- ☐ Weight control successful
- ☐ Do you have any special concerns of information we should be aware of:

  _____

  _____

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Patient Name:_____

Medical History Form

- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Reported Treadmill Test
- ☐ Echocardiogram
- ☐ Atrial Fibrillation/Fast Heart Beat
- ☐ High Cholesterol
- ☐ COPD (Chronic Obstructive Pulmonary Disease)
- ☐ Mitral Valve Prolapse
- ☐ Aneurysm
- ☐ Carotid Stenosis
- ☐ TIA (Transischemic Attack)
- ☐ history of Stoke Syndrome
- ☐ history of Hypertension
- ☐ history of Thyroid Disorders
- ☐ Chronic Liver Disease
- ☐ Depression
- ☐ Anxiety Disorder
- ☐ Asthma
- ☐ Diabetes Mellitus
  - ☐ Insulin Dependent
  - ☐ Non-Insulin Dependent
- ☐ Anemia
- ☐ Cancer
  - ☐ Radiation
  - ☐ Chemotherapy
- ☐ Gastric Diverticula
- ☐ Glaucoma
- ☐ Gastric Ulcer
- ☐ Arthritis
- ☐ Gout
- ☐ Blood Clot/DVT
- ☐ Blood Disease/Disorder
- ☐ Past Medical/Surgical History
- ☐ Gastric Surgery

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Patient Name:_____

Social History

☐ Alcohol Use	☐ Tobacco Use
☐ Drug Use	☐ current smoker
☐ Difficulty Understanding English	☐ tobacco non-user
☐ Physical Disability	☐ former smoker
_____	☐ never a smoker

Family History

☐ Cancer	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent Maternal/Paternal
☐ Heart Disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent Maternal/Paternal
☐ Hypertension/High Blood Pressure	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent Maternal/Paternal
☐ Early Deaths	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent Maternal/Paternal
☐ Diabetes	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent Maternal/Paternal
☐ Aneurysm	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent Maternal/Paternal
☐ Blood Clots	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent Maternal/Paternal
☐ CVA - Cerebrovascular Accident/Major Stroke	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent Maternal/Paternal
☐ TIA – Trans Ischemic Attack/Mini Strokes	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent Maternal/Paternal
☐ Other Family History	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent Maternal/Paternal

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