Instructions for New Patient Packet – Weight Loss

1. Print all paperwork *single-sided*.
2. In order to be seen, you **must** completely fill out pages 1 through 7 **and** 12 through 14.
3. You may complete pages 8 through 11 either prior to your appointment or after speaking with the doctor.
4. If you and the doctor choose a regimen which includes *Phentermine*, you will be required to complete pages 8 through 10 before receiving your prescriptions.
5. If you and the doctor choose a regimen which includes *any injections*, you will be required to complete page 11 before receiving your prescriptions.
6. Bring your valid driver's license and all documents to your appointment.

If you have any questions, please call the facility where you have scheduled your appointment. Thank you for choosing Padgett Medical Center as part of your healthy lifestyle.

Ocala, FL 34471 Ph (352) 369-0104 Fx (352) 369-0107
Tampa, FL 33625 Ph (813) 888-7710 Fx (813) 908-7711

First Name:_____ Last Name: _____

Date of Birth: _____ Age: _____ Height _____ Weight _____

Email: _____

Cell # _____ Home # _____ Social Security _____

Mailing Address _____

_____

City _____ State _____ Zip _____

Emergency Contact:_____ Phone #: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed Gender: □ M □ F Children□ No □ Yes, # ____

Do you have insurance? □ No □ Yes, with _____ Please provide a copy of your card.

How were you referred to our clinic? _____

Have you visited our website? □ No □ Yes, Please list suggestions for improvements and/or topics you felt were missing? _____

_____

_____

What goals are you hoping to achieve through Padgett Medical Center? _____

_____

_____

_____

_____

_____

_____

_____

_____

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PERMISSION FOR TREATMENT

I, _____, the undersigned, hereby voluntarily consent to medical care, diagnostic treatment, and/or minor surgical treatment deemed advisable and necessary in the diagnosis and treatment of my condition by any of the doctors and/or employees of Padgett Medical Center, LLC at any of their locations. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

PATIENT SIGNATURE: _____ DATE: _____

ADVANCED DIRECTIVES

All adults in health care settings have the right in the state of Florida to an "advanced directive". This is a written or oral statement, made and witnessed in advance of a serious injury or illness, stating how medical decisions will be made. An advanced directive enables you to state your choice, or name someone to make your choice for you, should you become unable to make decisions about your medical care. A copy of the advance directive law is available upon request.

I have read the above and understand I can receive further information on advance directives, if requested.

PATIENT SIGNATURE: _____ DATE: _____

FINANCIAL POLICY

I authorize payment of medical benefits directly to Padgett Medical Center for professional services provided. I understand that I am financially responsible for all charges for services provided to me by Padgett Medical Center, including all remaining balances.

PATIENT SIGNATURE: _____ DATE: _____

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NOTICE OF PRIVACY PRACTICES

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

SUMMARY:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information
2. The right to request corrections to your information
3. The right to request that your information be restricted
4. The right to confidential communications
5. The right to report a disclosure of your information
6. The right to a paper copy of this form

We want to assure you that your medical/protected health information is secure with us. If you have any questions regarding this form, please contact one of the office staff at Padgett.

I hereby acknowledge that I have read this copy of NOTICE OF PRIVIACY PRACTICES. I understand that if I have a question or complaint regarding my privacy rights, I may contact a member of the staff at Padgett Medical Center. I further understand the practice will offer me updates to the NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way.

PATIENT SIGNATURE: _____ DATE: _____

PATIENT PRIVACY QUESTIONNAIRE

Please list *anyone* whom we may inform of your medical condition and diagnosis (including appointment information, treatment, payment, and health care concerns). If a person's name is not listed, we are legally unable to give out any information *regardless of relationship with the patient*.

NAME: _____ PHONE: _____

ADDRESS: _____ CITY: _____

For release to more persons, please ask for an additional sheet.

_____ I authorize the above named person(s) to receive information having to do with my appointments, medical condition, and diagnosis (including treatment, payment and health care concerns).

_____ I DO NOT authorize the release of my information (my appointments, medical condition, and diagnosis, including treatment, payment and health care concerns) to anyone at this time. I understand if this changes, I will notify Padgett Medical Center, LLC and fill out a new form.

PATIENT SIGNATURE: _____ DATE: _____

_____
PMC Employee Initial

Ocala, FL 34471 Ph (352) 369-0104 Fx (352) 369-0107
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Patient Rights and Responsibilities

Welcome to Padgett Medical Center. Our goal is to provide quality health care to persons in this community. As a patient, you have rights and responsibilities. The clinic also has rights and responsibilities. We want you to understand these rights and responsibilities so you can help us to provide health care for you. Please read this statement and inform us if you have any questions.

Human rights: You have the right to be treated with respect and dignity regardless of race, religion, sex, or national origin.

Payment for services: You are responsible for all payments at time of visit. Please ask an associate if you have any questions.

Privacy: You have the right to have interviews, examinations, and treatment in privacy. Your medical records are also private. Only legally authorized persons will have access to your records.

Health care

- You are responsible for providing us accurate, complete, and current information about your health so that we can provide you proper treatment. You have a right and are encouraged to participate in decisions regarding your treatment.
- You have the right to information and explanations in the language you normally speak and in words you understand. You have a right to information about your health or illness, treatment plan (including risks), and expected outcome, if known. If you do not wish to receive this information, or if it is not medically advisable to share that information with you, we will provide it to legally authorized persons.
- If you are an adult, you have the right to refuse treatment to the extent permitted by law, and to be informed of the risks of refusing. **You are responsible for the outcome of refusing treatment.**
- You have the right to health care and treatment that is reasonable for your condition and within our capacity. You have a right to be transferred or referred to another facility for services that we cannot provide. However, we (Padgett Medical Center) are not financially liable for any additional costs incurred.
- You have a right to the appropriate assessment and management of your weight within the available resources of the clinic.

Clinic rules

- You have the right to receive a copy of your patient information, health services we provide, personal conduct polices, and the use of our property and resources. **You are responsible for obeying these rules.**
- You are responsible for appropriate use of our services, which include following our staff's instructions, and making and keeping scheduled appointments.
- If you do not change your appointment a minimum of 24 hours in advance, you will be charged a $25 fee. This will hold true for every time you change an appointment.
- If you are more than 15 minutes late for your appointment, you will be charged a $25 fee that same day.
- If we have not heard from you by 30 minutes past your scheduled appointment time, you will be considered a no show and lose your slot.
- You are responsible for the supervision of children you bring into the clinic. You are responsible for their safety, as well as the protection of others and our property.
- ***You may not smoke or loiter on the property.*** This includes the entire professional plaza.
- In an effort to be in good standing with our neighbors and the landlord, we ask you refrain from having anyone, family, friend, pets, etc., waiting in a car while you are here. You may bring one (1) additional person inside with you as you wait for your appointment. Please ask anyone else to come back after the appointment is over.
- Inappropriate conduct by the patient or anyone accompanying the patient **will not be tolerated.** Profanity, disorderly conduct, threats of violence, or acts of violence will result in the discharge of the patient from our facility. You, as the patient, are responsible for the actions of your guests.
- Please bring everything requested by the doctor and staff to your appointment. Failure to have any paperwork requested may result in a delay of your seeing the doctor and/or receiving your prescriptions.
- Presenting a forged document (prescription history, MRI, EKG, etc.) or altering a prescription written by the physician will result in discharge from the practice.
- Proper dress code is required. Please refrain from wearing tank tops, sleeveless shirts, or clothing with profanity. Casual dress is requested.

Hours of operation:

- Monday through Friday 9am – 5pm, except on major holidays.
- For after-hours emergencies, please go to the nearest emergency room.
- We do not accept walk-in patients. To schedule an appointment, please call that specific facility.
  Ocala – (352) 369-0104 Tampa – (813) 888-7710

Medical records

- Any request for copies of medical records takes 24 hours minimum. There is a charge for copies of your record ($1 per page for the first 25 pages, $0.25 per page for pages 26 and after). Please ask a staff member for a page count prior to requesting the full record be copied.
- Any request for billing statements take a minimum of one (1) week. The doctor has to review any statement before it is sent out. Please allow appropriate time when asking for this service. If records need to be sent with the statement, see above.

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HIPAA (Health Insurance Portability and Accountability Act) Information Release & Disclosure Notice

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

Purpose: Padgett Medical Center, LLC and its faculty, employees, and non-employees follow the privacy practices described in this Notice. Padgett Medical Center maintains your health information in records that are kept in confidential manner, as required by law. Padgett Medical Center must use and disclose or share your health information as necessary for treatment, payment, and health care operations to provide you with quality health care.

Use and Release of Your Health Information for Treatment, Payment, and Health Care Operations: Padgett Medical Center has to use and release some of your health information to conduct its business. We are permitted to use and release health information without authorization from you. Treatment includes sharing information among health care providers involved in your care. For example, your health care provider may share information about your condition with radiologists or other consultants to make a diagnosis. Padgett Medical Center may use your health information as required by your insurer to determine eligibility or to obtain payment for your treatment. In addition, Padgett Medical Center may use and disclose your health information to improve the quality of care, and for education and training purposes of Padgett Medical Center residents, and faculty.

How will Padgett Medical Center Use and Disclose My Health Information? Your health information may be used for the following purposes unless you ask for restrictions on a specific use or disclosure. *Note:* You have the opportunity to refuse some of these communications about your health information. The optional items are indicated by (*). Please let a staff member know if you wish to refuse any or all of the optional communications.

- (*) Padgett Medical Center directories, which may include your name, general condition, and your location in Padgett Medical Center.
- (*) Family members or close friends involved in your care or payment for treatment.
- (*) Disaster relief agency if you are involved in your care or payment for treatment.
- (*) To inform you of treatment alternatives or benefits or services related to your health.
- Appointment reminders.
- Public health activities, including disease prevention, injury or disability; reporting births and deaths; reporting reactions to medications or product problems; notification of recalls; infectious disease control; notifying government authorities of suspected abuse, neglect, or domestic violence.
- Health oversight activities, such as audits, inspections, investigations, and licensure.
- Law enforcement, as required by federal, state, or local law.
- Lawsuit and disputes, in response to a court or administrative order, subpoena, discovery request or other lawful request.
- Coroners, medical examiners, and funeral directors.
- To prevent a serious threat to health or safety.
- To military command authorities if you are a member of the armed forces or a member of a foreign military authority.
- National security and intelligence activities to authorized persons to conduct special investigations.
- Workers' Compensation. Your medical information regarding benefits for work-related injuries and illnesses may be released as appropriate.
- To carry out health care treatment, payment, and operations functions through business associates, such as to install a new computer system.

Your Authorization Is Required for Other Disclosures.

Except as described above, we will not use or disclose your medical information, unless you allow Padgett Medical Center in writing to do so. You may withdraw or revoke your permission, which will be effective only after the date of your written withdrawal.

Alcohol and drug abuse information has special privacy protections. Padgett Medical Center will not disclose any information identifying an individual as being a patient or provide any health information relating to the patient's substance abuse treatment unless the patient authorizes in writing; to carry out treatment, payment, and operations; or, as required by law.

You Have Rights regarding Your Health Information: You have following rights regarding your medical information, if requested on the form(s) provided by Padgett Medical Center:

- **Right to request restriction.** You may request limitations on your health information that we use or disclose for health care treatment, payment, or operations, although we are not required to comply with your request. For example, you may ask us not to disclose that you have had a particular procedure. We will release the information if necessary for emergency treatment. We will notify you in writing whether we honor your request or not.
- **Right to confidential communications.** You may request communications of your health information in a certain way or at a certain location, but you must tell us how or where you wish to be contacted.
- **Right to accounting of disclosures.** You must request a list of the disclosures of your health information that have been made to persons or entities for disclosures unrelated to health care treatment, payment, or operations within the past six (6) years for paper health records, and for electronic health records you may request three (3) years, including disclosures for treatment, payment, or operations. After the first request, there may be a charge.

- **Right to a Copy of This Notice.** You may request a paper copy of this Notice at any time, even if you have been provided with an electronic copy. You may obtain an electronic copy of this Notice in our office.

Requirements Regarding This Notice: Padgett Medical Center is required by law to provide you with this Notice. We will comply with this Notice for as long as it is in effect. Padgett Medical Center may change this Notice and these changes will be effective for health information we have about you as well as any information we receive in the future. Each time you register at Padgett Medical Center for health services, you may receive a copy of the Notice in effect at that time.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with: Office of Civil Rights, U.S. Dept. of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201

Contact Padgett Medical Center at (352) 369-0104 or (813) 888-7710 if:

- You have any questions about this Notice;
- You wish to request restrictions on uses and disclosures for health care treatment, payment, or operations; or

You wish to obtain a form to exercise your individual rights.

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Tampa, FL 33625 Ph (813) 888-7710 Fx (813) 908-7711

HIPAA INFORMATION RELEASE & DISCLOSURE NOTICE CONSENT

I acknowledge that I have **read, received,** and **understand** this HIPAA notice and may request a copy at any time.

PATIENT SIGNATURE: _____ DATE: _____

PATIENT RIGHTS & RESPONSIBILITIES ACKNOWLEDGEMENT

I acknowledge that I have read and received a copy of the **Patient Rights and Responsibilities**. I agree to follow and obey the rules and regulations set forth by Padgett Medical Center, LLC.

PATIENT SIGNATURE: _____ DATE: _____

_____
PMC Employee Initial

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PHENTERMINE INFORMED CONSENT

Instructions: Initial each of the following statements to show you understand and agree with them.

_____ I request the use of Phentermine, along with strict dietary restrictions for the purpose of weight loss. I understand that as part of the program, I will be given a limited physical, orientation to the program with supporting materials and I will be instructed on how to administer Phentermine myself. I understand that initial blood tests may be necessary to rule out any conditions that would disqualify me from the program. I will obtain these from my own physician or have them ordered through Padgett Medical for an additional fee.

_____ I understand there is no guarantee for the effectiveness of Phentermine. I agree that I am and will be under the care of another medical provider for all other conditions. Our doctor at Padgett Medical Center can work in conjunction with, but cannot replace, my regular primary care physicians, such as general practitioners or other specialists in family medicine or internal medicine. I understand our doctor at Padgett Medical Center can only prescribe Phentermine and medication necessary for this treatment and all other health matters should be through my regular physician(s).

_____Prior to my treatment, I have fully disclosed any medical conditions or diseases such as history of gallbladder disease, diabetes, autoimmune diseases, HIV, heart disease, liver disease, kidney disease, uncontrolled high blood pressure, seizure disorders, blood disorder (anemia, thalassemia, hemophilia, etc.) emphysema or asthma, and any history of stroke or cancer. These contraindications have been fully discussed with me. Further contraindications are outlined below. If I fail to disclose any medical condition that I have, I release the doctor and facility from any liability associated with this procedure.

_____I understand that it is my responsibility to inform our doctor at Padgett Medical Center if I am pregnant, if I am trying to become pregnant or if I become pregnant during the course of these treatments. I agree to immediately report any problems that might occur to my medical provider during the treatment program. I further understand that not complying with the dosage recommendations and dietary restrictions could increase risks and alter my results from the program. If I do not follow these recommendations and restrictions, I agree to release the doctor and facility from any liability arising as a result of this. I understand that I may quit the program at any time. While adverse side effects or complications are not expected, in the event that an illness does occur, I understand that if I experience an emergency situation, I understand that I need to go to an emergency facility right away. I understand I also need to contact Padgett Medical Center to inform them of the situation.

_____I understand Phentermine treatments may involve these risks and other unknown risks.

_____I understand that use of Phentermine is absolutely contraindicated during pregnancy and breastfeeding.

_____I understand that if there are any changes in my medical history or there are any changes in my medications or any other changes relevant to this procedure, I will advise our doctor at Padgett Medical Center at that time.

_____I agree for my before and after photos to be used in advertising, social media, or other networks; and my face will not be shown, only body pictures will be used.

_____I understand that complete patient confidentiality will be maintained at all times.

Contraindications

_____Patients with the following should not use Phentermine: Check the box next to all that apply to you)

- History of cardiovascular disease (e.g., coronary artery disease, stroke, arrhythmias, congestive heart failure, uncontrolled hypertension)
- During or within 14 days following the administration of monoamine oxidase inhibitors
- Hyperthyroidism
- Glaucoma
- Agitated states
- History of drug abuse
- Pregnancy
- Nursing
- Known hypersensitivity, or idiosyncrasy to the sympathomimetic amines

Warnings/Precautions

_____Patients taking Phentermine should be aware of the following risks. If any of the following occur, discontinue use and contact your doctor immediately.

- Coadministration with other drugs for weight loss is not recommended (safety and efficacy of combination not established).
- Rare cases of primary pulmonary hypertension have been reported. Phentermine should be discontinued in case of new, unexplained symptoms of dyspnea, angina pectoris, syncope or lower extremity edema.
- Rare cases of serious regurgitant cardiac valvular disease have been reported.
- Tolerance to the anorectic effect usually develops within a few weeks. If this occurs, phentermine should be discontinued. The recommended dose should not be exceeded.

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PHENTERMINE INFORMED CONSENT CONT.

Instructions: Initial each of the following statements to show you understand and agree with them.

- Phentermine may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle.
- Risk of abuse and dependence. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage.
- Concomitant alcohol use may result in an adverse drug reaction.
- Use caution in patients with even mild hypertension (risk of increase in blood pressure).
- A reduction in dose of insulin or oral hypoglycemic medication may be required in some patients.

_____ Patients taking insulin may need an alteration in their current dosage. Please check with your current doctor.

Adverse Reactions

_____ The following adverse reactions are described, or described in greater detail, in other sections:

- Primary pulmonary hypertension
- Valvular heart disease
- Effect on the ability to engage in potentially hazardous tasks
- Withdrawal effects following prolonged high dosage administration

_____ The following adverse reactions to phentermine have been identified:

- Cardiovascular: Primary pulmonary hypertension and/or regurgitant cardiac valvular disease, palpitation, tachycardia, elevation of blood pressure, ischemic events
- Central Nervous System: Overstimulation, restlessness, dizziness, insomnia, euphoria, dysphoria, tremor, headache, psychosis
- Gastrointestinal: Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances
- Allergic: Urticaria
- Endocrine: Impotence, changes in libido

Drug Interactions

_____ The following interactions with phentermine have been identified:

- Monoamine Oxidase Inhibitors: Use of phentermine is contraindicated during or within 14 days following the administration of monoamine oxidase inhibitors because of the risk of hypertensive crisis.
- Alcohol: Concomitant use of alcohol with phentermine may result in an adverse drug reaction.
- Insulin and Oral Hypoglycemic Medications: Requirements may be altered.
- Adrenergic Neuron Blocking Drugs: Phentermine may decrease the hypotensive effect of adrenergic neuron blocking drugs.

Interactions

_____ Patients may be at risk for a hypertensive crisis, if taking Phentermine while on an MAOI.

_____ Taking phentermine is not recommended for those currently taking: **Check all that apply to you**.

- ☐ Concomitant weight loss drugs, including SSRIs
- ☐ Fluoxetine
- ☐ Sertraline
- ☐ Fluvoxamine
- ☐ Paroxetine

_____ Patients with the following should take special precautions and consult their doctor before using Phentermine: **Check all that apply to you**

- ☐ Allergies to medicines, foods, or other substances
- ☐ Have a brain or spinal cord disorder
- ☐ Hardening of the arteries
- ☐ High blood pressure
- ☐ Diabetes
- ☐ High cholesterol or lipid level

_____ Phentermine may decrease hypotensive effect of guanethidine.

By signing below, I agree I have read and fully understand the above terms. All my questions have been addressed to my satisfaction. I agree to release the doctor and the facility from any liability associated with this procedure. In the event a dispute arises over the outcome of the procedure, I consent solely to arbitration as a legal means of settlement.

Patient Name (Please Print)	Physician Name
Patient Signature	Physician Signature
Date	Date

PMC Employee Initial

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INFORMED CONSENT FOR INJECTIONS

This document is intended to serve as confirmation of informed consent for injections ordered by the physician at Padgett Medical Center.

Instructions: Initial each of the following statements to show you understand and agree with them:

_____I have informed the physician of any known allergies to drugs or other substances, or of any past reactions to any medications or other substances.

_____I have informed the doctor of all current medications and supplements I am taking at this time.

_____I understand that I have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits, except in any emergency situation.

_____I understand:

1. the procedure involves inserting a needle into various areas of the body and injecting the medication prescribed to me by the physician at Padgett Medical Center.

2. the risks of injection therapies include but are not limited to:

- Occasional discomfort, bruising, and inflammation at the site of the injection.
- Dizziness or light-head feeling after the injections.
- Fainting or loss of consciousness during the procedure.
- Allergic reaction to the medication being administered.

_____I am aware that other unforeseeable complications could occur. I do not expect the physician to anticipate and or explain all risk and possible complications. I rely on the physician to exercise judgment during the course of treatment with regards to any procedures.

_____I understand the risks and benefits of the procedures and have had the opportunity to have all of my questions answered.

_____I understand that I have the right to consent to or refuse any proposed treatment at any time prior to its performance.

My signature on this form affirms that I have given my consent to injection therapy with any different or further procedures which, in the opinion of my physician, may be indicated or beneficial to me. My signature below confirms that:

1. I understand the information provided on this form and agree to the foregoing.

2. The procedure(s) set forth above has been adequately explained to me by my physician.

3. I have received all the information and explanation I desire concerning the procedure.

4. I authorize and consent to the performance of the injections/ procedure(s).

_____	_____
Patient Name Please Print	Physician Name
_____	_____
Patient Signature	Physician Signature
_____	_____
Date	Date

_____
PMC Employee Initial

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Patient Name _____ Date of Birth _____

Medical and Family History

Please mark an X in the Yes or No categories for the behaviors that apply to you.

Yes No

( ) ( ) Do you smoke Cigarettes/Cigars/Chew tobacco? If yes, how much per day _____
( ) ( ) Do you drink Alcohol? Frequency: ( ) Daily ( ) Weekly ( ) Occasionally ( ) Rare
( ) ( ) Do you consume caffeine or energy drinks? Frequency: ( ) Daily ( ) Weekly ( ) Occasionally ( ) Rare
( ) ( ) Do you drink Water? Glasses per day____

Please circle on the scale from 1 to 10 the stress level of your occupation.

1 2 3 4 5 6 7 8 9 10
Laid Back Stressed

Please list all operations and surgical procedures, including plastic surgery:

_____

_____

_____

Serious injuries, accidents or serious illness:

_____

_____

_____

List allergies to medications, foods, latex ***and your body's reaction to those substances***:

_____

_____

_____

_____

Please List ***all*** of your current medications. Include prescribed, non-prescribed, supplements, over the counter, and hormones: _____

_____

_____

_____

Are you currently taking COUMADIN? ☐ YES ☐ NO

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Patient Name _____ Date of Birth _____

Medical and Family History Continued

Please check the answer that applies to each question.

Females Only

	Yes	No		Yes	No
Breast Tenderness			Endometriosis		
Inability to reach orgasm			Infertility		
Lack of Sexual Desire			Menstrual Problem		
Night Sweats/Hot Flashes			Premenstrual Tension		
Vaginal Dryness			Wake up periodically in the middle of the night		

Males Only

	Yes	No		Yes	No		Yes	No
Erectile Dysfunction			Impotence			Inability to Ejaculate		
Lack of Sexual Desire			Other Testicular Problems			Prostate Problems		
Vasectomy								

Everyone

	N/A	Self	Sibling	Parents		Always	Sometimes	Never
Alcohol Abuse					Anger Aggression			
Anemia					Binge Eating			
Arthritis					Body/Joint Aches			
Asthma					Caffeine/Stimulant Cravings			
Auto-Immune Diseases					Compulsive/Emotional Eating			
Bipolar Disorder					Concentration Problems			
Breast Cancer					Decrease in Athletic Performance			
Cancer, Other:					Decrease in Strength/Stamina			
Congestive Heart Failure					Decrease Productivity			
COPD					Decreased Lean Muscle Mass			
Diabetes					Decreased Motivation			
Drug Abuse					Digestive Problems			
Elevated Cholesterol/Triglycerides					Dry Skin/Thinning Skin			
Endocrine Abnormalities					Glaucoma			
Endometriosis					Hair Loss			
Fibroids					Increased Fat on Stomach			
Gout					Increased Fatigue			
Heart Disease					Irritability/Anxiety			
High Blood Pressure/Hypertension					Low Mood Depression			
History of Blood Clots					Lowered Libido			
Kidney Disease					Memory/Foggy Thinking			
Liver Disease					Skip Meals			
Lung Disease					Sweet Cravings			
Polycystic Ovary Syndrome					Weight Gain			
Recreational Drug Use					Weight Loss			
Seizure Disorder								
Thyroid Disease								
Weight Control Problems								

Comments/anything important the doctor should know: _____

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Patient Name _____ Date of Birth _____

Current Physicians

In order to ensure proper care, the doctor(s) at Padgett Medical Center may have need to consult with other physicians currently treating you. Please fill out the following information about your current doctors. If you need additional space, see the receptionist for more paper.

_____ I understand that by filling out the following information, I am agreeing to allow Padgett Medical Center to discuss my treatment with the doctors/facilities listed below.

_____ I understand that this list does not preclude Padgett Medical Center from requesting records from doctors/facilities not listed below, in the future.

_____ I understand that it is my responsibility to inform Padgett Medical Center if I begin care under a new doctor/facility.

_____ I understand that it is my responsibility to inform Padgett Medical Center anytime I visit a quick care, urgent care, emergency room, or hospital.

Doctor	Type/Specialty	City, State	Phone Number	Date of Last Visit

_____ _____ ____/____/____
Patient Name (printed) Patient Signature Date

_____ I am choosing to not provide the information about my other doctors to Padgett Medical Center. I understand that this may delay my treatment. I also understand this choice may be over ridden if I choose to fill out a HIPAA release requesting information from a medical facility at a later date.

_____ _____ ____/____/____
Patient Name (printed) Patient Signature Date