Atlas Mens Health Institute

Dr. Dana Trippi **Dr. Erik Evensen**

Patient Name: (Last)_____(First)_____(MI)___

Name you prefer to be called: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Cellular: _____

E-mail Address:_____

Birthdate: _____Age: _____Sex: M F

(Please indicate with an * the telephone number you prefer to be contacted)

Employment Information:

Patient Employer: _____ Occupation: _____

Work phone No: _____Ext. _____

Social Security: _____Drivers License: _____

In Case of Emergency:

Name: _____Relationship: _____ Phone: _____

Patient's Spouse: _____ Phone: _____

Family Physician: _____ Phone: _____

Referred by: _____

Financial Policy:

Thank you for selecting ***Atlas Mens Health Institute*** for your health care needs. We are honored to be of service to you and your family. Please be advised that the **non-refundable** payment of $199.00 will be due at the time of the initial assessment (includes EKG, body composition, labs and initial physician consultation). Follow-up visits are $65.00, and any medications and injections are additional. Since weight-loss is generally not a covered benefit of most insurance, we do not accept insurance at this time. Patients have the option to submit paid in full receipts to their insurance company for reimbursement, but this is the sole responsibility of the patient. For your convenience, we accept all major credit cards, debit cards and cash. Physician paperwork including chart reviews are $75.00. Copies of medical records are $.65 per page. A $25.00 fee will apply to all cancelled appointments without a 24-hour business day notice, and a $65.00 fee for a no-show.

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

_____ _____

Patient's Signature Date

MEDICAL HISTORY

Please list the following:

Primary Care Physician:_____ Phone#_____

Cardiologist:_____ Phone#_____

Endocrinologist:_____ Phone#_____

Pulmonary:_____ Phone#_____

OB/GYN:_____ Phone#_____

- ☐ Asthma
- ☐ Cushing's Disease
- ☐ Diabetes II
- ☐ Heart Burn/Acid Reflux
- ☐ High Cholesterol
- ☐ Blood Clots
- ☐ High Blood Pressure
- ☐ Hypothyroidism
- ☐ Incontinence
- ☐ Infertility
- ☐ Insomnia
- ☐ Metabolic Syndrome
- ☐ Fatty Liver
- ☐ Arthritis/Disorder of Knees
- ☐ Arthritis/Disorder of Hips
- ☐ Arthritis/Disorder of Shoulders
- ☐ Arthritis/Disorder of Back
- ☐ Polycystic Ovaries
- ☐ Podiatric (Foot) Disorder
- ☐ Sleep Apnea
- ☐ Congestive Heart Failure
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Coronary Artery Disease
- ☐ Stroke
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ Irritable Bowel Syndrome
- ☐ Leukemia
- ☐ Heart Attack
- ☐ Ovarian Cancer
- ☐ Prostate Cancer
- ☐ Seizure Disorder
- ☐ Substance Addiction
- ☐ Uterine Cancer
- ☐ Valvular Heart Disease

Other Conditions Not Listed:_____

Please place a check mark in the box of the medical problems that you have been diagnosed with. Also, please fill in the bottom to add any other medical conditions that you have which are not listed.

Medical Problems That Run In Your Family:_____

Medications

Please place a check mark in the box of any medications that you are currently taking. Also, please complete the right portion so that we know any additional medications and your dose and time schedule.

Current Medications:

- ☐ Abilify
- ☐ Actos/Pioglitazone
- ☐ Avandia/Rosiglitazone
- ☐ Benadryl/diphenhydramine
- ☐ Birth Control Pills
- ☐ Cardura/Doxazosin
- ☐ Claritin/Loratidine
- ☐ Decadron
- ☐ Depakote/Valproic Acid
- ☐ Elavil/Amitryptilline
- ☐ Estrogen Replacement
- ☐ Haldol/Haloperidol
- ☐ Hytrin/Terazosin
- ☐ Inderal/Propanalol
- ☐ Insulin
- ☐ Lopressor/Toprol XL
- ☐ Lyrica
- ☐ Minipres/Prazosin
- ☐ Neurontin/Gabapentin
- ☐ Pamelor/Nortrypilline
- ☐ Prednisone
- ☐ Remeron/Mirtazapine
- ☐ Risperidal/Risperidone
- ☐ Steroid/Cortisone Injections
- ☐ Tegretol/Carbatrol
- ☐ Tenormin/Atenelol
- ☐ Zyprexa/Olanzapine
- ☐ OTC
- ☐ Naturopathic/Homeopathic Meds

Additional Medications/Dosages:

_____

_____

_____

_____

_____

_____

Allergies To Medications

Medications	Reactions
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY

Please fill in the following information

Are you currently smoking?	Yes ☐	No ☐
Do you have a history of smoking?	Yes ☐	No ☐
Do you drink alcohol?	Yes ☐	No ☐
If so, do you have a history of heavy drinking?	Yes ☐	No ☐

How much do you /did you drink? _____

Do you do street drugs?	Yes ☐	No ☐
Do you have a history of street drug use?	Yes ☐	No ☐

If so, what kind? _____

Who do you consider your support system? _____

REVIEW OF SYMPTOMS

Please check the box if you experience the symptom

- ☐ Fatigue
- ☐ Difficulty Sleeping
- ☐ Excessive Appetite
- ☐ Excessive Thirst
- ☐ Acne
- ☐ Excessive Hair
- ☐ Rash
- ☐ Edema
- ☐ Hair
- ☐ Double Vision
- ☐ Dizziness
- ☐ Headache
- ☐ Ringing in Ears
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Chest Pains
- ☐ Palpitations
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Low Back Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Excessive Urinating
- ☐ Loss of Urine Control

SURGICAL HISTORY

Please place a check mark in the box of any surgeries that you have had. Also, please include any additional surgeries not listed.

- ☐ Back Surgery
- ☐ Cholecystectomy
- ☐ C-Section
- ☐ Gastric Bypass
- ☐ Duodenal Switch
- ☐ Lap Band
- ☐ Hernia Repair
- ☐ Hip Surgery
- ☐ Hysterectomy
- ☐ Knee Surgery
- ☐ Plastic Surgery(please list)_____
- ☐ Shoulder Surgery
- ☐ Tonsils and Adenoids

ADDITIONAL SURGERIES

_____
_____
_____
_____
_____
_____

PSYCHIATRIC HISTORY

Please place a check mark in the box of any psychiatric diagnosis that you may have experienced or have been diagnosed with currently or in the past. Also, please complete the right portion so that we know any additional diagnoses you may have had.

- ☐ Bulimia Nervosa
- ☐ Anorexia Nervosa
- ☐ Binge Eating Disorder
- ☐ Laxative Abuse
- ☐ Other Eating Disorder
- ☐ Depression
- ☐ Anxiety
- ☐ Obsessive Compulsive Disorder
- ☐ Bipolar Disease
- ☐ Schizophrenia

ADDITIONAL PSYCHIATRIC HISTORY

_____
_____
_____
_____

Do you think of suicide? Yes ☐ No ☐
Have you ever attempted suicide Yes ☐ No ☐
Have you seen a psychologist or therapist currently or in the past? Yes ☐ No ☐
If so, when and what for:_____

_____

How much time do you spend each day thinking about food, shape and weight?_____

WEIGHT HISTORY

This Was My Weight During That Period In My Life

	Underweight	*Healthy*	*Overweight*	*Obese*	*Morbidly Obese*
0-12	☐		☐	☐	☐
13-18	☐		☐	☐	☐

19-25_____lbs

26-30_____lbs

31-35_____lbs

36-40_____lbs

41-45_____lbs

46-50_____lbs

51-60_____lbs

61-70_____lbs

71-80_____lbs

Recent Changes in Weight

Past 1 Month_____lbs

Past 6 Months_____lbs

Past 1 Year_____lbs

My Lowest Adult Weight_____lbs

My Highest Adult Weight_____lbs

My Ideal/Goal Weight_____lbs

These Were The Events Associated With My Weight Gain

☐	Childhood	☐	Major Illness	☐	Older Age
☐	Children	☐	Marriage	☐	Pregnancy
☐	College	☐	Menopause	☐	Puberty
☐	Divorce	☐	New Career	☐	Job Loss
☐	New Job	☐			

Other_____

The *Top Three* Reasons I Feel Have Caused My Weight Problem

☐	Age	☐	Genetics	☐	Not Enough Time
☐	Eat too Much	☐	Inactivity	☐	Poor Food Choices
☐	Emotional Eating	☐	Injury/Medical Illness	☐	Pregnancy
☐	Fast Food	☐	Medication	☐	Slow Metabolism
☐	Other_____				

The Top Three Reasons I Am Motivated To Lose Weight

☐	Avoid Discrimination	☐	Improve Medical Illness	☐	Look Better
☐	Be More Active	☐	Improve Pain	☐	Positive Role Model
☐	Improve Comfort	☐	Improve Sex Life	☐	Work Performance
☐	Improve Marriage	☐	Increase Energy		
☐	Other_____				

Diet History

Please describe a typical:

Breakfast	Lunch	Dinner
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe your snack habits:
What_____ **When**_____ **Where**_____

How often do you eat out?_____

What restaurants do you frequent?_____

How often do you eat fast food?_____

Who plans your meals?_____

Do you use a shopping list?_____

What time of day and what day/days do you shop for food?_____

Foods that you like:_____

Foods you dislike:_____

Foods that you crave:_____

Food Allergies:_____

I Engage In The Following Habits

	Always	Often	Rarely	Never
Breakfast Skipping	☐	☐	☐	☐
Drink Juices/Soda	☐	☐	☐	☐
Night Eating	☐	☐	☐	☐
Emotional Eating	☐	☐	☐	☐
Add Sugar Substitute	☐	☐	☐	☐
Crave foods during during specific times of month	☐	☐	☐	☐

Food(s) I Eat That I Feel The Guiltiest About

ACTIVITY HISTORY

The Most Active Time In My Life Was:

The Activities That I Enjoy Most Are:

The Biggest Barrier To Me Being Active Is:

My Activity Level Is Best Described As:

- ☐ Much More Than Average
- ☐ More Than Average
- ☐ Average
- ☐ Less Than Average
- ☐ Much Less Than Average

WEIGHT LOSS ATTEMPT HISTORY

Please fill in the following information

Diets

- ☐ American Heart Diet _____ lbs lost
- ☐ Atkins _____ lbs lost
- ☐ Blood Type _____ lbs lost
- ☐ Cabbage Soup _____ lbs lost
- ☐ Deal-A-Meal _____ lbs lost
- ☐ Diet for Dummies _____ lbs lost
- ☐ Duke Diet _____ lbs lost
- ☐ Isagenix _____ lbs lost
- ☐ Jenny Craig _____ lbs lost
- ☐ Low Fat _____ lbs lost
- ☐ Master Cleanser _____ lbs lost
- ☐ Nutrisystem _____ lbs lost
- ☐ Opti/MediFast _____ lbs lost
- ☐ Ornish _____ lbs lost
- ☐ Protein Power _____ lbs lost
- ☐ SlimFast _____ lbs lost
- ☐ South Beach _____ lbs lost
- ☐ Sugar Busters _____ lbs lost
- ☐ Suzanne Somers _____ lbs lost
- ☐ You On A Diet _____ lbs lost
- ☐ Zone _____ lbs lost
- ☐ Other _____ _____ lbs lost

Medications

- ☐ Wellbutrin _____ lbs lost
- ☐ Topirimate/Topamax _____ lbs lost
- ☐ Tenuate _____ lbs lost
- ☐ Orlistat/Xenical/Alli _____ lbs lost
- ☐ Bontril/Phendimetrazine _____ lbs lost
- ☐ Phen-Fen _____ lbs lost
- ☐ Phentermine _____ lbs lost
- ☐ Other _____ _____ lbs lost

Exercise

- ☐ Gym Membership _____ lbs lost
- ☐ Home Equipment _____ lbs lost
- ☐ Other Cardio _____ lbs lost
- ☐ Running _____ lbs lost
- ☐ Walking _____ lbs lost
- ☐ Weights _____ lbs lost
- ☐ Yoga _____ lbs lost
- ☐ Other _____ _____ lbs lost

Programs

- ☐ Bridges _____ lbs lost
- ☐ Deal-A-Mea _____ lbs lost
- ☐ Duke Center _____ lbs lost
- ☐ Inpatient Medical _____ lbs lost
- ☐ LA Weight Loss _____ lbs lost
- ☐ LEARN Program _____ lbs lost
- ☐ Outpatient Medical _____ lbs lost
- ☐ Weight Watchers _____ lbs lost
- ☐ Other _____ _____ lbs lost

Supplements

- ☐ Chromium _____ lbs lost
- ☐ Dexatrim _____ lbs lost
- ☐ Hoodia _____ lbs lost
- ☐ Laxativews _____ lbs lost
- ☐ L-Carnitine _____ lbs lost
- ☐ Lipotropics _____ lbs lost
- ☐ Metabo-Life _____ lbs lost
- ☐ Slim-Quick _____ lbs lost
- ☐ Trim-Spa _____ lbs lost
- ☐ Vit B12 _____ lbs lost
- ☐ Other _____ _____ lbs lost

Atlas Mens Health Institute

PATIENT INFORMED CONSENT

Please Initial The Following Paragraphs:

_____I hereby authorize Dr. Dana Trippi and/or Dr. Erik Evensen to assist me in my weight reduction efforts. I understand my treatment may involve, but is not limited to the use of appetite suppressants for more than 12 weeks and when indicated, in higher doses than the dose indicated in the appetite suppressant labeling. I understand that the medication will only be prescribed when the expected benefits are felt to be greater than the risks. I also understand that regular medical visits will be necessary while on the medications and that theses medications must be used with caution and under direct supervision of the provider.

_____**I have read and understand the following physician statement:** "Medications including the appetite suppressants have labeling that has been agreed upon by the maker of the medication and the Food and Drug Administration. This labeling contains, among other things suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter-term studies (up to 12 weeks) using the dosage indicated in the labeling. As a medical provider, I have found the appetite suppressant helpful occasionally for periods in excess of 12 weeks and at times in larger doses than suggested by the labeling. As a provider, I am **NOT** required to use medications as the labeling suggests, but I am required to use labeling as a source of information, along with my own clinical experience, the experience of my colleagues, recent longer term studies, and recommendations of university based investigators. Based on this, I may choose when indicated to use the appetite suppressants for longer periods of time, and at times, in increased doses, albeit very rarely. Such usage has not been as systematically studied as the usage suggested in the labeling, and it is possible, as with most other medications that there could be serious side effects as noted below. As a provider, I need to weigh the risks and benefits of the appetite suppressant use with the risk of remaining overweight."

_____**Risk of proposed treatment:** I understand this authorization is given with the knowledge that the use of appetite suppressants involves some risk and some hazards. Most appetite suppressants should be used with extreme caution by people who suffer
from glaucoma, alcoholism, psychotic illnesses, uncontrolled high blood pressure, advanced arteriosclerosis, thyroid overactivity, people who are on certain other medications, i.e. monoamine oxidase inhibitors (MAOIs), certain serotonin type migraine medications, antimanic agents (lithium), some over the counter decongestants, and any other over the counter or prescription form anorectic agents. The more common side effects of appetite suppressants include, but are not limited to nervousness, diarrhea or constipation, sleeplessness, headache, dry mouth, dizziness, temporary memory loss, weakness, allergic reactions, psychological imbalances, high blood pressure, palpitations and heartbeat irregularities, and gallstones. Although only seen in rare cases, pulmonary hypertension or heart valve disease may develop. These conditions are serious and can be fatal. More studies are currently being done to document this further. I am willing to undergo studies as indicated

by my weight loss physician if necessary for the purpose of ruling out underlying disease that may be a contraindication to the use of appetite suppressant.

_____**Patient responsibility:** As the patient, I understand it is my responsibility to follow instructions carefully and to report to the doctor treating me for my weight, any significant medical problems that I think may be related to my weight control program as soon as reasonably possible. I agree to notify my weight loss provider of any medical problems that I may have, that they are not aware of, or any results of labs/tests, ordered and reviewed by any other physician. I further acknowledge that I enter into this program in full knowledge and understanding that no physician, provider or staff of the weight loss physician has prior knowledge as to whether I would or would not have adverse effects due to the fact that each individual has a different biological and chemical make-up. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance. I understand that a balanced calorie counting program without the use of appetite suppressants may likely prove successful if followed, even though I would be hungrier than without the suppressant. I also understand that there are also risks of remaining overweight or obese. I understand that abrupt discontinuation of the appetite suppressant may result in lethargy or depression.

I understand that during the program, medications will be discontinued if:

1) I become pregnant, try to become pregnant, or suspect I am pregnant
2) I develop a contraindication or serious side effect of the medication
3) I do not comply with medical requirements, i.e. visits, med doses, etc.
4) I fail to lose and/or maintain weight appropriately
5) I use another medication that is not compatible
6) I have a planned surgery. Meds are to be stopped at least 2 weeks prior

I understand that occasionally other medications such as antidepressants, diabetic medications, diuretics, and anti-seizure medications are used for the purpose of aiding weight loss. I understand that these are considered off label use for weight loss, but can at times be of significant benefit. I understand that all medications carry a risk of side effects and that I need to weight the risk and benefits of all medications before use.

_____**No guarantee:** I understand that much of the success of the program will depend on my effort, and that there is no guarantee that the program will be successful. I understand that I will have to continue with sensible and nutritional eating habits and regular exercise all my life if I am to be successful long term.

_____**Patient consent/waiver:** I have read and fully understand this document and authorize and accept the proposed care regardless of risk. I affirm that my questions have been satisfactorily answered at this time. I realize that I should not sign this form if all items are not understood by me or if questions have not been answered to my satisfaction. I hereby release all providers and any and all employees from any liability associated and connected with my participation in this

weight loss program. I accept the risks as discussed above, in hopes of obtaining desired beneficial results of weight loss treatment.

_____**Labs/EKG:** I understand that it is my sole responsibility to follow up on pending labs and/or EKG results if I chose not to continue with this weight loss program prior to evaluation and interpretation of the labs and/or EKG results. I understand that any pending labs and/or EKG may reflect abnormalities which would need follow through with a primary care physician. I understand it is my responsibility to give Atlas Mens Health Institure the name of a primary care physician where labs and/or EKG can be sent for follow through and interpretation.

Patient signature:_____ **Date:**_____

Witness Signature:_____ **Date:**_____

Provider Declaration: I have explained the contents of this document to the patient and have answered all the patient's related questions. To the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies, and the risks concerning an overweight status. After being adequately informed, the patient has consented.

Provider signature:_____ Date:_____