TOTAL HEALTH
Solutions
A.E. Thomas, MD

NEW PATIENT QUESTIONNAIRE

Patient Information:

Name:(Last)_____ (First) _____ DOB _____

Address: _____City: _____State: _____Zip:_____

Primary Phone: _____Email Address: _____

Marital Status: _____ # of Children: _____

Employer: _____ Occupation: _____

Social Security Number: _____ Drivers License #_____

In Case of Emergency:

Name: _____ Relationship: _____ Phone: _____

I am interested in the following:

_____Primary Care _____Weight Loss Management _____Low Testosterone Management _____ Aesthetics

HOW DID YOU HEAR ABOUT US?

_____ TV _____ Magazine _____ Radio _____Flyer _____Other _____

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*Do you currently have or had a history of the following?

	YES		YES
Anemia		Addiction	
Angina		Anxiety	
Arthritis		Asthma	
Atrial Fibrillation		Blood Clots	
Bipolar		Colon Disease	
Cancer – TYPE - _____		Coronary Artery Disease	
Congestion Heart Failure		COPD/Emphysema	
Crohn's Disease		Depression	
Diabetes		Enlarged Prostate	
Gallbladder Disease		GERD (Reflux)	
Heart Attack (MI)		Hepatitis _____	
High Cholesterol		Hypertension (High Blood Pressure)	
Kidney Disease		Kidney Stones	
Irritable Bowel Disease		Liver Disease	
Migraine Headaches		Osteoarthritis	
Osteoporosis		Peptic Ulcer Disease	
Schizophrenia		Seizures/Epilepsy	
Skin Disease		Stroke	
Thyroid Disease			

Please list any other medical illnesses or problems and provide details for any of the above conditions:

_____

*Please check &/or list all family members that apply:

ILLNESS	Mother	Father	Sibling		ILLNESS	Mother	Father	Sibling
Alcoholism					Anemia			
Blood Disorder					Cancer – Type - _____			
Stroke					Dementia			
Diabetes					Kidney Disease			
Heart Disease					High Cholesterol			
Hypertension (High Blood Pressure)					Genetic Disease (sickle cell, cystic fibrosis)			
Mental Illness					Osteoporosis			
Heart Attack <50 yrs					Seizures/Epilepsy			
Thyroid Problems					Other: _____			

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Social History		
Tobacco Use _____ NO	_____ Daily _____ Weekly _____ Less _____ Former/Year Quit	_____Chewing _____Pipe _____ Cigar _____ Cigarette _____ Smokeless
Alcohol Use _____ NO	_____ Daily _____ Weekly _____ Less _____ Former/Year Quit	_____ Beer _____ Wine _____ Liquor _____ Other
Exercise Activity	_____Moderate ____ Vigorous ___Light __ Sedentary _____ Days/Week	Sleep Pattern: _____Changes _____ No Changes

Medications – List all medications you take, prescription and non-prescription, and the dosage

☐ **I DO NOT TAKE ANY MEDICATIONS**

MEDICATION NAME	***DOSAGE***

Medication and Food Allergies – List all known allergies (drugs, food, animals, etc.)

☐ **NO KNOWN ALLERGIES**

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Review of Systems

Please indicate ALL that you have experienced within the past 3 months

YES		YES		YES		YES	
CONSTITUTIONAL							
	Fever		Fatigue		Weight Gain		Weight Loss
	Chills		Feeling Poorly				Sweats
HEAD, EYES, EARS, NOSE & THROAT							
	Vision Problem		Nosebleed		Congestion		Hoarseness
	Decreased Hearing		Eye Pain		Snoring		Ringing in Ears
	Double Vision		Itchy Eyes		Dry Mouth		Vertigo
	Light Sensitivity		Neck Stiffness		Sore Throat		
CARDIOVASCULAR							
	Chest Pain		Cold hands or Feet		Irregular Heart Rhythm		Palpitations
	Leg Pain w/walking		Leg Swelling				
RESPIRATORY							
	Shortness of Breath		Wheezing		Coughing Up Blood		
	Chest Congestion		Coughing up Sputum				
GASTROINTESTINAL							
	Abdominal Pain		Diarrhea		Constipation		Blood in Stool
	Change in Bowels		Black/Tarry Stools		Vomiting Blood		Vomiting
	Decreased Appetite		Trouble Swallowing		Nausea		Heartburn
NEUROLOGICAL							
	Headache		Unsteady		Numbness		Tremor
	Dizziness		Disorientation		Tingling		Seizures
	Memory Lapses/Loss		Decreased Strength		Poor Coordination		Confusion
	Burning Sensation		Fainting				
MUSCULOSKELETAL							
	Joint Pain		Limb Pain		Muscle Pain		Neck Pain
	Back Pain		Joint Swelling		Muscle Weakness		Muscle Cramps
	Leg Swelling						
GENITOURINARY							
	Frequent Urination		Frequent Night Urination		Irregular Periods		Urinary Urgency
	Incontinence		Blood in Urine		Difficult Urination		Erectile Dysfunction
INTEGUMENTARY							
	Rash		Dry Skin/Itching		Change in a Mole		Change in Libido
PSYCHIATRIC							
	Depression		Anxiety		Insomnia		
HEMATOLOGIC/LYMPHATIC							
	Easy Bruising		Easy Bleeding		Swollen Lymph Nodes		
ENDOCRINE							
	Excessive Thirst		Heat Intolerance		Changes in Skin		Changes in Hair
	Cold Intolerance						

TOTAL HEALTH Solutions
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Total Health Solutions Weight Management Consent Form

I, _____, authorize Solutions Weight Loss, LLC, dba Total Health Solutions staff and physicians, to help me in my weight reduction efforts. I understand that my program may consist of a balanced diet, a regular exercise program, instruction in behavior modification techniques and the use of appetite suppressant medications. I understand that the abuse or overuse of appetite suppressants is potentially life threatening and is illegal.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program, which may include a prescription weight loss medication, may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand pursuant to State and Federal Laws prescriptions for appetite suppressants cannot be filled any sooner than once every four weeks. I understand I will not and cannot, for any reason, receive refills on prescriptions for appetite suppressants any earlier than once every four weeks. I understand that if I receive a prescription for a controlled substance weight loss medication it is necessary to follow up with the physician every 30 – 35 days so the physician can monitor my health while on this medication. I understand that it is illegal to obtain appetite suppressants from more than one physician and agree I will not obtain any appetite suppressants from other prescribing physicians.

I understand that the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits, lifestyle changes and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form. I have been given all the time I need to read and understand this form.

PATIENT SIGNATURE: _____ DATE: _____

WITNESS: _____

I attest to the best of my knowledge this medical information and background is complete and true. I agree to Total Health Solutions providers believing it to be TRUE, shall rely and act upon it in making medical decisions about my weight loss treatment.

Patient Signature: _____ Date : _____

Thank you for selecting Solutions Weight Loss for your weight care needs. We are honored to be of service to you and your family. Please be advised that payment of all services will be due at the time services are rendered. For your convenience we accept Visa, Mastercard, Debit Cards and Cash.

I have read and understand the above statement and agree to this statement.

Patient Signature: _____ Date: _____

HIPPA STATEMENT

I understand Total Health Solutions Privacy Practices. I have been offered a copy of Total Health Solutions Privacy Practice.

Patient Signature: _____ Date: _____

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