NOVA PHYSICIAN WELLNESS CENTER

♦ 3903 Fair Ridge Drive, Ste. # 209, Fairfax, VA 22033 ♦ 19415 Deerfield Ave, Ste.# 202, Lansdowne, VA 20176

♦ 8130 Boone Blvd, Ste. # 110, Vienna, VA 22182 ♦ 4820 31st St. South, Ste. # B, Arlington, VA 22206

♦ 3025 Berkmar Drive, Charlottesville, VA 22901

IF YOUR INSURANCE REQUIRES A REFERRAL, PLEASE MAKE SURE YOU BRING YOUR REFERRAL AT THE TIME OF YOUR APPOINTMENT.

**How did you hear about our program?_____

Patient History

Patient Name: First_____ Middle:_____ Last:_____

Address:_____ City:_____ State:_____ Zip code:_____

Home Phone:_____ Cell Phone:_____

Date of Birth:____/__/____ Age:_____ Gender: ☐ M ☐ F ☐Non-Binary ☐Transgender ☐ Intersex

Email Address:_____ ☐ I prefer not to say

Emergency Information

Name:_____ Relationship:_____ Phone:_____

Family Physician:_____ Phone:_____

Personal Medical History

Are you in good health at the present time to the best of your knowledge? ☐ Yes ☐ No

Are you taking any medications at the present time? ☐ Yes ☐ No **Circle for:** *"List of Medications attached"*

Medication Name:_____ Reason:_____

Medication Name:_____ Reason:_____

Medication Name:_____ Reason:_____

Any allergies to any medications? ☐ Yes ☐ No :_____

Dietary Restrictions? Allergies/Sensitivities? :_____

(Skip section if this does not apply to you) Gynecologic History:

Pregnancies: _____Number: _____ Dates: _____

Last Menstrual Period:_____ Are they regular? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No

Are you planning to become pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No

Personal Medical History (continued….)

Yes	No	Please check yes or no to the following conditions that apply to you:		Yes	No
		History of High Blood Pressure?	History of Diabetes?		
		History of Heart Attack or Chest Pain?	History of Swelling Feet:		
		History of Frequent Headaches:	Migraines?		
		History of Constipation (difficulty in bowel movements)?	History of Glaucoma?		
		History of Epilepsy?	History of Pancreatitis?		
		History of Impaired Kidney Function?	History of Thyroid Cancer?		
		Do you have a pacemaker?	History of eating disorders?		
Other:					

Family History *(if blood relative has suffered the following, please indicate relationship)*

☐Heart Attack_____ ☐Thyroid Cancer_____ ☐ Psychiatric Disorder_____

☐Hypertension _____ ☐Other Cancer _____ ☐Stroke _____
(Specify)

☐Arthritis_____ ☐Diabetes_____ ☐Obesity_____

☐Glaucoma_____ ☐Asthma_____ ☐Epilepsy _____

Surgical History

Specify Surgery	Date

Smoking Habit

☐Do not smoke ☐Have quit smoking _____ years ☐Current smoker _____ PPD ____PPW

NOVA PHYSICIAN WELLNESS CENTER

3903 Fair Ridge Drive, Suite 209, Fairfax, VA 22033

19415 Deerfield Ave, Suite 202, Lansdowne, VA 20176

8130 Boone Blvd, Suite 110, Vienna, VA 22182

4820 31st St. South, Ste. # B, Arlington, VA 22206

3025 Berkmar Drive, Charlottesville, VA 22901

Rules for Use of Anti-Obesity Control Medications

NOTE: SIGNING THIS FORM DOES NOT GUARANTEE THAT YOUR PROVIDER(S) AT NOVA PHYSICIAN WELLNESS CENTER WILL FIND YOU TO BE AN APPROPRIATE CANDIDATE FOR ANTI-OBESITY MEDICATIONS, BUT ONLY THAT YOU HAVE READ, UNDERSTOOD, AND AGREE TO THE TERMS OF MEDICATION USAGE SHOULD YOU AND MEDICAL PROVIDER DECIDE UPON THEIR USAGE NOW OR IN THE FUTURE.

Many anti-obesity medications are considered “controlled medications.” By law, a controlled medication can only be prescribed from one facility at a time; therefore I agree that only Nova Physician Wellness Center will prescribe anti-obesity medications for me. I agree that it is my responsibility to inform my physician(s) at Nova Physician Wellness Center and any other providers from whom I receive treatment of all medications prescribed to me. **I understand that the use of anti-obesity medications is contra-indicated with certain medical histories, allergies, or other medication use**. I agree that I will be completely honest in disclosing this information and will notify my physician(s) at Nova Physician Wellness Center of any changes to my medical history or medication usage. I understand that failure to do so can be dangerous to my health.

- **I understand that the medications are contraindicated in pregnancy and while breastfeeding.**
- I agree to take the medication only as prescribed and directed by the medical provider. I understand that taking medications in any way other than as directed and prescribed could affect my health and be dangerous. I also understand that medications are typically considered after a trial of failed weight loss with only nutritional/behavior modifications. If I am deemed a candidate for the medication program at Nova Physician Wellness Center, I am aware that the lowest effective dosage will be tried prior to increasing dosages.
- I understand that medication prescriptions can be filled at a pharmacy of my choice. I agree to use only one pharmacy at a time to fill any scheduled anti-obesity prescriptions, and I give my permission for Nova Physician Wellness Center to notify area pharmacies of the terms of this agreement.
- I will not share, sell, or trade my medication with anyone. I understand that doing so is illegal and will result in my discharge from the care of Nova Physician Wellness Center.
- I understand that the use of some of the anti-obesity medications beyond 12 weeks is considered “off label” or not initially approved by the U.S. Food and Drug Administration (FDA). I understand that my physician(s) at Nova Physician Wellness Center are experienced specialist(s) in obesity medicine who will, at times, elect/choose, when indicated, to use the anti-obesity medication(s) for longer periods of time as deemed appropriate for my individual treatment.
- I understand that I am to report any side effects or adverse reactions of my medications to the physician(s) at Nova Physician Wellness Center.
- I understand that it is my responsibility to follow the instructions carefully and that the purpose of this treatment is to assist me in my desire to decrease my body weight for improvement of health and to maintain weight loss. I understand that the purpose of medications for weight loss is to be used as an adjunct to a program that includes nutrition and/or physical activity and/or behavior modification.
- I agree that my physician(s) at Nova Physician Wellness Center may sometimes taper and/or stop my medication to evaluate its effect on my weight loss and/or hunger and health.
- I understand that much of the success of the program will depend on my efforts and that there are **NO GUARANTEES** in medical treatment in the disease of obesity. I also understand that I will have to continue monitoring my weight after active weight loss.

Patient Signature: _____ Date: ____/____/_____

NOVA PHYSICIAN WELLNESS CENTER

Weight Loss Program Consent Form

I, _____, acknowledge that I will be seen by both provider and nutritionist for each and every visit within limited exceptions. Losing weight and keeping it off can be daunting for anyone. Latest clinical trials and research studies have shown that intensive lifestyle interventions can reduce weight and prevent or mitigate obesity and other related comorbidities. Intensive lifestyle intervention requires a Long-term commitment and acknowledgment that the condition can be lifelong and that it requires sustainable lifestyle and behavior changes plus maintenance of these changes. It requires a multidisciplinary team approach of obesity specialists, trained nurse practitioners and Nutritionists/Dietitians and other medical professionals who have defined roles and communicate with each other in order to bring the optimal results for a patient.

I authorize Nova Physician Wellness Center and associated health care providers, to help me in my weight-reduction efforts. I understand that my program may consist of a balanced-deficit diet, a regular exercise program, instruction on behavior modification techniques, and may involve the use of anti-obesity medications. Other treatment options may include a very low-calorie diet or a protein-supplemented diet. I further understand that if medications are used, they have been used safely and successfully in private medical practices with experienced obesity medicine specialists as well as in academic centers for periods exceeding those recommended in the product literature.

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 having excess weight or obesity. Risks of this program are usually temporary, reversible, and may include but are not limited to nervousness, sleeplessness, headaches, electrolyte abnormalities, dry mouth, gastrointestinal disturbances, weakness, fatigue, pancreatitis, psychological problems, gallstones, high blood pressure, rapid or slowing of the heartbeat and heart irregularities, and risk of weight regain. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are 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 over time.

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

I have read and fully understand this consent form and it has been fully explained to me. My questions have been answered to my complete satisfaction.

_____ _____

Patient's Name (printed) Witness

_____ _____

Patient Signature Date

(or signature of person with authority to consent for patient)