4925 Rockwell Road
Winchester, KY 40391
Phone: (859) 744-1061
Fax: (859) 744-1062
www.nuyuhealthservices.com

New Patient History (*Please PRINT All information clearly) Date:*_____

Name_____ Preferred Nickname:_____Social Security#:_____
Date of Birth__/_____/_____Age_____Are you on Medicare?_____Spouse_____
Occupation:_____Employer name and Phone #_____
Primary Physician_____PCP Phone # _____
Preferred Pharmacy name:_____Location:_____Pharmacy phone:_____
Childproof medication bottle needed? □Yes □No **If no, sign here**:_____
Your address_____City/State_____Zip_____
□Home phone: ()_____-_____□Work: ( )_____-_____□Cell: ( )_____-_____

Please indicate which phone number you would like for us to use as your primary number.

Email: _____

- Your lifetime non-pregnant max weight: _____lbs
- Your goal weight: _____lbs
- Age when you were last at your goal weight:_____
- Overall goals: What do you hope to accomplish by being here?_____
- Have you ever had bulimia?_____
- Binge eating disorder?_____
- Anorexia?_____
- How many alcoholic beverages in a week? _____
- What was your weight: 1 year ago_____, 5 yrs ago_____ 10 yrs ago_____
- Do you smoke?_____how much/day?_____
- If you smoke: Since what age? _____
- If you used to smoke, when did you quit?_____
- Are you: Male or Female
- **LADIES:** Are you pregnant?_____Breastfeeding?_____
- Do you have abnormal periods?_____
- Date of Last Period? _____
- Are you menopausal or perimenopausal?
- What form of contraception do you use (including tubal ligation/male sterilization)?_____
- Do you have a history of drug abuse or drug related charges charges? _____

Current meds and doses:	**Reason taking it?**	**Over the counter meds/vitamins/herbals**
1) _____	_____	1)_____
2)_____	_____	2)_____
3)_____	_____	3)_____
4)_____	_____	4)_____
5)_____	_____	5)_____
6)_____	_____	6)_____
7)_____	_____	7)_____
8)_____	_____	8)_____

What **serious illnesses/hospitalizations** have you had in the past?_____
What **surgeries** have you had in the past?_____
What medications are you **allergic** to?_____
What **weight loss meds** have you tried in the past? _____
Any problems with them?_____When last used?_____What worked?_____
What **weight loss programs** have you tried in the past? _____
Any problems with them?_____What worked?_____
What did you learn from these programs regarding your weight?_____
Why do you think they haven't worked?_____
Why do you think you struggle with your weight?_____
What's a typical day of food like: Breakfast:_____Lunch:_____
Dinner:_____Snacks:_____
Circle your food weaknesses? Portion sizes, Too many carbs, Too little protein, Skipping meals, other:_____
Food dislikes:_____Food Cravings:_____
How many **ounces** of each of the following are typically consumed each day? (8oz = 1 cup)
Water: _____ Juice: _____ Milk:_____What % (whole, skim, 1%) _____
Soda: _____ Diet Soda: _____ Sports Drinks:_____What type? _____
Unsweetened Iced tea: _____ Sweet tea or lemonade: _____ Hot tea:_____Decaf?:_____
Coffee:_____Decaf?: _____ Other:_____(what is it?)

Name: _____

Do you have any food restrictions?_____

Are you struggling from any current stressful situation or emotional upset?_____

WHO in your **FAMILY** have had the following?(mom,dad, siblings, aunts/uncles, cousins, grandparents)

- Heart Disease/Heart Attack/ Congestive Heart Failure_____
- Cancer: (list type)_____
- Hypothyroidism_____
- High Cholesterol_____
- High Blood Pressure_____
- Sudden death < age 40 from medical condition_____
- Stroke_____
- Diabetes or "borderline diabetes"
- Mental illness (depression, bipolar, etc.)_____
- Drug/alcohol/medication abuse:_____
- Who in family struggles with weight?_____
- Other family medical conditions_____

Please **circle** the **medical conditions** that **YOU** have been diagnosed with in the past or currently.

- o Past or current drug or alcohol problems
- o Any current illegal drug use or medication misuse
- o Depression or anxiety
- o Diabetes: Type 1(juvenile) or 2(adult)?
- o Gestational Diabetes
- o Insulin Resistance/Prediabetes/ Borderline Diabetes/Dysmetabolic Syndrome
- o Polycystic Ovarian Syndrome
- o Heart Burn
- o Glaucoma (Open or Narrow Angle?)
- o High Cholesterol
- o High Blood Pressure
- o Heart Disease/Heart Attack/Heart Failure
- o Arrhythmia
- o Heart Valve Problems/ Heart Murmurs
- o Do you have a pacemaker: yes or no
- o Do you have a defibrillator: yes or no
- o History of passing out (syncope)
- o Asthma
- o Other Lung diseases (Type:_____)
- o ADHD/ADD
- o Bipolarism or other psychiatric conditions? _____
- o Kidney Diseases (Type:_____)
- o Liver Diseases (Type:_____)
- o Obstructive sleep apnea (use a CPAP?)
- o Insomnia/ other sleep disorders
- o Thyroid Disorders (Low or High or Other:_____)
- o Other Chronic Medical Conditions:_____ _____

****

Please circle if you have been having any of the following **symptoms**

1) Weakness
2) Dry, Coarse skin
3) Tired/fatigue
4) Slow speech
5) Slow movement
6) Coldness and cold skin
7) Diminished sweating
8) Thick tongue
9) Coarse hair
10) Pale skin
11) Constipation
12) Gain in weight
13) Loss of hair
14) Difficulty breathing
15) Swollen feet
16) Hoarseness
17) Loss of appetite
18) Poor memory
19) Nervousness
20) Heart palpitations
21) Brittle nails
22) Swelling of face & eyelids
23) Excessive or painful menses
24) Emotional Instability
25) Depression
26) Headaches

☐ **Please check here if NONE of the above 26 symptoms apply to you**

****

Exercise *frequency*?
☐ None
☐ 1-2x/week
☐ 3-5x/week
☐ Daily

What is the *intensity*?
☐ None
☐ Light (brisk walking, golfing, doubles tennis)
☐ Moderate (biking, low impact aerobics)
☐ Moderately hard (running, aerobics, hockey)
☐ Very hard (Sprinting, speed swimming)

For *how long*?
☐ None
☐ Under 10 minutes
☐ 10-20 minutes
☐ 20-30 minutes
☐ over 30 minutes

Do you have any physical restrictions to exercise? (what are they)_____

****

1. Do you make yourself sick because you feel uncomfortably full? Y or N
2. Do you worry you have lost control over how much you eat? Y or N
3. Have you recently lost more than 15 pounds in a three-month period? Y or N
4. Do you believe yourself to be fat when others say you are too thin? Y or N
5. Would you say that food dominates your life? Y or N

****

(Continued on next page)

Name: _____

1. Have you ever felt you should cut down on your alcohol drinking? Yes or No
2. Have people annoyed you by criticizing your alcohol drinking? Yes or No
3. Have you ever felt bad or guilty about your alcohol drinking? Yes or No
4. Have you ever had an alcoholic beverage first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)? Yes or No

Lifestyle challenges: Which of the following seem to sabotage your weight loss efforts:

1. Lack of time for planning & self	2. Eating late/waking up eating	3. Eating too fast
4. Comfort/stress eating	5. Liquid calories such as alcohol	6. Always hungry
7. Enjoyment of food	8. Specific food cravings like carbohydrates	9. Boredom eating
10. Social Events	11. Mindless eating/Habit	12. Other:

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling asleep, staying asleep, or sleeping too much.				
d. Feeling tired or having little energy.				
e. Poor appetite or overeating				
f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
g. Trouble concentrating on things such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
i. Thinking that you would be better off dead or that you want to hurt yourself in some way				
Totals				

If you checked off any problem of the above chart, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult	Somewhat Difficult	Very Difficult	Extremely Difficult
0	1	2	3

Are you ready for lifestyle changes to be a part of your weight control program? _____

If yes, rate on a scale of 1-10 (1 being a little ready, 10 being extremely ready)_____ Are you willing to keep a food journal? _____

Which of the following do you think would help you on your weight loss journey?

____Learning how to eat "real food" and making my own healthy choices
____Food delivered right to my door to just eat that
____A program with mainly protein shakes/bars and one sensible dinner
____I suspect I might have an eating disorder and want further work-up
____What I really need is: _____

HOW DID YOU HEAR ABOUT NuYu Health Services?

- **My family member, friend or co-worker** who is currently a patient here inspired me to start. *Please share who this was so we can say thank you to them. Their name please:* _____
- **My doctor's office referred me to you. Dr. or PA name:** _____
- **Internet (**Google, Yahoo, Facebook) What website? _____
- **TV Commercial** (What station?) _____
- **Radio** (Which station?) _____
- **Mailer to house** (Which one?) _____
- **Movie Theater** _____
- **Other:** _____

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Informed Consent for Treatment

We want you to know that medical weight loss is an important medical decision in your health care. We are informing you through lectures and printed materials that we strive to work with you carefully and safely to help you achieve a medically significant weight loss. To help achieve this loss and help you in maintaining the weight loss long term, you must understand we may prescribe various different nutritional plans, exercise programs, and when appropriate use medicines short term and long term. You will be informed on how the medicines work, possible side effects, and know possible consequences of the medicines, dietary, and exercise activities planned. Sometimes the use of medicines, length of use of medicine, or medication dosings may be used in an "off label" manner. This means the doctor may be using the medicines safely in a manner other than initially approved by the FDA. The use of meds will always be within the scope of accepted medical Bariatric (weight loss) medicine. Please note that the use of medications for weight loss is optional, and no weight loss treatment (including use of medications) guarantees successful weight loss.

Your Role

1. Provide **honest** and complete answers to questions about your health, weight problem, eating activity, medication or drug usage, and lifestyle patterns to help us help you.
2. Devote the **time and effort** necessary to complete and comply with the course of treatment.
3. Allow us to share information with your personal physician if necessary.
4. Make **follow-up appointments** so that we can help you the best, allowing necessary blood tests as needed.
5. Advise the clinic staff and dr. of any concerns, problems, complaints, symptoms, or questions you develop.
6. Inform your personal physician of your weight loss efforts and have or establish a primary physician before beginning this program.

Possible Side Effects

1. **Reduced weight.** By reducing your caloric intake, you may see a variety of **temporary and reversible** side effects including, but not limited to, increased urination, momentary dizziness, reduced metabolic rate, cold sensitivity, slower heart rate, dry skin, fatigue, constipation, diarrhea, bad breath, muscle cramps, changes in menstrual pattern, dry or brittle hair, or hair loss. Medication side effects may include any of the above plus dry mouth, mild headaches, and very rarely a racing or pounding heart rate or an elevation in blood pressure or other more rare side effects. This will be closely monitored as safety is our number one priority.
2. **Reduced potassium levels or other electrolyte abnormalities.** We monitor electrolyte levels periodically and correct them if they become too low. If they were not corrected, these can result in muscle cramps, heart rhythm irregularities and other symptoms as above. Always inform us if you are on or begin a water pill. We will be following your levels with occasional blood testing.
3. **Gallstones.** Overweight people are at risk for having or developing gallstones. One study reports that 1 in 10 persons entering a weight loss program may have silent or undiagnosed gallstones. Active weight loss can produce new stones or cause established stones to develop symptoms. The pain is usually in the right upper abdomen and may spread to the back. Gallbladder problems may require medications or even surgery to remove the gallbladder. Notify your primary doctor or us if you develop symptoms of gallstones including abdominal pain, fever, nausea, and vomiting.
4. **Pancreatitis**. Inflammation of the bile ducts or pancreas gland may be associated with gallstones, and may be precipitated by eating a large meal after a period of strict dieting. It may require hospitalization, and rarely can be associated with life threatening complications. Notify us or your primary physician if you develop symptoms such as pain in the left upper abdominal quadrant, fever, or vomiting.
5. **Pregnancy.** Notify us if you become pregnant. Some overweight patients have irregular ovulation and weight loss may increase ovulatory regularity and the chance of becoming pregnant. If pregnant, you must change your diet to avoid further weight loss. A restricted diet can damage a developing fetus. Also, any weight loss medications must be discontinued if pregnancy occurs since we do not want you to continue to lose weight during that time. You should take precautions to avoid becoming pregnant during weight loss.
6. **Sudden death**. Patients with obesity, especially those with associated high blood pressure, diabetes, or heart disease have a higher risk of sudden death and development of a serious potentially fatal disease known as primary pulmonary hypertension. Rare instances of sudden death have occurred while obese patients are undergoing weight loss even in a medically supervised program. No cause and effect relationship with the diet program and sudden death has been established.
7. **Risk of weight regain.** Obesity is a chronic condition. The majority of patients who lose weight have a tendency to regain unless in some type of maintenance program and long-term efforts at controlling the weight are continued. We will provide you with a maintain plan and plan to help prevent weight regain.

Signature: _____ Date: _____

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Your Rights and Confidentiality

You have the right to leave treatment at any time without any penalty, although you do have a responsibility to make sure we know you are discontinuing treatment. Your personal physician must be able to assume your medical care.
From time to time, patient treatment information is used in the collection of statistics to compare results, and improve the treatment of obesity. This information may be shared with other practitioners, researchers, and the scientific and medical community. Strict confidentiality of individual personal information and records will be maintained.
Please note that our Physicians do not take calls outside NuYu Health Service's office hours. If you feel you are experiencing a medical emergency **at any time**, go to the nearest emergency room immediately for treatment.
(HIPAA)
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION (HIPAA)
Uses and Disclosures of Information that We May Make Without Written Authorization: For treatment, payment, healthcare operations, as required by law, abuse or neglect, or communicable diseases, public health activities, health oversight activities, judicial and administrative proceedings, law enforcement, organ donation, research, workers compensation, appointments and services, marketing, business associates, military, inmates or person in police custody, coroners, medical examiners, funeral directors.
Uses and Disclosures of Information That We May Make Unless You Object: We may use and disclose protected health information in the following instances without your written authorization unless you object. (Disaster Relief & Persons Involved in your case.)
If you object, please notify the Privacy Contact identified at the end of this document.
Persons Involved in Your Health Care: Unless you object, we may disclose protected health information to a member of your family, relative, close friend, or other person identified by you who is involved in your health care or the payment for your health care. We will limit the disclosure to the protected health information relevant to that person's involvement in your health care or payment. We may leave messages for you to call us or leave basic lab test results on your home phone unless you direct otherwise.
Notification: Unless you object, we may use or disclose protected health information to notify a family member or other person responsible for your care of your location and condition.
Person(s) Authorized to Receive Information _____
Physician Office(s) Authorized to Receive Medical Information _____
Medical Residents, Medical Students, and Training Physicians may observe or participate in your treatment or use your PHI to assist in their training. You have the right to refuse to be examined, observed, or treated by them.
Newsletter and Other Communications - We may use your PHI to communicate to you by newsletters, mailings, or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our practice is participating.
Your Right Concerning Your Protected Health Information: You have the following rights concerning your protected health information. To exercise any of these rights, you must submit a written request to our Privacy Officer.
1. To request additional restrictions.
2. To receive communications by alternative means.
3. To inspect and copy records.
4. To request amendment to your record.
5. To request accounting of certain disclosures.
6. To receive a copy of our complete confidentiality notice. (Electronic copy found on our website.)
7. To receive a copy of the bill to submit to your insurance. We will code your visit as medically correct as possible. Please note in rare instances a new diagnosis or prescription that you submit to your insurance may affect your insurability and or your insurance rates.
8. To receive notice of a breach
9. Right to restrict certain disclosure to your health plan.

Complaints You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.
Changes to this notice are located at NuYu Health Services
Entities to Whom This Notice Applies: This notice applies to the Kentucky Bariatric, Inc. d/b/a NuYu Health Services, their associated clinics, the physicians, employees, and volunteers who work there.
Privacy Officer Contact: If you have any questions about this notice, request a copy of the complete notice or if you want to object to or complain about any use of disclosure of exercise any right as explained above, please contact our Active Medical Director at Address: 4925 Rockwell Road, Winchester, KY 40391 (859) 744-1061

I, the undersigned, have reviewed this information on the front and the back page of this document, and have had an opportunity to ask questions and have them answered to my satisfaction.

_____ _____

Patient Signature **Date**

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Name:_____ (Please Print)

FINANCIAL OPTIONS

Payment is due at time of service.

NuYu Health Services accepts Cash, Visa, MasterCard, Discover, or Flex Card as payment.

Credit/Debit Card (Flex account cards)

If paying by credit/debit card, the card must bear the patient's name (photo id to be presented).
Payments to be made using another person's credit/debit card must have written authorization on file in our office no later than the time of the first visit. Photo id must also be presented for the person authorizing the charges.

Missed appointments, or appointments not cancelled 24 hrs in advance may be charged at late fee, due at the next visit or billable if treatment is discontinued.

If payment is not made for any reason, you agree to pay any fees incurred while collecting payment, including up to an additional 40% of the balance if the account is placed for collections with a third party agency.

_____ _____

Patient Signature **Date**

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RULES FOR USE OF WEIGHT LOSS CONTROL MEDICATIONS

NOTE: SIGNING THIS FORM DOES NOT GUARANTEE THAT YOUR PHYSICIAN WILL FIND YOU TO BE AN APPROPRIATE CANDIDATE FOR WEIGHT LOSS MEDICATIONS, BUT ONLY THAT YOU HAVE READ, UNDERSTAND, AND AGREE TO THE TERMS OF MEDICATION USE SHOULD YOU AND YOUR PHYSICIAN DECIDE UPON THEIR USE NOW OR IN THE FUTURE.

Many weight loss medications are considered "controlled medications." By law, a controlled medication can only be received from one facility at the same time. I agree that only NuYu Health Services will prescribe scheduled weight loss medications for me. I agree that it is my responsibility to inform my doctor and any other doctors from whom I receive treatment of this contract, and that it is my responsibility to inform any and all doctors from whom I receive treatment if I am prescribed and/or taking any scheduled medications. NuYu Health Services may also notify my other doctors of the terms of this contract.

I understand that the use of weight loss medications is contraindicated with certain medical histories, allergies, or other medication use. I agree that I will be completely honest in disclosing this information & will notify my NuYu Health Services physician of changes to my medical history or new medication usage. I understand that failure to do so can be dangerous to my health.

I agree to take the medication only as prescribed by NuYu Health Services. I understand that taking medications in any way other than prescribed may be dangerous to my health. I understand medications are typically only considered after a trial of weight loss with only nutritional/behavioral changes. If benefit outweighs the risks after this point, the lowest effective dose will be tried prior to increasing dosages.

I agree to arrange for prescription refills for scheduled medications from NuYu Health Services only during regular clinic hours. I understand that controlled medications are not refilled in advance to time of refill. Medications are typically dispensed only in one month increments and only via physician approval during physician appointment with appropriate vital signs. I understand that missing my appointment may mean being out of the medications for a small time period as controlled medications are not refilled via phone. I understand that NuYu Health Services is not obligated to replace any medications or prescriptions that are lost or stolen for any reason.

I understand that medication prescriptions can be filled typically at NuYu Health Services or another pharmacy of my choice. If I use a pharmacy other than NuYu Health Services, I agree to use only one pharmacy to fill any weight loss scheduled prescriptions and I give my permission for NuYu Health Services to notify area pharmacies of the terms of this agreement.

I will not use any illegal drugs or substances. I will not obtain or use any controlled substances illegally.

I will not share, sell, or trade my medication with anyone. I understand doing so is illegal, will result in my discharge from my physician's care, and may cause harm to the other person including possible death. I will not allow any other individual to take my medication under any circumstances.

I understand that the use of many weight loss medications beyond 3 months is considered off-label usage. I

understand I am to report any side effects or adverse reactions of medications to my NuYu Health Services provider.

I authorize my NuYu Health Services physician and my pharmacy to cooperate with any investigation of my drug use by legal authorities. This includes, but is not limited to, the release of my medical and pharmacy records and answering questions about me.

My physician may sometimes taper and/or stop my medication to evaluate its effect on my weight loss and/or hunger and health. I will continue to comply with all parts of the agreement during those evaluation periods.

_____ _____

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I understand that Kentucky law requires physicians prescribing controlled medications (including weight loss medications) to monitor patients' use of these medications. This monitoring may include an initial drug screening panel & KASPER report. I understand KASPER reports list what controlled substance prescriptions I have filled in the past several years. Further monitoring may include random drug screens, random pill counts, and repeat KASPER reports every three months while in the NuYu Health Services program. Therefore, I understand that I am to bring in my unused weight loss medications to my appointments as they may be randomly required. I will cooperate with random pill counts. I will allow random drug tests of my urine and/or blood. I understand that I am responsible for any cost of them. I understand that this required monitoring could result in the delay and/or inability of my physician to prescribe these types of medications to me.

I understand that weight loss medications may assist in weight loss, but that there is no guarantee they will do so. I understand weight loss medications can only be used with proper nutritional and behavioral changes. Failure to comply with nutritional and behavioral changes may result in physician discontinuing medication. If weight loss is not improved with use of medications, I understand my physician will need to stop or change medications.

I understand my physician can discontinue weight loss medications at any time & will do so if weight loss plateaus. I understand that if weight loss medications are used, the plan is to use them only during weight loss, and then to taper off of them once goals have been met. I will be evaluated monthly to see if medications can and should be refilled.

I understand that weight loss medications are just one option to assist in weight loss, but are not required to lose weight. There are many options for weight loss although all patients will be instructed on nutritional, behavioral, and psychological changes. Just like any medication, weight loss medications can have a risk of side effects. Such side effects may include (but are not limited to), dry mouth, constipation, anxiety, jittery sensation, headache, insomnia, allergic reaction, heart palpitation (rare), elevated blood pressure (rare). Addiction is listed as a potential side effect (although this has not been reported if used as prescribed.) I understand it is my responsibility to notify my NuYu Health Services physician if I have any side effects.

If weight loss medications are used over 1 month, they should be tapered off unless you become pregnant or have a serious side effect from the medication in which case they can be stopped immediately. Failure to taper off of weight loss medications may result in rebound hunger, fatigue, depression, gain in weight, and other symptoms. I understand that if I desire to discontinue medications for any reason (including simple inability to continue program), I will contact NuYu Health Services to obtain a proper exit plan based on my current medical conditions.

Unused medications may be returned to NuYu Health Services for proper disposal, or follow the guidelines at www.fda.gov/consumer.

Females only: I certify that I am not pregnant. I agree and understand that I must notify my prescriber if I plan to become pregnant or am unsure if I am pregnant. I agree not to take weight loss medications if I become pregnant.

My signature placed on this contract indicates that I fully understand each statement and have had the opportunity to ask any questions pertaining to this. All of my questions have been answered to my satisfaction. I understand that if I break any part of this agreement, I may be discharged from my provider's care.

You may request a copy of this signed contract.

Patient name (print): _____ Date: _____

Patient signature: _____

Witness signature: _____Witness name (print): _____