

Please list foods you typically snack on:

Do you suffer from uncontrollable cravings, or do you feel out of control around certain foods? Yes No

If yes, please explain and/ or identify the foods you typically crave: _____

Do any of these apply to you? Check all that apply.

<input type="checkbox"/> Eating large portions	<input type="checkbox"/> Skipping breakfast
<input type="checkbox"/> Eating too much sugar	<input type="checkbox"/> No exercise
<input type="checkbox"/> Eating too many fatty foods	<input type="checkbox"/> Don't drink enough water
<input type="checkbox"/> Use too much salt	<input type="checkbox"/> Eat when not really hungry
<input type="checkbox"/> Eat too fast/ not eat mindfully	<input type="checkbox"/> Eat a lot of fast food
<input type="checkbox"/> Eat a lot of junk food	<input type="checkbox"/> Eat little or no fruit
<input type="checkbox"/> Eat little or no vegetables	<input type="checkbox"/> Skip meals often

Do you use a sugar substitute? Yes No

Do you consume diet drinks? Yes No

If yes, how many per day? 1 can (12 oz) 2 cans (24 oz) 3+ cans (36 oz)

Do you consume regular soda? Yes No

If yes, how many daily? 1 can (12 oz) 2 cans (24 oz) 3+ cans (36 oz)

In your household, who plans meals? _____

Who does the cooking? _____

Who does the grocery shopping? _____

How frequently do you eat meals away from home (at restaurants)?

Everyday 5 times per week 3 – 4 times per week 1 – 2 times per week Never

Please describe your typical daily food intake, using yesterday as an example if necessary:

Morning meal Time:	
Snack Time:	
Mid-day meal Time:	
Snack Time:	
Evening meal Time:	
Snack Time:	

Obesity-related conditions

Please check if you have any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Reflux/belching of sour fluid | <input type="checkbox"/> Bulimia/excessive vomiting | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Coughing or choking at night | <input type="checkbox"/> Daily headaches | <input type="checkbox"/> swollen ankles/feet |
| <input type="checkbox"/> Daytime falling asleep | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Gout | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> High lipids | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Leakage of urine |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Sleep apnea | |

Other conditions: _____

Other habits

Do you smoke?	Yes	No	Packs/day: _____
Have you ever been a smoker?	Yes	No	Age started: _____ Age quit: _____
Do you consume alcohol?	Yes	No	Drinks/day: _____
Do you use recreational drugs?	Yes	No	Type/frequency: _____

Please check the yes if you have had any of the following medical conditions:

Yes	Condition	Yes	Condition
	Allergies		Heart palpitations
	Anemia		Heavy/excessive drinking
	Asthma		Hemorrhoids
	Bladder/kidney infections		Hepatitis
	Blood transfusions		Kidney stones
	Cancer		Leg-cramping
	Colitis or Irritable Bowel Syndrome		Liver disease
	Easy bruising		Lung disease/Pneumonia
	Epilepsy/seizures		Migraine/ severe headaches
	Excessive/heavy bleeding		Polycystic Ovary Disease
	Fainting		Rheumatic fever
	Food allergies or sensitivities		Stroke
	Frequent nausea		Thyroid problems
	Heart attack		Tuberculosis
	Heart failure		Tumors
	Heart murmur		Ulcers

Family History

Please check all that apply

Condition	Mother	Father	Sibling	Grandparent (specify maternal or paternal)	Aunt/ Uncle (specify maternal or paternal)
Diabetes					
↑ Blood Pressure					
High Cholesterol					
Obesity					
Stroke					
Heart Disease					
Cancer					

Financial Policy:

Thank you for selecting The Davis Clinic for your health and weight management needs. We are honored to be of service to you. This serves to inform you of our billing requirements and our financial policy. Please be advised that payment is due for all services rendered at the time services are rendered. For your convenience, we accept MasterCard, Visa, cash, money orders and cashier's checks.

All monies due will be collected at the time of service. We will gladly bill your insurance company on your behalf; however, reimbursement by your insurance company is not guaranteed. Any reimbursements available from them will be sent directly to you.

I understand the financial policies set for by The Davis Clinic and agree that should my account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

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

Patient's Signature

Date

929-B Gessner Road, Suite 106
Houston, Texas 77024
P: 713.464.6000
F: 713.464-6002
www.thedavisclinic.com

Medically-Supervised Weight Loss Program Consent Form

I _____ authorize Dr. Garth P. Davis and whomever he may designate as their assistants, to help me in my weight reduction efforts. I understand that my program may consist of a nutritionally-balanced, reduced-calorie diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein-supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices, 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 remaining overweight or obese. Risks of the medically-supervised weight loss program may include, but are not limited to, nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and/or heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight or obese include, but are not limited to, tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, depression, infertility, cancer, stroke, gout, gallbladder disease, and/or 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 that much of the success of this program will depend on my personal 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 and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged to take my time in reviewing this form, and have been given all the time I need to read and understand this form.

NOTE: If you have any questions regarding the risks or hazards of the proposed treatment, or any questions concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

PATIENT SIGNATURE

DATE

PATIENT PRINTED NAME

WITNESS SIGNATURE

Informed Consent for Use of Appetite Suppressants

I. Procedure and Alternatives: I, _____, authorize Dr. Garth P. Davis to assist me in my weight reduction efforts. I understand that my treatment may involve, but may not be limited to, the use of appetite suppressants for a prescribed period which may be longer than 12 weeks and, when indicated, in higher doses than the dose indicated in the appetite suppressant labeling.

I have read and understand my doctor's statements listed below:

"Medications, including appetite suppressants, have labeling worked out between the makers 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 dosages indicated in the labeling. As a bariatric physician, I have found the appetite suppressants helpful for periods in excess of 12 weeks, and at times in larger doses than those suggested in the labeling. As a physician, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer-term studies, and recommendations of university-based investigators. Based on all of these resources of information, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses on certain patients, when warranted as appropriate and responsible in their weight management. Such usage has not been as systematically studied as that 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 bariatric physician, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time, and, when indicated, in increased doses; however, you, the patient, must decide if you are willing to accept the risks of side effects associated with longer-term use, even if they are potentially serious, for the possible help the appetite suppressants used in this manner may give."

I understand it is my responsibility to follow the instructions given to me by my physician very carefully, and to report to the doctor treating me for my excess weight, any significant medical problems that I think may be related to the medically-supervised weight loss program as soon as possible.

I understand the purpose of this treatment is to assist me in decreasing my excess body weight and to maintain this weight loss. I understand my continuing to receive an appetite suppressant is dependent on my progress in weight reduction and weight maintenance.

I understand there are other ways and programs that may be able to assist me in decreasing my excess body weight and to maintain this weight loss. For example, a balanced, calorie counting program or an exchange eating program without the use of the appetite suppressants may likely prove successful if followed; however, I would likely be hungrier without the appetite suppressants.

II. Risks of Proposed Treatment: I understand this authorization is given with the knowledge that the use of appetite suppressants for more than 12 weeks and in higher doses than the dose indicated in the labeling may involve some inherent risks and hazards. The more common may include, but not be limited to, nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heartbeat, and/or heart irregularities. Less common, but more serious risks may include primary pulmonary hypertension and valvular heart disease. These and other possible risks could be serious or even fatal.

III. Risks Associated with Being Overweight or Obese: I am aware that there are certain risks associated with remaining overweight or obese, including but not limited to, high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, depression, infertility, cancer, stroke, gout, gallbladder disease, and/or sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

IV. Guarantee Clause: I understand that much of the success of the program will depend on my personal efforts and commitment to the program, and that there are no guarantees or assurances that the program will be successful. I also understand and agree that I will have to continue watching my weight for my lifetime if I am to be successful.

V. Patient's Consent: I have read and fully understand this consent form and realize that I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the use of appetite suppressants.

NOTE: If you have any questions regarding the risks or hazards of the proposed treatment, or any questions concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

PATIENT SIGNATURE

DATE

PATIENT PRINTED NAME

VI. Physician Declaration: I have explained the contents of this document to the patient and have answered all the patient's related questions, and, to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of appetite suppressants, the benefits and risks associated with alternative therapies, and the risks of continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving appetite suppressants in the manner indicated above.

PHYSICIAN SIGNATURE

DATE



THE DAVIS CLINIC

Dr. Robert Davis

Dr. Garth P. Davis

Dr. John A. Primomo

929-B Gessner Road, Suite 106

Houston, Texas 77024

713.464.6000

NOTICE OF OUR COMMITMENT TO PROTECT YOUR PRIVACY

TO OUR VALUED PATIENTS:

At The Davis Clinic, we are continually striving to provide the highest standards of care possible while providing services for you, our patient. As part of this effort, we are updating our processes for handling Personal Health Information (the information found in your medical record) and are committed to providing you with privacy and protection. Our policy for health information disclosure shows our commitment to maintaining your privacy and our utmost confidentiality.

In most cases, there will be little change as to how we communicate with patients. We will continue to communicate by phone and/or fax for the purpose of medical treatment with our patients and their designated family members, friends or significant others; however, we will limit any disclosure of your medical information to others unless you have given us prior written authorization to do so. **Therefore, we ask that you provide us with a list of names of individuals whom we may discuss or disclose your health information and/or medical treatment with, and with whom you waive your right to privacy.** In addition, we ask that you provide us with your current mailing address, phone number(s) and email address so that we may better serve you.

We are required by law to maintain the privacy of and provide individuals with the attached notice of our legal duties and privacy practices with respect to protected health information. If you have any questions, comments or concerns, please ask to speak with Kimberly Taylor, our Administrative Director, or call her at our office.

Your signature below is acknowledgement of your receipt of our Notice of Privacy Practices and grants us permission to speak with the individuals noted below concerning your care.

I authorize the physicians and/or staff at The Davis Clinic to speak to or provide information concerning my health and/or medical treatment to the following individuals:

_____	_____
_____	_____
_____	_____

Printed Name

Signature

Date



Patient Guidelines and Consent for Use of E-Mail Communications

To better serve our patients, this office has established an e-mail address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at info@thedavisclinic.com. Please remember, however, that this form of communication is not appropriate for use in an emergency or urgent matter. The turnaround time for routine patient communication is approximately 72 hours. The service provider may also delay message delivery. Should you require immediate or urgent attention, email communication is NOT appropriate.

Types of communication that are appropriate for e-mail include:

- Scheduling inquiries
- Non-urgent medical advice
- Billing or insurance questions
- Test and lab results
- Educational materials

When you are sending e-mail, please put the subject of your message in the subject line so we can process your request more efficiently. Some forms of communication are not appropriate and will not be handled via e-mail such as mental health issues, HIV, etc. Also, be sure to include your name and return telephone number in the e-mail. We also ask that you acknowledge receipt of the e-mail by using the auto reply feature.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of e-mail, third parties may have access to messages. When communicating from your work, you should be aware that your company may consider e-mail company property and your messages may be monitored. In addition, you should be aware that, although addressed to your surgeon or a certain staff member, all staff members may have access to this information.

I understand that The Davis Clinic will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond The Davis Clinic's control.

I understand and agree to the above e-mail policy.

Patient signature

Witness (optional)

Date