# Family Medical Clinic of Crystal Springs, PLLC

**James W. Ervin, Jr., M.D.**
**Laura J. Miller, M.D.**
**Jennifer M. Sojourner, CFNP**
104 W. Railroad Avenue South
Crystal Springs, MS 39059
Telephone: (601) 892-3063
Fax: (601) 892-3570

Thank you for your interest in the Bariatric/Weight Loss Program at Family Medical Clinic of Crystal Springs, PLLC. Our goal is to provide a comprehensive evaluation that would allow us to design the most effective weight loss program for you individually. By completing the attached packet, you will allow us to get a clearer picture of the factors contributing to your weight issues.

Please find enclosed the following components in our packet:

1. Health History Questionnaire- complete in as much detail as possible.
2. Medical Information Release-complete so that we may request the results of any lab work you have had done in the past 24 months by other providers.
3. Food Journal-by completing this journal you allow us a picture of your usual diet.
4. **InBody guidelines**-at each visit you will have a body composition performed on our InBody analyzer; read and follow these instructions to ensure the scan will be as accurate as possible.
5. Weight Loss Program Consent Form-review and sign the consent form. This gives us permission to prescribe anti-obesity medications to assist with weight loss, if indicated.

Feel free to contact the office if you have any questions. Thank you again for your interest in our weight loss services. We look forward to serving you.

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## NEW PATIENT MEDICAL HISTORY FORM

Name: (First)______________________________ (Last) ______________________________ (MI)____
Date of Birth: _____/_____/__________ Date of Visit: _____/_____/__________
Phone: (Home/Cell)______________________ (Work) ______________________ Gender: M / F
Referred By: ______________________________

How does your weight affect your life and health? ________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

**Weight History**

When did you become overweight?

☐ Childhood ☐ Teens ☐ Adulthood ☐ Pregnancy ☐ Menopause

Did you ever gain more than 20 pounds in less than 3 months? Y / N If so, how long ago? _________
As best you can remember, how much did you weigh one year ago? _____
Five years ago? _____ 10 years ago? _____

Triggers for your weight gain (check all that apply):
☐ Stress ☐ Marriage ☐ Divorce ☐ Illness ☐ Medication abuse ☐ Travel ☐ Injury
☐ Nightshift work ☐ Insomnia ☐ Quitting (circle all that apply): Smoking / Alcohol / Drugs

Previous weight-loss programs (check all that apply):
☐ Weight Watchers ☐ Nutrisystem ☐ Jenny Craig ☐ LA Weight Loss ☐ Atkins
☐ South Beach ☐ Zone diet ☐ Medifast ☐ Dash diet ☐ Paleo diet
☐ HCG diet ☐ Mediterranean diet ☐ Ornish diet ☐ Other: ______________________

What was your maximum weight loss? ________________________________________________
What are your greatest challenges with dieting? ___________________________________________
_____________________________________________________________________________

Have you ever taken medication to lose weight? (check all that apply):
☐ Phentermine(Adipex) ☐ Meridia ☐ Xenecal/Alli ☐ Phen/Fen
☐ Phendimetrazine(Bontril) ☐ Topamax ☐ Saxenda ☐ Diethylpropion
☐ Bupropion(Wellbutrin) ☐ Belviq ☐ Qsymia ☐ Contrave
Other: ______________________
What worked? ____________________________________________________________________
What didn't work? ________________________________________________________________
Why or why not? _________________________________________________________________

## Nutritional History

How often do you eat breakfast? _____ days per week at _____:_____ a.m.
Number of times you eat per day: _____
Do you get up at night to eat? Y / N   If so, how often? _____ times

Food triggers (check all that apply):
☐ Stress ☐ Boredom ☐ Anger ☐ Seeking Reward ☐ Parties ☐ Eating Out
☐ Fast Food ☐ Other: ____________________

Food cravings:
☐ Sugar ☐ Chocolate ☐ Starches ☐ Salty ☐ High Fat ☐ Large Portions
Favorite foods: ________________________________________________

## Medical History

Exercise type: ________________________________________________
Duration: _____ hours _____ minutes   Number of times per week: _____
What prevents you from exercising? ________________________________

How many hours do you sleep per night? _____   Do you feel rested in the morning? _____

Past medical history (check all that apply):
☐ Heart attack ☐ Angina ☐ Gall bladder stones ☐ Sleep apnea
☐ High blood pressure ☐ Stroke ☐ Indigestion/reflux arthritis ☐ Thyroid
☐ High cholesterol ☐ Diabetes ☐ Celiac disease ☐ Anxiety
☐ High triglycerides ☐ Gout ☐ Pancreatitis ☐ Depression
☐ Infertility ☐ Polycystic Ovarian Syndrome
☐ Cancer (type/s): ____________________________________________
Have you ever be diagnosed with an eating disorder? Y / N   If yes, which one? ______________

Past surgical history (check all that apply):
☐ Gastric bypass ☐ Gastric banding ☐ Gastric sleeve ☐ Gall bladder ☐ Heart bypass
☐ Hysterectomy ☐ Other: ____________________________________

Medications (list all current medications and dosages):

______________ ______________ ______________ ______________
______________ ______________ ______________ ______________

Allergies:
(Medications)__________________________________________________
(Food)_______________________________________________________

## Social History

Smoking: ☐ Never ☐ Current smoker (_____ packs/day) ☐ Past smoker (quit _____ years ago)
Alcohol: ☐ Never ☐ Occasional ☐ Regularly (_____ drinks per day)
Prior treatment for alcoholism? Y / N
Drugs: ☐ Never ☐ Current ☐ Past ☐ Type of drugs: ________________
Marijuana: ☐ Never ☐ Current user (_____ times/day)

## Family History

Obesity (check all that apply): ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Diabetes (check all that apply): ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Other (check all that apply): ☐ High blood pressure ☐ Heart disease ☐ High cholesterol
☐ High triglycerides ☐ Stroke ☐ Thyroid problems ☐ Anxiety ☐ Depression
☐ Bipolar disorder ☐ Alcoholism ☐ Cancer (type/s): ______________________________

Other: ____________________

## Gynecologic History

Age periods started? _____ Age periods ended _____

Periods are: Regular / Irregular Heavy / Normal / Light

Number of pregnancies: _____ Number of children: _____

Age of first pregnancy: _____ Age of last pregnancy: _____

## System Review

(Check all that apply)

☐ Recent weight loss more than 10 pounds

☐ Recent weight gain more than 10 pounds

| | | |
|---|---|---|
| ☐ Acne | ☐ Skin rash | ☐ Cough |
| ☐ Snoring | ☐ Shortness of breath | ☐ Chest pain |
| ☐ Difficulty breathing when flat | ☐ Fainting/Blacking out | ☐ Palpitations |
| ☐ Swelling ankles/extremities | ☐ Abdominal pain | ☐ Bloating |
| ☐ Constipation | ☐ Diarrhea | ☐ Food intolerance |
| ☐ Dysphagia/difficulty swallowing | ☐ Indigestion | ☐ Nausea/vomiting |
| ☐ Increased appetite | ☐ Decreased appetite | ☐ Heartburn |
| ☐ Gas and bloating | ☐ Urinary frequency/urgency | ☐ Slow urine flow |
| ☐ Nighttime urination | ☐ Blood in stools | ☐ Back pain (upper) |
| ☐ Back pain (lower) | ☐ Joint pain | ☐ Muscle aches/pain |
| ☐ Dizziness | ☐ Headaches | ☐ Seizures |
| ☐ Weakness/low energy | ☐ Anxiety | ☐ Depression |
| ☐ Insomnia | ☐ Memory loss | ☐ Inability to concentrate |
| ☐ Mood changes | ☐ Nervousness | ☐ Loss of interest |
| ☐ Cold intolerance | ☐ Excessive sweating | ☐ Hair changes |
| ☐ Heat intolerance | ☐ Blood clots | ☐ Fatigue/tiredness |

**(Women only)**

| | | |
|---|---|---|
| ☐ Absence of periods | ☐ Hot flashes | ☐ Change in bladder habits |
| ☐ Abnormal/excessive menstruation | ☐ Facial hair | |

Comments: ______________________________________________

______________________________________________

______________________________________________

**Why I Want to Lose Weight...**

Before you begin your weight-loss journey, it is important to spend time reflecting on why YOU want to lose weight. Make sure that that these are personal motivators and are not intended to please others.

Reviewing this list frequently will help keep you on track and focused on your personal commitment to take control of your health!

1.________________________________________

2.________________________________________

3.________________________________________

4.________________________________________

5.________________________________________

Describe the physical benefits you hope to get by losing weight:

Describe the functional benefits you hope to get by losing weight:

Describe the medical benefits you hope to get by losing weight:

Describe the psychological benefits you hope to get by losing weight:

# PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: ______________________________ DATE: ____________

| Over the last *2 weeks,* how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)* | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| **1.** Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| **2.** Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| **3.** Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| **4.** Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| **5.** Poor appetite or overeating | 0 | 1 | 2 | 3 |
| **6.** Feeling bad about yourself—or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| **7.** Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| **8.** Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| **9.** Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |
| | add columns | ____ | + ____ | + ____ |
| *(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).* | TOTAL: | ____ | | |

| **10.** If you checked off *any problems,* 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 at all | ____ |
| Somewhat difficult | ____ |
| Very difficult | ____ |
| Extremely difficult | ____ |

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# Epworth Sleepiness Scale

Name: ______________________________

Date: ______________________________

Your age: (Yr) ______________ Your sex: ☐ Male ☐ Female

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:-

0 = would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

| Situation | Chance of dozing |
|---|---|
| Sitting and reading | |
| Watching TV | |
| Sitting, inactive in a public place (e.g. a theatre or a meeting) | |
| As a passenger in a car for an hour without a break | |
| Lying down to rest in the afternoon when circumstances permit | |
| Sitting and talking to someone | |
| Sitting quietly after a lunch without alcohol | |
| In a car, while stopped for a few minutes in the traffic | |
| Total | |

Score:

0-9 Normal Range
10-12 Borderline
13-24 Abnormal

# BED Screening Questionnaire

Please answer the following questions regarding your eating patterns and behaviors within the last 3 months. For each question, choose the answer that best applies to you.

| During the last 3 months, did you have any episodes of excessive overeating (i.e., eating significantly more than what most people would eat in a similar period of time)? | Yes | No |
|---|---|---|

*NOTE: IF YOU ANSWERED "NO" TO QUESTIONS 1, YOU MAY STOP, THE REMAINING QUESTIONS DO NOT APPLY TO YOU.*

| Do you feel distressed about your episodes of excessive overeating? | Yes | No |
|---|---|---|

| Within the past 3 months... | Never Or Rarely | Sometimes | Often | Always |
|---|---|---|---|---|
| **During your episodes of excessive overeating,** how often did you feel like you had no control over your eating (e.g., not being able to stop eating, feel compelled to eat, or going back and forth for more food)? | | | | |
| **During your episodes of excessive overeating,** how often did you continue eating even though you were not hungry? | | | | |
| **During your episodes of excessive overeating,** how often were you embarrassed by how much you ate? | | | | |
| **During your episodes of excessive overeating,** how often did you feel disgusted with yourself or guilty afterward? | | | | |
| **During the last 3 months,** how often did you make yourself vomit as a means to control your weight or shape? | | | | |

# Weekly Food Journal

| | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| Date | | | | | | | |
| Breakfast | | | | | | | |
| Lunch | | | | | | | |
| Dinner | | | | | | | |
| Snacks | | | | | | | |
| Calories | | | | | | | |
| Water | | | | | | | |
| Exercise | | | | | | | |

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## WEIGHT LOSS PROGRAM CONSENT FORM

I, ______________________________, authorize Dr. James Ervin 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)*

## RULES FOR USE OF ANTI-OBESITY CONTROL MEDICATIONS

NOTE: SIGNING THIS FORM DOES NOT GUARANTEE THAT YOUR PROVIDER(S) AT [your clinic name] 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 DR. JAMES ERVIN 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 Family Medical Clinic of Crystal Springs, PLLC will prescribe anti-obesity medications for me. I agree that it is my responsibility to inform my physician(s) at Family Medical Clinic of Crystal Springs, PLLC 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 Family Medical Clinic of Crystal Springs, PLLC any changes to my medical history or medication usage. I understand that failure to do so can be dangerous to my health.

I agree to take the medication only as prescribed and directed by Dr. James Ervin. 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 Family Medical Clinic of Crystal Springs, PLLC, 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 Family Medical Clinic of Crystal Springs, PLLC 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 Family Medical Clinic of Crystal Springs, PLLC.

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 Family Medical Clinic of Crystal Springs, PLLC 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 Family Medical Clinic of Crystal Springs, PLLC.

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 Family Medical Clinic of Crystal Springs, PLLC 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: ____/____/________

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Prepare for your InBody Test by adhering to the following instructions:

- Hydrate well the day before – consistent water
- Do not drink caffeine on the day of your test
- Do not eat for 3-4 hours prior to testing
- Do not exercise 6-12 hours prior to testing
- Do not take InBody Test after a shower or sauna
- Do not consume alcohol for 24 hours prior to testing
- Insure access to both feet with removable footwear (no socks or pantyhose)
- Do not wear jewelry- all jewelry will have to be removed prior to testing
- There is no need for lotion/ointment on your hands and feet
- Measure after standing for at least 5 minutes
- Warm up yourself for 20 minutes before a test performed in winter
- For females, avoid having measurement during menstrual period as total body water will be higher than normal
- Individuals with pacemakers or other electronic medical devices should not take the InBody Test

# *FAMILY MEDICAL CLINIC OF CRYSTAL SPRINGS, PLLC*
# *AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE OF HEALTH INFORMATION*

Patient Name ______________________________ Date of Birth ______________

Address ______________________________________________

Phone Number ______________________________ Fax Number ______________

☐ Request to Copy/Inspect **A signed copy of this Authorization will be provided to you.**

I authorize (Name of Facility) ______________________________

(Address) ______________________________
to use/disclosure health information about me as described below:

- ☐ Complete Medical Record
- ☐ History and Physical
- ☐ X-rays and reports
- ☐ Laboratory Test Results
- ☐ Immunization Record
- ☐ Other (List specific items) ______________

Date(s) of Service ______________________

This information may be disclosed to and used by the following:

*FAMILY MEDICAL CLINIC OF CRYSTAL SPRINGS, PLLC*
*104 WEST RAILROAD AVENUE, SOUTH*
*CRYSTAL SPRINGS, MS 39059*
*PHONE: (601)892-3063*
*FAX: (601)892-3570*

**For the purpose of:**

☐ Further Medical Care ☐ Insurance Eligibility/Benefits ☐ Inspection/Copying of my records
☐ Legal Investigation or Action ☐ Personal ☐ Changing Physicians
☐ Other (please specify) ______________________

This Authorization will expire ______________________ (a date or event).

This information is being provided from records whose confidentiality may be protected by State and/or Federal Law. I understand that this authorization is voluntary and I may refuse to sign this authorization. I acknowledge that Family Medical Clinic of Crystal Springs, PLLC will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits if applicable, on whether I sign this Authorization, unless (a) the treatment being provided is research-related and the Protected Health Information is to be used for the research; or (b) the health care that Family Medical Clinic of Crystal Springs, PLLC is providing is being provide solely for the purpose of providing the Protected Health Information to a third party.

I understand the information in my health record may include information relating to sexually transmitted disease acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about treatment of alcohol/drug abuse.

I understand that your facility may receive compensation for medical record copying in accordance with State Law.

I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the clinic's office manager. I understand that the revocation will not apply to information that has already been released in response to this authorization.

______________________________ ______________
Signature of Patient (or parent/guardian of minor) Date

______________________________________________
Name of Patient (Please Print) If patient is a minor, name of person signing and relationship to minor.

______________________________ ______________
Witness Date