Family Medical Clinic
of Crystal Springs, PLLC

James W. Ervin., Jr., M.D.
Jennifer M. Sojourner, CFNP
Mary Kamryn Brewer, CFNP

104 West Railroad Avenue South
Crystal Springs, MS 39059
Phone: 601-892-3063
Fax: 888-927-0375

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 will allow us to design the most effective weight loss program for you individually. The weight loss packet allows us to get a clearer picture of the factors contributing to your weight issues.

Please return the completed packet to our office.

*(**Please Note**: Once your completed packet is received by our office, it must be reviewed by Dr. Ervin; then someone from our office will contact you about an appointment.)*

Our packet includes:

1. ***Health History Questionnaires***-complete in as much detail as possible
   a. Patient Medical History Form
   b. Patient Health Questionnaire (PHQ-9)
   c. Epworth Sleepiness Scale
   d. BED Screening Questionnaire

2. ***Weight Loss Program Consent Form***– review and sign. This gives us permission to prescribe anti-obesity medications to assist with weight loss, if indicated.

3. ***Rules for Use of Anti-Obesity Control Medications***– review and sign

4. ***InBody Test Instructions***– at each visit a body composition analysis will be performed with our *InBody* scanner; following these instructions provides the most accurate scan

5. ***Authorization for Release, Use and Disclosure of Health Information***– complete and sign one authorization for each provider/medical office who has obtained lab work on you in the past 24 months.

FAMILY MEDICAL CLINIC OF CRYSTAL SPRINGS, PLLC

104 W. Railroad Avenue South
Crystal Springs, MS 39059
Phone: (601) 892-3063
Fax: (888) 927-0375

James W. Ervin, Jr., M.D.

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-9 (PHQ-9)

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 fidgety 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 in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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**
☐	☐	☐	☐

Family Medical Clinic of Crystal Springs, PLLC

EPWORTH SLEEPINESS SCALE (ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would *doze off or fall asleep* during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never *doze or fall asleep* in a given situation, and 3 meaning there is a very high chance that you would *doze or fall asleep* in that situation.

How likely are you to *doze off or fall asleep* in the following situations, in contrast to just feeling tired? Even if you haven't done some of the activities recently, think about how they would have affected you.

Use this 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

It is important that you circle a number (0 to 3) for EACH situation.

SITUATION	**CHANCE OF DOZING**			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (theater/meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (with no alcohol)	0	1	2	3
In a car, while stopped in traffic	0	1	2	3

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

TOTAL SCORE _____

Name: _____

Date: _____

Revised 06/22

BED Screening Questionnaire

Name:_____Date:_____

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?				

Family Medical Clinic
of Crystal Springs, PLLC

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 (VLC) 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 Name (printed) Witness

_____ _____

Patient Signature Date

(or signature of person authorized to consent for patient)

RULES FOR USE OF ANTI-OBESITY CONTROL MEDICATIONS

NOTE: SIGNING THIS FORM DOES NOT GUARANTEE THAT DR. JAMES ERVIN AT FAMILY MEDICAL CLINIC OF CRYSTAL SPRINGS, PLLC 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 Dr. James Ervin at 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 of 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 can 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 Dr. James Ervin is an experienced specialist 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 Dr. James Ervin 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 Dr. James Ervin 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: ____/____/_____

Family Medical Clinic
of Crystal Springs, PLLC

James W. Ervin., Jr., M.D.
Jennifer M. Sojourner, CFNP
Mary Kamryn Brewer, NP

104 West Railroad Avenue South
Crystal Springs, MS 39059
Phone: 601-892-3063
Fax: 1-888-927-0375

Quick tips to prepare for your InBody Analysis

For the most accurate results we recommend following these preparation guidelines.

- Do not eat for 3-4 hours before testing
- Do not exercise for 6-12 hours before testing
- Ensure access to both feet with removable footwear and socks
- Do not drink caffeine on the day of your test and be well hydrated
- Do not shower or sauna immediately prior to test
- Avoid putting lotion on hands and feet before testing
- Individuals with pacemakers or other electronic devices should not use the InBody
- For women, avoid testing if you are pregnant or menstruating
- Do Not Wear Jewelry while being tested

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 ***Family Medical Clinic of Crystal Springs, PLLC***
104 West Railroad Avenue, South
Crystal Springs, MS 39059
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:

Name_____

Address_____

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