Welcome to Our Practice

Please answer the following questions so we can better assist your healthcare needs.

Patient Information

Date_____ _____ Date of Birth_____/_____/_____

Name_____
(First name) Middle Initial) (Last Name) (Maiden)

Address_____Phone (____)_____
(street)

City_____State_____ Zip Code_____

Employer_____Occupation_____

Email Address_____

Emergency contact_____Phone_(_____)_____

Family Doctor/Family NP:_____ Their Phone :(_____)_____

How did you hear about us?

◯ Facebook ◯ Billboard (Please tell us if so! ☺)

◯ Google search

◯ Friend --Friend's name_____

Rivergate

Medical History

Name_____DOB_____Age_____Date_____

Date of last physical exam:_____

Physician's Name:_____Phone(_____)_____.

Medication allergies:
□ No Known drug allergies

_____ _____ _____

Current Medications:

Medication	Dose	Frequency	Medication	Dose	frequency

Social History

Sex: □ Female □ Male
Marital status: □ Single □Married □divorced □ widowed □separated
Tobacco use: □No □Yes if yes packs per day _____years_____
Caffeine Use: □ No □Yes if yes check all that apply □ coffee □Tea □soda □supplement
Alcoholic beverage consumption □ No □Yes if yes how much and how often_____

Medical History (circle all that apply)

High blood pressure Heart disease Diabetes stroke anxiety depression Asthma GERD Cancer High cholesterol Atrial fibrillation thyroid disease
Other_____

Surgical history (circle all that apply)

Appendectomy cholecystectomy thyroidectomy hemorrhoidectomy hysterectomy breast surgery tubal ligation colonoscopy hernia repair. Cesarean section Other_____

Family History:

Mother	Diabetes	Heart disease	HTN	Cancer	obesity	Strokes	Thyroid disease
Father	□	□	□	□	□	□	□
Sister	□	□	□	□	□	□	□
Brother	□	□	□	□	□	□	□
Grandmother	□	□	□	□	□	□	□
Grandfather	□	□	□	□	□	□	□
Aunt	□	□	□	□	□	□	□
Uncle	□	□	□	□	□	□	□

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Initial
Physician Supervised Weight Loss Program

Name_____ **D.O.B**_____ **Date**_____

What is your desired weight?(goal weight)_____
What is the most you have weighed ?_____ and how old were you?_____
What is the least you have weighed ? _____and how old were you?_____
What barriers to losing weight do you have? _____

1. Do you want to lose weight? □No □Yes
2. Are you willing to dedicate to a weight loss program? □ No □Yes
3. Do you have a history of Depression, Paranoia, or psychosis? □No □Yes
4. Do you have a history of Drug or Alcohol dependence? □No □Yes
5. Do you currently use illicit Drugs? □No □Yes
6. Are you ready for lifestyle change to be part of your weight control program? □No □Yes
7. Are you willing to keep a food Journal? □No □Yes
8. 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.
   - □Healthy meal plan Food delivered right to my door ready to eat
   - □ A program with protein shakes and one sensible dinner.
   - □what I really need is...

   _____

   _____

   What diet plans have you used in the past? (circle all that apply)

Calorie counting Fasting Nutrisystem Weight watchers Jenny Craig South beach Adkins Beach body Keto Medications? _____

Other_____

Physical activity (Exercise)

Frequency □daily □weekly or _____times per week.
For how long □15-30 min □30- 45 min □45-60 min or other_____
What activity (exercise) □Walking/jogging □strength training (weights) □biking □swimming □group fitness □exercise video □in home gym □gym membership □aerobics □ pilates/Yoga □other_____

Are you physically able to exercise □No □Yes

Review of Systems

PLEASE INDIVIDUALLY CHECK EACH CONDITION YOU CURRENTLY HAVE

Name: _____ Date of Birth: _____

Constitutional
- [] High Blood Pressure
- [] Fatigue
- [] Change in appetite
- [] Headaches/migraines

Ears/nose/mouth/throat
- [] Hearing loss
- [] Nosebleeds
- [] Trouble swallowing
- [] Bleeding gums
- [] Sore throat
- [] Problems with thyroid
- [] Sinus Trouble

Neurological
- [] Headaches
- [] Numbness/tingling
- [] Tremors
- [] Seizures/Epilepsy
- [] Stroke

Skin
- [] Rashes
- [] Lesions
- [] Ulcers
- [] Jaundice

Endocrine
- [] Thyroid issues
- [] Diabetes

Respiratory
- [] Cough
- [] Shortness of breath
- [] Wheezing
- [] Emphysema/COPD
- [] Asthma

Gastrointestinal
- [] Constipation
- [] Nausea/vomiting
- [] Abdominal pain
- [] Heartburn/acid reflux
- [] Irritable bowel syndrome
- [] Hepatitis Type _____

Musculoskeletal
- [] Joint pain/stiffness
- [] Muscle pain/weakness
- [] Back pain/problems
- [] Arthritis
- [] Carpal tunnel syndrome
- [] Fibromyalgia
- [] Gout

Cardiovascular
- [] Chest pain/angina
- [] Palpitations
- [] Murmur
- [] Swelling of feet/ankles
- [] Congenital Heart lesion
- [] Heart Disease
- [] Pacemaker
- [] High Cholesterol

Other
- [] Chemical dependency
- [] Chemotherapy
- [] Chronic fatigue syndrome
- [] Rheumatic Fever
- [] Scarlet Fever
- [] Tuberculosis
- [] HIV/AIDS

Eyes
- [] Glaucoma
- [] Eye glasses/contacts
- [] Blurred/double vision

Genitourinary
- [] Problems with urination
- [] Blood in urine
- [] Kidney stones
- [] Prostate enlargement
- []Polycystic Ovarian Disease (PCOS/PCOD)

Hematologic/lymphatic
- [] Bleeding/bruising tendency
- [] Blood clots
- [] Cancer
- [] Anemia (low blood count)
- [] Blood Disease

Psychological
- [] Bipolar
- [] Depression
- [] Anxiety
- [] Psychiatric care
- [] Stress

Please list any psychiatric history including diagnoses & treatments: _____

_____

_____

Please list & describe any other medical conditions not listed above: _____

_____

_____

Rivergate

ALL FEMALE PATIENTS SHOULD READ AND SIGN THIS PAGE

WOMEN ONLY-

Do you have regular periods? Yes No

Have you ever been pregnant? Yes No

Number of pregnancies_____

Please Circle one:

Have you ever had a tubal ligation (tying of tubes),

ablation, or hysterectomy? Yes No

Do you currently have an IUD or take birth control pills? Yes No

Have you ever been pregnant in the past 12 months? Yes No

If you answered yes, when did you deliver?_____

Vaginal/ C-section delivery?_____

Have you had your post-partum follow-up visit with your OB yet? Yes No

Are you currently breastfeeding? Yes No

PLEASE NOTE:

The medical providers and staff at Rivergate Medical, LLC recommend and strongly encourage the consistent use of contraception to avoid pregnancy during treatment with our medications for ALL females of childbearing age. This is due to the increased risk of teratogenicity (fetal harm/damage) with the use of our medications.

By signing below, I am stating that I have read this document and understand the importance of using contraceptive methods while taking these medications. I understand if I should become pregnant, I should discontinue the use of these medications immediately and report my pregnancy to Rivergate Medical and its healthcare providers.

_____ _____

Signature Date

_____ _____

Printed Name Date of Birth

_____ _____

Witness Signature Date

Rivergate

Patient Informed Consent For Appetite Suppressants

We want you to know that medical weight loss is an important 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 nutrition plans, exercise programs, and when appropriate use medicines short 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.

Procedures and Alternatives

I, _____(Patient) authorize Rivergate Medical, LLC to assist me in my weight reduction and maintenance efforts. I understand my treatment may involve the use of appetite suppressants for up to 12 weeks for short-term medications, and longer when indicated as indicated on the appetite suppressant labeling. I understand the use of many weight loss medications beyond 3 months is considered off-label usage.

Many weight loss medications are considered "controlled medications". By law, a controlled medication can only be received from one facility at a time, I agree that Rivergate Medical will prescribe scheduled weight loss medications for me. Rivergate Medical may also notify my other providers of the terms of this contract.

I have read and I understand the following:

1. I agree to take the medication only as prescribed by Rivergate Medical. I understand that taking medications in any way other than prescribed may be dangerous to my health.
2. I understand that controlled medications are not refilled in advance to time of refill. Medications are dispensed in one month increments and only via provider during provider appointment with appropriate vital signs. I understand that missing my appointment may mean being out of the medication for a time- up to 6 months.
3. I understand the Rivergate Medical is not obligated to replace any medications or prescriptions that are lost or stolen for any reason.
4. 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 and with notify Rivergate Medical of any changes to my medical history or new medication usage.
5. I understand that the medications prescriptions can be filled typically at any pharmacy of my choice. I agree to use only one pharmacy to fill any weight loss prescriptions.
6. I will not use any illegal drugs or substances. I will not obtain any controlled substances illegally.
7. I will not share, sell, or trade my medications with anyone. I understand doing so is illegal, will result in my discharge from the care of Rivergate Medical, and may cause harm to the other person including possible death.

I authorize Rivergate Medical 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.

Risks of proposed treatments

I understand the possible side effects of weight loss medications can include but is not limited to: reduced weight, reduced or abnormal electrolyte levels, gallstones, pancreatitis, nervousness, sleeplessness, headaches, dry mouth, weakness, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could be serious or fatal.

Your role

1. Your role is to provide honest and complete answers to questions about your health, weight problem, eating activity, medications 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. Make and keep follow-up appointments so that we can help you best, allowing necessary blood tests as needed. Patient more than 15 minutes late may be rescheduled.
4. Advise the provider of any concerns problems, complaints, symptoms or questions you develop.
5. Inform your personal physician of your weight loss efforts and have or establish a primary physician before beginning this program.
6. Notify us if you become pregnant and immediately stop any weight loss medications.

Risks associated with being overweight or obese

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendenceies related to high blood pressure., diabetes, heart disease and arthritis.

No Guarantee

I understand that much of the success of the program will depend on my effors and that there are no guarantees or assurances that the program will be successful. I also understand that I have to continue watching my weight all of my life if I am to continue being successful.

Rivergate Medical LLC reserves the right to refuse service to any patient.

_____ _____

Signature of patient Date

Rivergate

I, _____(patient), wish to enter into the weight loss program directed by Dr. Michael Bobb, DO, or Arlie Bobb, CNP. I understand this program includes diet, exercise, behavioral and lifestyle changes, and appetite suppressants when appropriate. I understand that the abuse or overuse of appetite suppressants is potentially life-threatening and illegal.

Appetite suppressants are controlled substances that are regulated by State and Federal Laws. I understand pursuant to State and Federal Laws prescriptions for controlled substances cannot be filled any sooner than once every 4 weeks. I understand I will not and cannot, for any reason, receive refills on prescriptions for appetite suppressants any earlier than once every 4 weeks.

I understand that if I participate in the acquisition of appetite suppressants for multiple healthcare providers, for any reason, I am participating in and illegal action and may be held liable for criminal activity.

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.

This notice describes how medical information about you may be used and disclosed, how you can get access to this information (HIPAA)
Uses and discloses 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, she does show an administrative proceedings, law enforcement, organ donation, research, Worker's Compensation, appointments and services, marketing, his associates, military, inmate or person in police custody, corners, medical examiner's, funeral directors.

Uses and discloses of information that we may make unless you object: We may use and disclosed protected health information in the following instances without your written authorization unless you object- disaster relief and persons involved in your case. Persons involved in your healthcare: Unless you object, we may disclose protected health information to a family member, 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 were payment. We may leave messages for you to call us or leave basic lab tests results on your home phone unless you direct otherwise.

You have the following rights concerning her protected health information. She requests additional restrictions, to receive communications by alternative means, to inspect and copy records, to request a measurement here record, to request accounting of certain disclosures, to receive a copy of our complete confidentiality noticed, to receive a notice of a breech, the right to restrict certain disclosure to her health plan.

Financial Policy:

This is to inform you of our billing requirements and our financial policy. Please be advised that payments for all services will be due at the time services are rendered. We accept Cash, credit cards, and flex spending cards. We do not accept checks.

No refunds.

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

Signature of Participant: _____ Date:_____

Witness: _____ Date: _____

I have explained the contents of this document to the patient and have answered all of the patient related questions, to the best of my knowledge. I feel this 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 an overweight state. After being adequately informed, the patient has consented to treatment involving suppressants in the manner indicated above.

_____ _____

Healthcare Practitioner Date