Larry A. Richardson, M.D., P.A.

1230 Rayford Bend
Spring, TX 77386
281-292-2300

To be completed by staff

BMI _____ % Body Fat_____

Date: _____
Of Appointment

MEDICAL HISTORY QUESTIONNAIRE

Do **NOT** leave any questions **BLANK**

CONTACT via EMAIL ☐ **Y** ☐ **N**

Email: _____

Social Security No.: _____ Driver's License No.: _____ State: _____
(MUST HAVE)

Name: _____ Sex: _____ Age: _____ DOB: _____
Last First Middle Mo/Day/Yr.

Address: _____ City: _____ State: _____ Zip: _____

Mailing Address for correspondence from this office: (if different) _____

Phone: Home: (___) _____ Work: (___) _____ Marital Status: Sgl Mar Wid Div Se

Cell: (___) _____ E-mail: _____

Occupation: _____ Employer: _____

Spouse's Name: _____ Phone: (___) _____ Employer: _____

Alternate Contact: Name/Address: _____ Phone: (___) _____

Relative's Name/Address: _____ Phone: (___) _____

Family Physician: _____ Date Physician Last Seen: _____ Reason: _____

ALLERGIES TO MEDICATION: _____

Write "NONE" if no medication allergies

Please check any of the following medications you are presently taking and list drug and dosage

- ☐ Birth Control Pills, Patches, Shots, IUDS _____
- ☐ Hormones (include shots) _____
- ☐ Allergy Sinus Medication (include shots) _____
- ☐ Fluid/Water Pill _____
- ☐ Insulin or other Diabetic Medications _____
- ☐ Over the Counter Medications _____
- ☐ Vitamins, Herbs _____
- ☐ **Present Medications not listed above (include dosage if known)** _____

GENERAL (Check Appropriate Box)

Y	N	
☐	☐	Alcohol use
☐	☐	Beer, whiskey, Wine, Cocktail – Amt _____ per week
☐	☐	Emotional/Social Problems (including sexual)
☐	☐	Prior use marijuana, cocaine, amphetamines. When? _____
☐	☐	**SMOKE** (circle): Cigarettes, Cigar, Pipe – Amt _____
☐	☐	Coffee/Tea/Colas: _____cups/oz. per day
☐	☐	Exercise Regularly _____ type
☐	☐	Recent weight change _____lbs. lost/gained

Rate your General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Rate your Physical Fitness: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Rate your Mental State: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Self & Family Status

Health Status (Check if positive / yes)	**Self**	**Parents**	**Brothers Sisters**
Cancer……	☐	☐	☐
Diabetes……	☐	☐	☐
Epilepsy or Blackouts…….	☐	☐	☐
Glaucoma ……	☐	☐	☐
Heart Attack (MI)……	☐	☐	☐
High Blood Pressure……	☐	☐	☐
Liver Problems / Hepatitis…..	☐	☐	☐
Migraines……	☐	☐	☐
Stroke……	☐	☐	☐
Thyroid Problems……	☐	☐	☐

☐ **Check here if none of the ABOVE apply to you**

HISTORY OF MEDICAL PROCEDURES AND HOSPITALIZATIONS

	Comments	**Date**
List Previous Hospitalizations or surgeries	_____	_____
	_____	_____
	_____	_____

REVIEW OF SYSTEMS

For this section, please check ANY problem you have had. WRITE IN THE LAST TIME YOU EXPERIENCED that problem NEXT TO the item checked AND how frequently that problem (I.e. none, currently, daily, weekly, monthly, yearly, etc.). Please include this information, AS WELL AS when the problem checked started AND how it is being treated (if it is being treated)

CENTRAL NERVOUS SYSTEM

- ☐ Excessive moodiness/PMS
- ☐ Fatigue
- ☐ Depression
- ☐ Seizures
- ☐ Blackouts
- ☐ Shakiness/nervousness
- ☐ Fainting Spells
- ☐ Headaches
- ☐ Tingling
- ☐ Double vision
- ☐ Dizziness
- ☐ Blurred Vision
- ☐ Difficulty Sleeping
- ☐ Numbness
- ☐ Other _____

SENSORY SYSTEM

- ☐ Nosebleeds
- ☐ Sore throats-frequent
- ☐ Swallowing problem
- ☐ Hoarseness
- ☐ Ringing in ears
- ☐ Other _____
- ☐ Hearing Loss
- ☐ Sinusitis/Sinus Congestion

CIRCULARTORY/RESPIRATORY SYSTEM

- ☐ Angina/chest pain
- ☐ Swollen ankles or feet
- ☐ Previous heart attack
- ☐ Irregular pulse
- ☐ Shortness of breath
- ☐ Heart murmur
- ☐ Leg pain with walking
- ☐ Bruise easily
- ☐ Pleurisy
- ☐ Rheumatic fever history
- ☐ Anemia; Varicose veins
- ☐ Palpitations (fast beats)
- ☐ Cold numb feet
- ☐ Asthma; Emphysema
- ☐ Other _____

DIGESTIVE SYSTEM

- ☐ Ulcer
- ☐ Abdominal pain - chronic
- ☐ Irritable bowel/colitis
- ☐ Indigestion/heartburn
- ☐ Hiatal hernia
- ☐ Gall bladder trouble
- ☐ Diverticulitis
- ☐ Constipation
- ☐ Stomach ache
- ☐ Diarrhea (Chronic)
- ☐ Hemorrhoids (piles)
- ☐ Other _____

GENITO-URINARY SYSTEM

- ☐ Currently on dialysis
- ☐ Stones (Calculi)
- ☐ Difficult/painful urination
- ☐ Decrease in force of urine
- ☐ Kidney removed or missing
- ☐ Trouble with urine control
- ☐ Excess urination (day/night)
- ☐ Sugar, albumin, or pus in urine
- ☐ Other _____

MUSCOLO-SKELETAL SYSTEM

- ☐ Joint pain (Where: _____)
- ☐ Arthritis
- ☐ Back pain
- ☐ Muscular aches or cramps
- ☐ Weakness of hands/legs/feet
- ☐ Muscle jerking
- ☐ Gout
- ☐ Joint swelling (Where:_____)
- ☐ Other _____

INTEGUMENTARY SYSTEM

- ☐ Change in Skin
- ☐ Rash
- ☐ Change in hair (Describe)
- ☐ Other _____
- ☐ Polyp/Tumor/Cancer

(Where: _____)

FEMALES ONLY

	Y	N		Y	N
Currently nursing a baby?	☐	☐	Regular menstrual cycle if no, what problems do you have: _____	☐	☐

REMINDER: Did you remember to list last occurrence/frequency of all problems checked above?

Have you taken fluid/water pills in the past? ☐ Y ☐ N How long ago? _____

_____

If you have taken fluid/water pills in the past, please give details on this line: name, frequency, for how long, side effects, how effective, etc.

_____

Are you currently on fluid/water pills? _____ how long on them? _____ take how often? _____

Name of pill: _____

What is your height? _____ Present weight? _____ How long at present weight? _____

What do you think is your ideal weight? _____ Your personal goal weight? _____

Have you ever taken any appetite suppressants? ☐ Y ☐ N If YES please give details asked for below:

_____

Name of drug	**year taken in**	**for how long?**	**list any side effects or other remarks**

_____

Name of drug	**year taken in**	**for how long?**	**list any side effects or other remarks**

How did you hear about this physician's practice? (If through a friend/relative, please list name): _____

INSURANCE: Those wishing to file office visits with their insurance company should also list on a separate sheet of paper any medical problems (see opposite page) you are hoping to help improve with weight reduction. Besides listing the problem, you MUST also list (1) how long you have had this problem, (2) when it was first diagnosed and by whom, (3) how it has been treated (medications, therapy, etc.), and what results you have had to date. This is also true if you have had previous weight reduction attempts – list program(s), dates, amounts lost, how successful, etc. as this information is generally required by many insurance carriers when considering coverage of claims.

IMPORTANT NOTICE: Pregnancy is advised against while on many pharmacological agents. If there is the slightest chance you are currently pregnant, you MUST perform a pregnancy test/check BEFORE starting any medications prescribed by this physician. Since weight loss can affect hormonal balance, other contraception (such as abstinence, condoms, etc.) in addition to or besides birth control pills should be utilized during susceptible times of your menstrual cycle as a precautionary measure. If unsure of when this is, consult your gynecologist or family physician.

BE ADVISED that almost any form of medical/pharmacological therapy is not without risks and benefits. Patients losing weight, especially large amounts in short periods of time, can have a higher incidence than the general population of problems, including (but not limited to) low blood glucose, electrolyte imbalances, weakness, mood swings, hair loss, cardiac (heart) irregularities, loss of muscle and lean body tissue, menstrual irregularities, infertility, skin changes, cold intolerance, constipation, nervousness, restlessness, irritability, euphoria, lack of concentration, insomnia, elevated or lowered blood pressure, rapid heart rate, chest heaviness or pain, itching, and/or rashes.

ALSO, BE ADVISED that weight loss can cause an increase in cholesterol supersaturation of bile, as well as decreased gallbladder concentration and increased biliary stasis which may lead to the formation of gallstones. Such an event can potentially lead to a gallbladder attack possibly requiring treatment or gallbladder removal (surgery). However, other risk factors for potential gallbladder problems include obesity, age over forty, and being female. It will be your choice to participate in weight reduction having been informed of these potential complications.

OF COURSE, excessive weight may also have many other potential risks, including (but not limited to) diabetic tendencies, gallbladder attacks, arteriosclerosis, stroke, cancers, coronary events, and other heart problems. It is the responsibility of each individual patient to discuss their concerns and medical problems with the physician.

BY SIGNING below, I indicate that I understand the information listed above and WILL NOT START ANY THERAPY by this physician until I have been given an opportunity to ask questions about my condition, alternate forms of treatment, risks of non-treatment, the treatment and medications to be used, and the risks and hazards involved. I also understand that ALCOHOL use while on this programs' medication and while attempting to reduce weight is ADVISED AGAINST by this physician.

I AGREE to contact this physician at the first sign of any complications in conjunction with this treatment program. I also certify that the information I have supplied on this chart is complete and accurate.

X_____ _____

(Patient/Guardian Signature) (Date)

Witness _____

**** DO NOT WRITE ON THIS PAGE****

PHYSICAL EXAMINATION SHEET

MEASUREMENT DATA:

Height: _____ Gender ____M____F Weight: _____

Blood Pressure: _____ Pulse: _____ BMA/BMI: _____ % Body Fat: _____

Circumference: Neck_____ Waist_____ Hip_____ Waist to Hip Ratio:_____

General Appearance: Good___ Fair___ Poor___ Explain: _____ Birthday_____ Age_____

Oriented x 3, Person___ Place___ Date___ Neg/Normal: _____ Detected: _____

PHYSICAL EXAM:

HEAD & NECK	**Neg/ Normal**	**Defect**		**Neg/ Normal**	**Defect**		**Neg/ Normal**	**Defect**
Head	☐	☐ _____	Pupils	☐	☐ _____			
Neck Glands	☐	☐ _____	Pharynx	☐	☐ _____			
CHEST								
Lungs	☐	☐ _____	Heart	☐	☐ _____	Murmur	☐	☐ _____
ABDOMEN								
Abnormal masses	☐	☐ _____	Tenderness	☐	☐ _____			
EXTREMITIES								
Varicose veins	☐	☐ _____	Edema	☐	☐ _____	Cold	☐	☐ _____
Ulcers	☐	☐ _____	Deformities	☐	☐ _____			
JOINTS								
Inflammation	☐	☐ _____						
SKIN								
Rashes	☐	☐ _____	Scaling	☐	☐ _____	Discoloration	☐	☐ _____
Tattoos	☐	☐ _____						

ASSESSMENT:

Primary Diagnosis code E66.3 Adiposity, Excess Weight _____

Additional Diagnosis codes referred to Patients Primary Care Physician: _____ 272.0 Elevated Cholesterol,

_____ 796.2 Elevated Blood Pressure, _____ 401.9 Hypertension, _____ 719.4 Joint Pain, _____ 277.7 Insulin Resistance

_____ 250.0 Diabetes, _____

Patient needs counseling with MA _____ No? _____ Yes? Reviewing the following checked subjects:

- _____ Behavior Modification Therapy
- _____ Essential Nutrition Information
- _____ Nutritional Nuggets
- _____ Exercise Guidelines
- _____ Successful Patient Guidelines

Plan:

- _____ Medications continued with: No Changes
- _____ Begin Medication Regimen
- _____ Patient will work toward appropriate intervals
- _____ Testing will be monitored at appropriate intervals
- _____ Patient verbalizes understanding of program goals along with medication use and precaution
- _____ Risks, benefits and side effects outlined in Appetite Suppression Informed Consent Form were discussed
- _____ Recommended Calories
- _____ Patient verbalized understanding: _____ YES _____ NO-Refer for counseling

_____, M.D.

Signature of Examiner _____

OFFICE POLICY AGREEMENT

As a patient of Family Weight & Wellness Clinic•Medi-Spa, I agree to adhere to office policies stated below. I understand that these policies are in place to ensure that my care is not delayed or interrupted due to scheduling or financial issues. I also understand they are in place to ensure that the schedules of the health care providers and other patients are not delayed or interrupted.

- I agree to arrive at least 15-20 minutes (or 30 minutes if I am a new patient) prior to my scheduled appointment time to check in and complete or update any patient information forms. As a courtesy to other patients, we request that you arrive on time. If you arrive later than your designated appointment, you may be asked to reschedule.
- I understand that it is my responsibility to provide current and complete personal and medical information, contact addresses and phone numbers, prior to my appointment and on an ongoing basis afterward.
- I understand that all the payments must be paid prior to my appointment and if I am unable to do so, my appointment will be rescheduled.
- As a part of my health monitoring while participating in the weight management program, I understand that after my initial visit, I will have a repeat ECG (electrocardiogram) performed six (6) months later, and then yearly after that. I will have screening blood work on my initial visit, and if results are normal, this testing will be performed yearly. **These monitoring procedures may be performed at different intervals if my medical condition(s) warrant more frequent monitoring.**
- If I am unable to keep my appointment, I understand that I must notify Family Weight & Wellness Clinic•Medi-Spa at least 24 hours before my appointment time. After two no-shows without 24-hour advance notification, my account will be charged with a no-show fee per incident at $25 per no show for an office visit.
    - The no-show fees are part of my account balance and must be paid BEFORE my next appointment can be scheduled.

I agree to adhere to all the above office policies of Family Weight & Wellness Clinic•Medi-Spa.

_____	_____	_____
Name (Printed)	**Signature**	**Date**

PATIENT FINANCIAL AGREEMENT

Thank you for allowing our office the privilege of serving your medical needs. Family Weight & Wellness Clinic•Medi-Spa is a place where the genuine care and welfare of our clients is our highest mission. That is why it is very important that you completely understand our financial policies. Please read the listed information and contact your account representative or our office at any time with questions.

1. You must remit your payment in full at the time the services are rendered.
   For your convenience, we accept cash, Master Card, Visa, Discover, American Express and CareCredit. ***We do apologize for any inconvenience as we do not accept checks.***
2. Your insurance is a contract between you, your employer and the insurance company. **We are not a party to that contract**. Therefore, you are ultimately responsible for all charges incurred with our office from the date the services are rendered.
3. If any Pre-certifications are required by your insurance company for any testing or treatment, you are responsible to contact them. This is ultimately the responsibility of the patient or insured person, and our office cannot be held responsible.
4. Occasionally, insurance companies require your medical records in order to process our claims. By signing below, you are also authorizing Family Weight & Wellness Clinic•Medi-Spa to send your complete medical records to your insurance company once they are requested.

Notes:

- If you have any questions regarding our financial policies, please don't hesitate to ask us. We are here to help you.
- By my signature, I certify that I have read and agree to the terms of the above and understand I am fully responsible for any charges incurred.
- A photocopy of this document shall be considered as effective and valid as the original.

_____	_____
Signature of Patient	Signature of Witness
_____	_____
Printed Name of Patient	Printed Name of Witness
_____	_____
Date	Date

No Show / Cancellation policy Effective March 1, 2019

Due to the nature and availability of our practice it is important to us that we have a No show / Cancellation policy in place. This also will give our guests on the waiting list an opportunity to be seen earlier if possible.

Therefore, we require at least a **24 hour notice prior to your wellness appointment or 48 hour notice prior to your cosmetic appointment if you are unable to keep it as scheduled**. If you do not call to cancel your appointment within that 24 hour wellness or 48 hour cosmetic window, there will be a $50 fee charged to your credit card at the end of that business day.

CREDIT CARD AUTHORIZATION:

Patient name: _____

Name on card: _____

CC #: _____

CC type (circle): MasterCard VISA AMEX Discover CareCredit

Exp date: _____ 3 digit code _____

Cardholder signature: _____ Date: _____

By signing, I understand and I have read the No Show/ Cancellation Policy for Family Weight & Wellness Clinic•Medi-Spa.
This policy will also help us expedite any orders, supplements or cosmetics you may need shipped directly to you from our office the same day the order is placed.

OR

DISCONTINUE CREDIT CARD BILLING:

By discontinuing my credit card authorization, I understand my account will still incur charges as set forth in the No show/ Cancellation policy. Also, as a new guest, with this discontinuation or without a valid credit card on file, I understand I am not guaranteed that my appointment time will be held without confirmation.

Date: _____ Signature: _____

1230 Rayford Bend, Spring, TX 77386 • Phone 281-292-2300 • Fax 281-367-0605

NOTICE TO ALL MEDICARE, MEDICAID, CHAMPUS, WPS &/ OR TRICARE BENEFICIARIES

Family Weight & Wellness Clinic•Medi-Spa does not participate in Medicare, Medicaid, Champus, WPS or TriCare programs and has chosen to opt out of Medicare. Family Weight & Wellness Clinic• Medi-Spa has found that due to the minimalistic fees allowed by these government agencies, we are unable to meet overhead expenses. Family Weight & Wellness Clinic•Medi-Spa is a Free Enterprise and would like to be able to extend quality medical care to you; however, due to the rules instituted by the government of the United States pertaining to these government agencies, the practice is unable to administer medical care to patients covered by them unless you read and sign the attached Waiver.

WAIVER

I understand that Family Weight & Wellness Clinic•Medi-Spa is not a Medicare, Medicaid, Champus, WPS or TriCare provider and has chosen to opt out of Medicare.

I accept full financial responsibility for any charges incurred.

Further, I understand that by signing this form, I waive my right to seek reimbursement from Medicare, Medicaid, Champus, WPS or TriCare or file any claims to Medicare, Medicaid, Champus, WPS or TriCare for these services. Additionally, I understand that I am unable to file to Medicare, Medicaid, Champus, WPS or TriCare even if it is merely to get a denial in order to file to any other insurance policies.

☐ I do not have Medicare or Medicaid

_____	_____
Signature of Patient	Signature of Witness
_____	_____
Printed Name of Patient	Printed Name of Witness
_____	_____
Date	Date

HIPAA POLICY

Our notice of privacy practices provides information about how we may use and disclose protected health information about you. The notice contains a patient rights section describing your rights under the law. You have the right to review our notice before signing this consent. The term of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how we protect health information about you if it's used, disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review the notice.
- The practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information, but the practice does not have to agree to those restrictions.
- The patient may revoke this consent at any time and all future disclosures will then cease.
- The practice may condition treatment upon execution of this consent.

I authorize Family Weight & Wellness Clinic•Medi-Spa to release my medical records or insurance information as necessary to process my medial claims and coordinate or manage my health care.

Due to HIPPA, the following information must be updated **by each patient annually**:

HIPAA - ACKNOWLEDGEMENT OF REVIEWOF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Names and Phone/Fax Numbers/Email of individuals who are authorized to receive my medical information:

1 _____

2 _____

3 _____

4 _____

(Circle Y or N)
Y N It is ok to send me an e-mail
Y N It is ok to send me a postcard/flyer/newsletter

For telephone messages on your voicemail or cell phone, please check one of the following:-

1. ____ OK to leave a message re: items such as lab results, vitamins, refills etc.
2. ____ Please do not leave specific message but a general message is OK.
3. ____ Do not leave any messages at all.

_____
Signature of Patient / Parent if minor

_____ _____
Printed Name of Patient Printed Name of Parent if minor

_____ _____
Date Relationship to Patient

Changes to this document must be submitted in writing. This Form is in compliance with HIPPA guidelines. A copy of these guidelines is available upon request.