Demographic Information

Name:_____ Date of Birth:_____
Last First Middle

Address:_____

City/State:_____ Zip Code:_____

Home #:_____ Cell #: _____ Work #: _____

Sex: Male / Female (circle) Age:_____ Marital Status: S M D W (circle)

Insurance:_____

Employer:_____ Occupation: _____

Emergency contact:_____

Relationship: _____ Phone: _____

Primary Care Physician information:

Name:_____ Phone:_____

Address:_____ City/State:_____ Zip:_____

Labs:

Labs ordered by PCP:

Date:_____ RN initials:_____

Family History

Has anyone in your family had any of the following: (Place an X on "GP" if grandparent, "M" if mother, "F" if father, "S" if siblings, and "C" if one or more children):

High blood pressure	GP	M	F	S	C	_____
High cholesterol	GP	M	F	S	C	_____
Heart disease	GP	M	F	S	C	_____
Stroke	GP	M	F	S	C	_____
Diabetes	GP	M	F	S	C	_____

Additional Comments:

_____
_____
_____
_____

Personal Medical History:

Max. Adult Weight:_____

Previous weight reduction methods:_____

_____

Circle "Yes" or "No" to the following questions:

1.	Are you pregnant?	Yes	No
2.	Are you breastfeeding for less than twelve weeks and would like to continue breastfeeding?	Yes	No
3.	Do you have an active eating disorder such as anorexia or bulimia?	Yes	No
4.	Are you taking anti-seizure medications (e.g., Trileptal®) or antipsychotic medications?	Yes	No
5.	Have you had bariatric surgery /gastric bypass/banding surgery (Lap Band®) within the last 12 months?	Yes	No
6.	Do you have heart disease or have had an abnormal ECG or stress test?	Yes	No
7.	Do you have kidney disease, a history of kidney failure, or dialysis?	Yes	No
8.	Do you have liver disease?	Yes	No
9.	Are you taking any medications that requires frequent medical monitoring (e.g., bloodwork) such as Coumadin, lithium or ant seizure medication?	Yes	No
10.	Are you under the age of 18?	Yes	No

Have you had any of the following medical illnesses / events? If so, please provide appropriate information.

Illness:	Date of Onset:	Date of hospitalization and / or surgery:	Comments:

Thyroid disorder _____

Tuberculosis _____

Rheumatic fever _____

Heart disease / failure

(e.g., stroke/heart attack/surgery) _____

High blood pressure _____

Kidney disease/Kidney stones _____

Liver disease _____

Ulcer disease _____

Bowel disease _____

Psychiatric conditions

(e.g., depression, anxiety attacks, bipolar disorder, schizophrenia) _____

Thrombophlebitis (blood clots) _____

Diabetes / Pre diabetes _____

Sleep apnea- CPAP? Y/N _____

Gout _____

Asthma _____

Gallstones _____

Cancer _____

Seizure disorder _____

Substance/Alcohol addiction _____

Surgeries _____

Other current medical conditions or chronic illness:

_____

_____

_____

_____

Review of Systems

Do you presently have any of the following? (circle Yes or No)

Cardio-Respiratory			Comments:
Chest Pain / pressure	Yes	No	_____
Rapid or irregular heart beat	Yes	No	_____
Shortness of breath	Yes	No	_____
Swelling of legs and / or feet	Yes	No	_____
Gastro-Intestinal			
Indigestion or heartburn	Yes	No	_____
Nausea or vomiting	Yes	No	_____
Bowel movements:			
Average frequency: Per day:_____ Per Week: _____			
Constipation	Yes	No	_____
Diarrhea	Yes	No	_____
Abdominal cramps/bloating	Yes	No	_____
Abdominal pain	Yes	No	_____
Gallbladder symptoms	Yes	No	_____
Musculoskeletal			
Joint pain	Yes	No	_____
Swelling of joints	Yes	No	_____
Back pain	Yes	No	_____
Other			
Daytime sleepiness	Yes	No	_____
Loss of hair	Yes	No	_____
Physical Activity			
Do you consider yourself an active person	Yes	No	_____
Do you do physical activity on a regular basis	Yes	No	_____
If so, what type?_____			
How many times per week? _____			
Do you walk a mile or more a day?	Yes	No	_____
Do you have any physical restrictions during activity?	Yes	No	_____
Psychological			
Are you presently involved in individual or group counseling or therapy?	Yes	No	_____

Allergies

Have you ever had a reaction to any of the following:			If yes, please explain:
Milk/Dairy products	Yes	No	_____
Soy products	Yes	No	_____
Wheat gluten	Yes	No	_____
Other food	Yes	No	_____
Drugs or medication	Yes	No	_____

Do you ever use the following?			Amount and frequency:
Tobacco	Yes	No	_____
Alcohol	Yes	No	_____

Do you have other medical issues or concerns?	Yes	No	If yes, please explain:

_____
_____
_____
_____

Medication History

Are you currently using any of the following medications?

Blood pressure medication	Yes	No
Cardiac medication	Yes	No
Antidepressants	Yes	No
Pain medication	Yes	No
Antacids	Yes	No
Anti-coagulants (blood thinners)	Yes	No
Weight-loss medication	Yes	No
Diabetes medication	Yes	No
Gout medication	Yes	No
Stomach medication	Yes	No
Thyroid medication	Yes	No
Anti-seizure medication	Yes	No
Medication to treat schizophrenia	Yes	No
Medication to treat bipolar disorder	Yes	No
Laxatives	Yes	No
Aspirin	Yes	No
Other medications (include non-prescription items)	Yes	No

Please list current medications and dosage including vitamins, herbal supplements and over the counter medications:

Drug	**Dose and Frequency**

The information contained in this document is true and complete.

Patient Signature:_____ Date:_____

Oklahoma Heart Institute

Sleep Care

Name _____ DOB _____

Height _____ Weight _____
Age _____ Male/Female

STOP-BANG Obstructive Sleep Apnea (OSA) Questionnaire

Chung F et al Anesthesiology 2008 and BJA 2012

STOP		
Do you **SNORE** loudly (louder than talking or loud enough to be heard through closed doors)?	YES	NO
Do you often feel **TIRED**, fatigued, or sleepy during daytime?	YES	NO
Has anyone ever **OBSERVED** you stop breathing during your sleep?	YES	NO
Do you have or are you being treated for high blood **PRESSURE**?	YES	NO

BANG		
BMI more than 35kg/m?	YES	NO
AGE over 50 years old?	YES	NO
NECK circumference greater than 16 inches (40 cm)?	YES	NO
GENDER: male?	YES	NO
TOTAL SCORE		

High risk of OSA: Yes to 3 or more questions
Low risk of OSA: Yes to less than 3 questions

Untreated OSA carries serious long term consequences including heart disease, stroke, diabetes, car accidents, sexual dysfunction and death. For this reason, it is strongly recommended that you have a formal evaluation for OSA from a sleep medicine center. Take this form to your primary care physician, or contact Oklahoma Heart Institute Sleep Care at 918-592-0999, option 2, to arrange an evaluation by a board-certified sleep physician who can advise any necessary testing and treatment.

THE EPWORTH SLEEPINESS SCALE

The Epworth Sleepiness Scale (ESS) was developed and validated by Dr. John Murray of Melbourne, Australia. It is a simple, self-administered questionnaire which is widely used by sleep professionals in quantifying the level of daytime sleepiness.

Name:_____

DOB:_____

Date:_____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not 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 lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL SCORE	_____

Authorization to Use and Disclose Images, Voice Recordings and/or Testimonials

Patient Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

1. I hereby authorize Hillcrest HealthCare System ("Provider") to use and disclose the following information about the individual listed above ("Patient"): (a) photographs, digital images and other visual recordings that contain Patient's image, likeness and/or other Patient identifiable health information, including, if applicable, images of Patient taken before and after the receipt of services from Provider; (b) recordings of Patient's voice and other audio recordings containing Patient identifiable health information; (c) biographical information and other protected health information about Patient, including any information included in testimonials or reviews provided by Patient in oral, written, video or other form; and (d) information indicating that Patient received medical services from Provider and describing such services and Patient's diagnosis.

2. Provider may use and disclose the information described above in, and the create, marketing materials, publications, websites, presentations, advertisements and any other distribution media, including using and disclosing Patient's information in print media, on the radio, TV, Provider's website, blogs and social media platforms such as Facebook, Twitter, LinkedIn and YouTube. Any person or entity who receives, encounters or views these items or accesses Provider's website, marketing materials or other media may obtain this information. The purpose of this use and/or disclosure is to promote and provide publicity to Provider. Provider may contract with third parties to capture the image, voice or other information described above, and the information may be used and disclosed by these third parties consistent with this authorization.

3. This authorization will remain in effect until revoked by Patient unless state law requires a shorter time period. This authorization may be revoked at any time by sending a written notice to Provider at Hillcrest HealthCare System, Attn: Privacy Officer. However, expiration and/or revocation will not effect on any uses or disclosures already made by Provider in reliance on this authorization. For example, Patient's information may continue to appear in promotional materials created or released by Provider prior to receiving the revocation for so long as those materials are distributed, disseminated or have not expired, and information may continue to be available on the internet, social media and other media for an indefinite time even when it is no longer included on Provider's website or Provider's other promotional materials. Once Patient's information is used and/or disclosed pursuant to this authorization, it may be further used or disclosed by the recipient(s) and may not be protected by the HIPAA Privacy Rules (45 CFR Parts 160 and 164). I understand that I may refuse to sign this authorization and that Provider will not condition treatment pf Patient on whether I sign this authorization.

4. Patient will receive no financial compensation for the use of Patient image or other information as described in this authorization. Provider **will not** receive financial

remuneration (compensation) from third parties in exchange for the use and disclosure of Patient's information.

Signature: _____ Date: _____

Print name: _____

If signed by personal representative, describe relationship: _____

*This Form to be used in conjunction with the Form entitled "**Authorization to Use and Disclose Images, Voice Recordings and/or Testimonials**"

APPEARANCE, PHOTOGRAPHY, MEDIA AND TESTIMONIALS CONSENT AND RELEASE

I, the undersigned, authorize **Hillcrest HealthCare System** and its affiliates, parents, subsidiaries, licensees, successors, designees, and assigns (collectively, "**Provider**") to videotape and/or photograph me and record my voice, conversations, and sounds, including the right to publish, distribute, display, perform, exhibit, transmit, copy, regarding Provider and its services, employees or staff, and including photographing, taping, and/or recording my medical condition(s) or treatment(s), or biographical information I may provide (collectively, the "**Materials**"). I understand that for purposes of this Appearance, Photography, Media and Testimonials Consent and Release (this "**Consent**"), the terms "image," "voice" and "photograph" encompass still photographs, digital images, audiotapes and any other method to reproduce or edit my likeness, image or voice, now known or hereafter developed.

I expressly understand and agree that Provider shall be the owner of the results and proceeds of such Materials for any and all purposes whatsoever in perpetuity, free and clear of all claims whatsoever by me and/or on my behalf, with the right, throughout the world, an unlimited number of times in perpetuity, to copyright, to use, to publish, and to license others to use in any manner, including on the Internet or other digital means, all or any portion thereof, free of any payment, royalty, or other compensation of any kind to me.

I represent that any statements made by me during my appearance or in the Materials are true to the best of my knowledge and that neither they nor my appearance will violate or infringe upon the rights of any third party. I hereby waive any right of inspection or approval of the Materials and my appearance in such Materials and the uses to which such Materials may be put. I agree that the Materials may be edited in the sole discretion of Provider and that Provider is under no obligation to use the Materials. I acknowledge that Provider will rely on this permission potentially at substantial cost to Provider and hereby agree not to assert any claim of any nature whatsoever against anyone relating to the exercise of the permissions granted hereunder.

I hereby forever release and discharge Provider, and its respective members, officers, employees, customers and representatives from any and all claims, demands, actions, liabilities and damages whatsoever arising out of or attributable to, in whole or in part, the use of the Materials.

I hereby acknowledge that neither Provider nor any of its agents or employees have made any representations or warranties of any kind with respect to any medical or other advice or information that I may receive in connection

with my appearance and that I have not relied on any such representations or warranties in agreeing to participate in the recording of my voice and/or likeness as described above.

I am signing this Consent as my voluntary act and deed, having read it in its entirety and understanding the contents thereof to my satisfaction, and I acknowledge that it is binding upon me, my legal representatives, heirs and assigns. I understand that this Consent will be signed contemporaneously with the form entitled Authorization to Use and Disclose Images, Voice Recordings and/or Testimonials (the "**Authorization**"), and I agree that in the event of conflict between the two documents, the terms of the Authorization shall govern.

Signature of Individual or Legal Representative: _____

Print Name: _____ Date: _____

Relationship of Legal Representative to Patient (e.g., parent, guardian):
_____

11.2019

Patient Informed Consent

Medically Supervised Weight Loss Participants and Participants with No Medical Supervision

Patient's Name: _____ Phone: _____

Healthcare Provider: _____

Healthcare Provider Address: _____
Street

_____
City State Zip Code

_____
Phone Fax

This document contains important health information about certain risks associated with losing weight. Please read this carefully.

The WLWC (Weight Loss and Wellness Center) @ OHI (Oklahoma Heart Institute) *is designed to provide a healthy meal plan combined with coaching, physical activity, and healthy lifestyle behaviors in an effort to facilitate healthy weight loss and weight loss maintenance.*

Medical studies indicate that people who are overweight or obese (with a BMI of 25 or greater) are at increased risk of many health problems and diseases including coronary heart disease and heart attacks, high blood pressure, strokes, increased cholesterol levels, diabetes, gallbladder disease, kidney disease, gout, osteoarthritis, neurological disorders and certain types of cancer. Although no guarantees are made with regard to the results of this Program, the likelihood that health risks associated with being overweight will be reduced is statistically better with the achievement of an ideal body weight.

Possible Associated Side Effects and Risks

It is important to know that certain health risks have been associated with losing weight. Any weight loss program may be associated with side effects, including but not limited to the following: dizziness or light-headedness, bowel changes, muscle cramps, fatigue, temporary anemia, cold sensation, menstrual irregularities, dry skin, temporary skin rash, and temporary hair loss.
The following may also be associated with weight loss: the aggravation of pre-existing gallbladder disease and/or the development of gallstones. The development of gallbladder disease could result in the need for surgical removal of the gallbladder. These conditions can also cause inflammation of the pancreas. Pancreatitis can be a serious condition and become a chronic problem lasting after any gallbladder disease has been resolved. A small percentage of people may develop symptoms related to gallbladder disease during any weight reducing diet, including this diet using meal replacement products. A small percentage of people after a considerable weight loss (usually 50 or more pounds) may develop temporary neurological symptoms such as limb weakness or numbness. Avoiding activities that cause compression on nerves such as prolonged crossing of legs may prevent this.

Active Weight Loss Plan or **Lean Weight Loss Plan** – **Some** patients on these plans will be medically supervised.

These diet plans, combined with increases in physical activity and weight loss, may result in changes in medical conditions and/or the need to adjust medications. You should consult with your PCP (primary care provider) prior to starting any weight loss program.

I understand that the possibility always exists that the combination of any significant disease, such as obesity, with methods employed for its treatment, such as this Program, may lead to previously unobserved or unexpected ill effects. Please consult with your PCP if you have any concerns regarding these risks.
I understand that, in addition to any additional guidance I may receive from the Program medical staff, the Program has the following restrictions and conditions, and **I CANNOT participate if**:

- I am pregnant or become pregnant (Note: *if I become pregnant or suspect that I am pregnant, I will immediately notify my health educator/coach and understand that I will not be allowed to continue in the Program.)*
- I am breastfeeding for less than twelve weeks and would like to continue breastfeeding.
- I have an active eating disorder (e.g. anorexia or bulimia).
- I am actively abusing alcohol, prescription or non-prescription drugs.
- I am under 18 years of age
- I have had bariatric surgery within the last 12 months
- I am actively using any of the following treatments for obesity: nerve stimulation therapy (e.g. VBLOC), placement of an intragastric (stomach) balloon (e.g. ORBERA or aspiration pump therapy (AspireAssist).

If I am taking any medications, I understand that weight loss, dietary changes and increased physical activity may affect the dosage or need for the medication.

If I am deemed to need Medical Supervision*: I understand that the Program Medical Providers may make any needed adjustments with my permission or I may contact my PCP or specialty healthcare provider to adjust my medication (particularly BP, thyroid, diabetes and diuretic medications).*

If I am deemed to NOT need Program Medical Supervision: *I agree to contact my PCP if I have any additional medical concerns or questions about my medications (particularly BP, thyroid, diabetes and diuretic mediations) or if instructed/requested to do so by the program RN.*

For Patients Who Require Medical Supervision by the WLWC Medical Providers

I understand that:

a) I will be weighed weekly by a member of the Program staff
b) Physician, Nurse Practitioner or Physician Assistant will perform my initial physical exam
c) I will be seen at most weekly weigh-ins by Program RN to discuss any possible side effects, review medications and any medication changes and to take my BP
d) I will meet with a WLWC Medical Provider at scheduled intervals to review progress, lab values (if any new lab has been drawn), any unusual symptoms such as lightheadedness or low BP or low blood sugars
e) Program Medical Staff will manage conditions that are directly affected by participation in the weight-loss program (such as BP and Diabetes medication adjustments) as needed and will communicate with my primary care provider about this with my permission.
f) Initial Lab will be drawn as baseline. Additional follow-up lab may be drawn based on results of previous lab, rate of weight loss or if medical provider deems otherwise necessary.

Patients on the **Lifestyle Maintenance Plan** will **NOT** be medically supervised.

For All Patients

I understand that:

a) I must eat my basic meal replacement prescription and that failure to do so may be harmful to my health. The program staff has the right to end my participation in the Program if I am unable to do this.
b) Medication changes that may be needed as a result of weight loss, the weight-loss diet or increases in my physical activity will be managed by the Program Medical Provider(s) and if needed, in collaboration with my primary care provider (PCP) or specialist.
c) Current and any future medical problems will continue to be treated by my PCP.
d) If, at any time, the Program medical staff feels that it is in my best interest, they may discharge me from the Program. It is my responsibility to attend all medical appointments. Since my absence may be detrimental to my health or success in the Program, I may be discharged from the Program if I do not attend.

Lifestyle Maintenance Plan

I understand that after Active Weight Loss or Lean Protein Weight Loss plans the Program offers a plan called Lifestyle Maintenance. I may decide to enter this plan either initially or after participating in either of the above mentioned plans after weight loss has occurred.

The primary goal of the Lifestyle Maintenance Plan is to learn how to better manage my weight by:

a) Incorporating higher levels of physical activity into my daily routine
b) Reducing overall calorie intake through the use of meal replacements, eating vegetables and fruits, and making healthier food choices
c) Maintaining the weight loss I have achieved and if needed, perhaps, lose additional weight

I understand that current medications and medical conditions may be affected as a result of practicing the lifestyle changes promoted in weight maintenance and any additional weight loss I may achieve while in weight maintenance. As a result, I may require adjustments to medications for, but not limited to:

a) Diabetes medications
b) Blood pressure medications (including diuretics)
c) Anti-coagulant therapy (Coumadin/Warfarin)

I agree to contact my healthcare provider for the management of these and any other medications or medical conditions that may be affected as a result of practicing the lifestyle changes promoted in the Lifestyle Maintenance Plan.

Important Information for Patients Who Are Taking Medication to Treat Diabetes

If your diabetes medication includes insulin, non-insulin injectable medications, and/or oral agents, be aware that your daily food intake, increased physical activity and/or weight loss will have an impact on your blood sugar.

During the weight loss phase of your diet, your medication may have been adjusted or even discontinued – based on your blood sugar readings - by the Program Medical Providers. During maintenance, if you are taking diabetes medications, you agree to contact your PCP regarding:

- The frequency of finger-stick blood sugar monitoring your PCP prefers
- Blood sugar guidelines for contacting your PCP (less than X, more than X)
- Diabetes medication adjustments

You understand that dietary changes, increased physical activity and ongoing weight management and possible additional weight loss in the Maintenance phase will continue to have an impact on diabetes and diabetes medications.

NOTE*: If you are using a concentrated insulin (e.g. U-500) or if you are taking high doses of insulin (greater than approximately 100 units per day), you acknowledge you understand that you are at an increased risk of low blood sugar (hypoglycemia). This may occur from reducing calorie intake and increasing physical activity -- you agree to contact your PCP or Endocrinologist for adjustment of your insulin during your participation in the Lifestyle Maintenance Plan in order to minimize your risk of hypoglycemia.*

Important Information for Patients Who are Taking Diuretics (water pills) and Other Drugs for High Blood Pressure

- Your PCP or medical provider specialist may have prescribed medication to help control your hypertension (high blood pressure). Sometimes these medications are also prescribed for other reasons, such as for control of migraine headaches or for symptoms of benign prostatic hypertrophy (enlarged prostate) etc.

- During weight loss, these medications may have been adjusted or even discontinued (as your BP responded to your weight loss and lowered) --- to prevent possible side effects such as dizziness, weakness or fainting.

- If you are being Medically Supervised, the Program Medial Providers will monitor and make adjustments to these meds

- If you do not meet the criteria to be medically supervised and are taking any blood pressure medications or diuretics, it is very important that you have continued contact with your PCP to continue to evaluate your blood pressure and medications. You agree to contact your PCP/specialist if you experience any symptoms of low blood pressure, such as excessive fatigue or dizziness, especially upon changing position.

Important Information for Patients Who are Taking the Anticoagulant (blood thinner) Coumadin (aka Warfarin)

As your food intake changes from your previous dietary intake – whether on Active Weight Loss Plan, Lean Weight Loss Plan or Lifestyle Maintenance plan, your intake of vitamin K (which counteracts the effect of Coumadin on thinning your blood) - may alter the effectiveness of your medication. You may need to have your Coumadin dosage adjusted from time to time based on your regular blood tests through your PCP. You should consult with your PCP to determine how frequently your blood should be monitored.

Informed Consent

I acknowledge responsibility for my own health. I have read and understand this notice - including the need to discuss my participation in this Program with my healthcare provider/primary care provider before beginning the Program. I acknowledge that, to the best of my ability, I have disclosed any and all medical conditions to the Program's medical staff, with the understanding that this information is necessary to provide and coordinate my care with my primary medical provider, and to also insure that I am an appropriate candidate for treatment in this Program.

To the fullest extent permitted by law, I hereby assume all risks and hazards associated with or which may arise from such treatment, hereby releasing the Weight Los and Wellness Center @ OHI (WLWC) and all of it' respective affiliates, agents and employees, from any liability from said treatment or Program, except where injury or damage is the proximate result of gross negligence on the part of the above mentioned Program, persons or entities.

The undersigned has read and understood the above information.
This Informed Consent applies to any and all Plans in the Program.

Patient Signature: _____ Date: _____

Patient PRINTED Name: _____

Witness Signature: _____ Date: _____

Witness PRINTED Name: _____