# OSPI

## Weight Loss Program

## Patient Questionnaire

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: Male / Female Occupation: _____

Please complete the following statements by circling the correct response.

1. I have been overweight since childhood. Yes or No
2. I have never weighed more than I do now. Yes or No
3. I am unmotivated to lose weight. Yes or No
4. I eat large amounts of food at one time. Yes or No
5. I skip breakfast often. Yes or No
6. I skip lunch often. Yes or No
7. I skip dinner often. Yes or No
8. I drink alcohol greater than 4 days a week. Yes or No
9. I eat cookies, cakes, or ice cream regularly. Yes or No
10. I feel sad, depressed, or blue. Yes or No
11. I eat high fat foods between meals or at night. Yes or No
12. I eat cheese or pizza regularly. Yes or No
13. I use butter, margarine, or mayonnaise regularly. Yes or No
14. I eat red meat, cold cuts, or hot dogs regularly. Yes or No
15. I eat nuts, dips, or chips regularly. Yes or No

16. I smoke. Yes or No

17. I have little interest in doing things. Yes and No

18. I feel my eating out is out of control sometimes. Yes or No

19. I have purged, vomited, or used laxatives to lose weight. Yes or No

20. I exercise regularly. Yes or No

21. I like being physically active. Yes or No

22. I think I can exercise right now. Yes or No

I want to lose _____ pounds

My goal weight is _____

My usual breakfast is _____

My usual lunch is _____

My usual dinner is _____

# Patient Medical History

Name: _____ Date of Birth: _____

Allergies to medication: _____

Answer the questions below with yes or no

1) Do you have a history of diabetes and or high blood sugar?

2) Have you ever had a definite or suspected heart attack?

3) Do you have a history of thyroid, liver, or kidney disease?

4) Have you ever been told by a health care professional that you had an abnormal resting or exercising (treadmill) electrocardiogram (EKG)?

5) Have you ever had coronary bypass surgery or other heart surgery?

If you answered yes to any of questions 1-5, please describe:

_____

_____

_____

_____

6) Do you currently have chest pain, shortness of breath, difficulty breathing, feeling faint, swelling of the ankles, or heart palpitations at rest or on exertion?

7) Do you currently smoke or have recently quit smoking in the past 6 months?

8) Do you have uncontrolled high blood pressure?

9) Have your father, brothers, mother, or sister had heart disease prior to age 55?

10) Do you exercise? If so, how frequent? For what duration?

11) Are you currently under treatment for blood clots?

12) Have you been told by a health care professional that you should not exercise?

13) List all current medications:

_____

_____

_____

I verify that I have answered this health questionnaire accurately and completely.

Patient Signature: _____ Date: _____

# Beck Depression Inventory

Please answer each question based on how you feel today. Circle the score (0-3) for each of the 21 questions listed below.

| | | |
|---|---|---|
| 1. | 0 | I do not feel sad. |
| | 1 | I feel sad. |
| | 2 | I am sad all the time and I can't snap out of it. |
| | 3 | I am so sad and unhappy that I can't stand it. |
| 2. | 0 | I am not particularly discouraged about the future. |
| | 1 | I feel discouraged about the future. |
| | 2 | I feel I have nothing to look forward to. |
| | 3 | I feel the future is hopeless and that things cannot improve. |
| 3. | 0 | I do not feel like a failure. |
| | 1 | I feel I have failed more than the average person. |
| | 2 | As I look back on my life, all I can see is a lot of failures. |
| | 3 | I feel I am a complete failure as a person. |
| 4. | 0 | I get as much satisfaction out of things as I used to. |
| | 1 | I don't enjoy things the way I use to. |
| | 2 | I don't get real satisfaction out of anything anymore. |
| | 3 | I am dissatisfied or bored with everything. |
| 5. | 0 | I don't feel particularly guilty. |
| | 1 | I feel guilty a good part of the time. |
| | 2 | I feel quite guilty most of the time. |
| | 3 | I fell guilty all the time. |
| 6. | 0 | I don't feel I am being punished. |
| | 1 | I feel I may be punished. |
| | 2 | I expect to be punished. |
| | 3 | I feel I am being punished. |
| 7. | 0 | I don't feel disappointed in myself. |
| | 1 | I am disappointed in myself. |
| | 2 | I am disgusted with myself. |
| | 3 | I hate myself. |
| 8. | 0 | I don't feel I am any worse than anybody else. |
| | 1 | I am critical of myself for weaknesses or mistakes. |
| | 2 | I blame myself all the time for my faults. |
| | 3 | I blame myself for everything bad that happens. |

9.
0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10.
0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't even though I want to.

11.
0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12.
0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13.
0 I make decisions about as well as I ever did.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14.
0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.

15.
0 I can work about as well as before.
1 It takes extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16.
0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.
0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything,
3 I am too tired to do anything.

18.
0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19.
0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more that fifteen pounds.

20.
0 I am no more worried about my health than usual.
1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think of anything else.

21.
0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I have almost no interest in sex.
3 I have lost interest in sex completely.


Orthopedic & Sports Performance Institute

Phentermine and Bontril SR (phendimetrazine) are appetite suppressants that have been taken safely by millions of people; they have been shown along with diet and exercise to help promote weight loss. As with any medication there is a possibility of side effects or an adverse reaction. Common side effects are dry mouth, nervousness, difficulty sleeping, and an occasional dull headache. It takes approximately 4-7 days for your body to adjust to the medication. Benadryl can be taken to assist with falling asleep. Less common side effects include mental disturbances, heart palpitations, increased blood pressure, chest pain, shortness of breath, swelling of your feet and or ankles, exercise intolerance, dizziness, upset stomach, constipation, itching ,skin rash, sexual problems or difficulty urinating. These medicines come with the rare potential to cause pulmonary hypertension and heart valve damage. This risk is increased slightly when appetite suppressants are taken along with an antidepressant.

In case of serious side effects, stop taking the medication and seek immediate medical attention at your local ER. All patients on weight loss medications are required to be evaluated every 30 - 45 days and have an initial EKG. While taking these medications avoid taking the following: Decongestant medications (Sudafed/ Pseudoephedrine, Tylenol Sinus, Clariten D, Zyrtec D and Allegra D), stimulant medications, high doses of caffeine, other weight loss medication, ephedrine, MAO inhibitors and alcohol use. Please consult the clinic staff prior to starting any new medications. Persons with the following medical conditions CAN NOT take Phentermine or Bontril: Uncontrolled high blood pressure, heart disease, history of heart attack, arteriosclerosis (clogging of the arteries), severe heart murmurs, history of stroke, liver or kidney failure, overactive thyroid, glaucoma, uncontrolled anxiety, depression and those with a history of drug dependency (or addiction prone personalities). Phentermine and Bontril is NOT to be taken while pregnant or breast feeding.

Phentermine comes in different strengths 15mg, 30mg and 37.5mg, Bontril SR only has one dose 105mg. All doses can be taken once a day. The prescriber will work with you to help determine the proper dose for you. Phentermine or Bontril should not be crushed or chewed and capsules should never be opened. The tablets can be safely broken in half.

- All clients must lose weight monthly to remain compliant with our program. Noncompliant patients may have treatment discontinued without notice with no liability to the clinic.
- No one under the age of 16 will be allowed to participate in medication assisted weight loss. Those under the age of 18 must be accompanied by a parent or guardian on the first visit.
- No client who has An initial BMI of less that 27 will be allowed to participate in our weight loss program and goal weight cannot be below 24 BMI.
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Signature_____Date_____

Practitioner_____Date_____