Male Patient Registration Form

blue sky MD®

Patient Information:

Patient/Child First Name: _____ MI: _____ Last Name: _____

Age: _____ Date of Birth: _____ Occupation: _____

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown Language: ☐ English ☐ Spanish ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Widow/widower ☐ Divorced Soc. Sec. #: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____ Drivers License #: _____

Primary Care Provider: _____

Referring Doctor: _____

Parent/Guardian (REQUIRED IF PATIENT IS UNDER 21 YEARS):

NOTE: Per NC Law, Both Parents can be held responsible for medical bills for minors, a medical practice is NOT bound by any separation agreement, divorce or child support order.

Parent/Guardian: _____ Birth Date: _____

Address (if different from above): _____

Social Security # (required): _____ Employer: _____

Preferred Phone #: _____

In case of an emergency, who would you like to be contacted?

Contact Name: _____ Relationship to Patient: _____

Home Phone #: _____ Work Phone #: _____

By signing, you agree the information above is correct and give permission for Lamond Family Medicine and Blue Sky to file claims on your behalf.

HIPAA CONSENT: Without signed consent, we can NOT share information regarding your medical care (including family). Please list anyone you would like to have this information below. (leave blank if you would not like any additional individuals to have information regarding your care.

1. _____ Patient/Guardian Signature: _____

2. _____ Date: _____

Financial Policy and Signature on File

I authorize the release of any medical pertinent information to my consulting provider, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of benefits to both LaMond Family Medicine and Blue Sky MD.

I understand that I am financially responsible for all services rendered **including** for the following reasons: 1) no proper referral at the time of service or referral is invalid/expired 2) incorrect/invalid insurance information given or failure to give new updated insurance information 3) Expenses not covered by insurance 4) deductible not met 5) services rendered are deemed medically unnecessary by insurance. ***Failure of insurance company to pay does not excuse patient's financial responsibility. It is patient's responsibility to know what is and is not covered by their insurance policy/plan (including Medicare beneficiaries).***

Payment is required for all services at the time they are rendered including co-payments and any outstanding balances. You may be balance billed per your insurance contract guidelines for any amount not collected or known at the time of service. Outstanding balances not addressed/ paid in a timely fashion may be forwarded to collections and may be reported to your credit.

Returned Checks: In the event a check is returned for Non Sufficient Funds, we will assess a $25.00 charge in addition to your current balance to cover the bank charges incurred by our office due to Non Sufficient Funds. Your signature below signifies your understanding and willingness to comply with the policies of this office and your insurance plan.

Prescriptions: Please bring a list of your current medications with you at the time of your appointment. We will NEVER call in ANY pain medications, antibiotics or narcotics to any drug store. If you need a prescription refill, please call your pharmacy and ask that they fax a refill request to our office. Our providers will review the request and refill the prescription by return fax or we may request you make a follow up appointment if necessary. Please allow 24 hrs for a response to refill requests. Samples are given at scheduled appointments ONLY and can ONLY be given by the doctor.

Missed Appointments: We charge $50.00 for any no show appointment not cancelled within 24 hrs. This charge will be billed directly to you. Please help us to serve you better by keeping all scheduled appointments. If you "no show" to 3 appointments within 1 year, we have the right to dismiss you from our practice for non compliance.

***Patient OR Guardian Signature for Financial and Office Policies:** _____

(Refusal to sign does NOT prevent responsibility/obligation regarding this office's financial policy).

HIPAA COMPLIANCE STATEMENT - THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At this practice, we are committed to protecting your privacy. We comply with all federal, state, and local laws. This notice describes how we use your health information. It describes some of your rights and some of our responsibilities.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION - Each time you visit our offices, we record your symptoms, physical examination, test results, diagnosis, and treatment. This information enables us to plan for your care, communicate with others who care for you, report to your insurance carrier, bill for our work, and improve the quality of our care to you.

YOUR RIGHTS - Although your medical chart belongs to our practice, the information contained in the chart is yours. You have the right to inspect your records, obtain a copy of your chart for a small fee, correct your records, and tell us not to release your information to certain parties.

OUR RESPONSIBILITIES - We are required to maintain the privacy of your health information, send needed health information to other medical providers, and release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission.

EXAMPLES OF HOW YOUR INFORMATION IS USED - Your health information will be recorded and used to plan your treatment. Reports may be sent to other doctors to help them plan your treatment. Claims will be sent to your insurance company. The information in the claims will include confidential information such as your name, address, diagnosis, and treatment. In providing your care, we may communicate with other individuals or businesses. Examples include other physicians and/or laboratories. To protect your privacy, we ask our business associates to safeguard your information.

OTHER NOTICES - We may leave a message at your home, at your business, on your answering machine or on your voicemail. We may mail you a postcard or other written notices. We may need to disclose your information to your family members or other people helping with your care. In doing so, we will use our best judgment. We may disclose information to others as required by law or if subpoenaed. If you were injured on the job, we will need to disclose your health information to your workers compensation insurance company. We may, from time to time, update these policies.

FOR MORE INFORMATION, QUESTIONS OR TO REPORT A PROBLEM - If you have concerns or would like additional information, you may contact the Office Manager.

Signature: (HIPAA Policy) _____ Date:_____

REMINDER: Please bring a current copy of your mammogram and pap smear (within the last 12 months) to your initial consultation.

Please print this form to bring to your lab appointment, or you can email it to info@blueskymd.com.

Health History

blue sky MD™
blueskymd.com

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

List your prescribed drugs, over the counter medications and supplements

Name of Drug:	Strength:	Frequency Taken:

Personal Health History:

List any **medical problems** that other doctors have diagnosed:

Year:	Medical Problem:	Treatment/Medication(s): *(if prescribed)*

Allergies to medications:

Name of Drug:	Reaction:

Surgeries:

Year:	Type of Surgery:	Surgery Reason:

Hospitalizations:

Year:	Reason:

Health History (Continued)

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Family Health History: **(Please comment on general, weight and psychiatric history)**

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Father

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer

☐ Unknown ☐ Other _____

Mother

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer

☐ Unknown ☐ Other _____

Paternal Grandfather

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer

☐ Unknown ☐ Other _____

Paternal Grandmother

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer

☐ Unknown ☐ Other _____

Maternal Grandfather

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer

☐ Unknown ☐ Other _____

Maternal Grandmother

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer

☐ Unknown ☐ Other _____

Children How many children: _____ Ages: _____ _____ _____ _____ _____ _____

Health Habits

Exercise: (check your selection) ☐ Sedentary (no exercise) ☐ Lightly active (1-3 days per week)

☐ Moderately Active (3-5 days per week) ☐ Very Active (6-7 days per week)

☐ Caffeine ☐ Coffee ☐ Tea ☐ Cola ☐ None _____ # of cups/cans per day?

Do you drink alcohol? ☐ Yes ☐ No If yes, what kind? _____

How many drinks per week? _____ Are you concerned about the amount you drink ☐ Yes ☐ No

Have you ever used Tobacco? ☐ Yes ☐ No If yes, do you currently use tobacco? ☐ Yes ☐ No

Cigarettes (packs/day): _____ Chew (#/day): _____ Pipe (#/day): _____ Cigars (#/day): _____

# of years: _____ Year quit: _____

Mental Health

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Little interest or pleasure in doing things?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

Feeling down, depressed, hopeless?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

Are you currently seeing a counselor/ or mental health therapist? ☐ Yes ☐ No

If not, would you like to be referred ☐ Yes ☐ No

Mark by and describe (if needed) any significant symptoms you suffer from in the following areas:

- ☐ General (fatigue, night sweats, unexplained weight change) _____
- ☐ Eyes (visual trouble, trouble with eye pressure, eye redness/discharge) _____
- ☐ Ears (difficulty hearing, ringing in the ears) _____
- ☐ Nose (chronic discharge/drainage) _____
- ☐ Throat (sore throat) _____
- ☐ Lungs (wheeze, shortness of breath, snoring, asthma, wake gasping for breath) _____
- ☐ Chest/Heart (chest pain, palpitations, irregular heartbeat, hx rheumatic fever) _____
- ☐ Hematology (easy bruising, trouble with blood clotting, nose bleeds, miscarriage) _____
- ☐ Stomach/GI (abdominal pain, nausea, vomiting, heartburn/reflux) _____
- ☐ Bladder (kidney stones, urinary frequency, blood in urine, prostate problems) _____
- ☐ Bowel (blood in stool, constipation, diarrhea, change in stool) _____
- ☐ Circulation (varicose veins, leg swelling/edema) _____
- ☐ Musculoskeletal (back pain, joint pains, leg pain) _____
- ☐ Neurology (headaches, dizziness, passing out, migraine, stroke) _____
- ☐ Allergy (hives, rash, itching) _____
- ☐ Sleep (Trouble falling asleep, staying asleep, snoring, never feel rested) _____
- ☐ Psychiatric (depression, anxiety, bipolar) _____

Weight Intake and History

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Patient Information:

Patient Height: _____ Current Weight: _____ Goal Weight: _____

1. When did you begin gaining excess weight? (Give reasons, if known): _____

_____

2. Previous diets you have followed (Give dates and results of weight loss):

_____

_____

_____

4. Do you wake up hungry at night? ☐ Yes ☐ No

5. Food allergies: _____

6. Food dislikes: _____

7. What foods do you crave: _____

8. Do you frequently skip meals? ☐ Yes ☐ No

9. Have you ever been prescribed any of the following medications?:

☐ Phentermine ☐ Ozempic ☐ Victoza ☐ Qsymia ☐ Other

10. Do you have any of the following conditions?:

☐ Medullary Thyroid Disease/MEN Syndrome ☐ Active Pancreatitis

11. Do you have any of the following conditions? (Mark X on any that apply)

☐ Recent Heart Attack in the last six months

☐ Seizure Disorder (active/currently treated)

☐ Arrhythmias, valvular heart disease or Atrial Fibrillation which requires Coumadin

☐ Active GI Bleed/Peptic ulcer disease in the past 6 month

☐ Severe kidney or liver disease

☐ Congestive Heart Failure

☐ Recent TIA (mini stroke) or Stroke in the past 6 months

☐ Glaucoma

☐ Drug or alcohol addiction**

☐ Bulimia/Anorexia other uncontrolled psychiatric disturbances

☐ Age under 18 or over 70

☐ Breast Feeding

☐ Type 1 diabetes or Type 2 Diabetes which requires Insulin**

THIS SURVEY ASKS
About your eating habits in the past year

blue sky MD®

In the Past 12 Months:	Never	Less than Monthly	Once a Month	2-3 Times a Month	Once a week	2-3 Times a Week	4-6 Times a Week	Every Day
1. I ate to the point where I felt physically ill.	☐	☐	☐	☐	☐	☐	☐	☐
2. I spent a lot of time feeling sluggish or tired from overeating.	☐	☐	☐	☐	☐	☐	☐	☐
3. I avoided work, school or social activities because I was afraid I would overeat there.	☐	☐	☐	☐	☐	☐	☐	☐
4. If I had emotional problems because I hadn't eaten certain foods, I would eat those foods to feel better.	☐	☐	☐	☐	☐	☐	☐	☐
5. My Eating behavior caused me a lot of distress.	☐	☐	☐	☐	☐	☐	☐	☐
6. I had significant problems in my life because of food and eating. These may have been problems with my daily routine, work, school, friends, family, or health.	☐	☐	☐	☐	☐	☐	☐	☐
7. My overeating got in the way of me taking care of my family or doing household chores.	☐	☐	☐	☐	☐	☐	☐	☐
8. I kept eating in the same way even though my eating caused emotional problems.	☐	☐	☐	☐	☐	☐	☐	☐
9. Eating the same amount of food did not give me as much enjoyment as it used to.	☐	☐	☐	☐	☐	☐	☐	☐
10. I had such strong urges to eat certain foods that I couldn't think of anything else.	☐	☐	☐	☐	☐	☐	☐	☐
11. I tried and failed to cut down on or stop eating certain foods.	☐	☐	☐	☐	☐	☐	☐	☐
12. I was so distracted by eating that I could have been hurt (e.g., when driving a car, crossing the street, operating machinery).	☐	☐	☐	☐	☐	☐	☐	☐
13. My friends or family were worried about how much I overate.	☐	☐	☐	☐	☐	☐	☐	☐
Total Score:								
Provider Review:								

Male Symptom AMS Questionnaire

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Which of the following symptoms apply to you at this time?

Please, mark the appropriate box:	*None*	*Mild*	*Moderate*	*Severe*	*Extremely Severe*
•Decline in your feeling of general well-being (general state of health, subjective feeling)	☐	☐	☐	☐	☐
•Joint pain and muscular ache (lower back pain, joint pain, pain in a limb, general back ache)	☐	☐	☐	☐	☐
•Excessive sweating (unexpected/sudden episodes of sweating, hot flushes independent of strain)	☐	☐	☐	☐	☐
•Sleep problems (difficulty in falling asleep, difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness)	☐	☐	☐	☐	☐
•Increased need for sleep, often feeling tired	☐	☐	☐	☐	☐
•Irritability (feeling aggressive, easily upset about little things, moody)	☐	☐	☐	☐	☐
•Nervousness (inner tension, restlessness, feeling fidgety)	☐	☐	☐	☐	☐
•Anxiety (feeling panicky)	☐	☐	☐	☐	☐
•Physical exhaustion / lacking vitality (general decrease in performance, reduced activity, lacking interest in leisure activities, feeling of getting less done, of achieving less, or having to force oneself to undertake activities)	☐	☐	☐	☐	☐
• Decrease in muscular strength (feeling of weakness)	☐	☐	☐	☐	☐
• Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use)	☐	☐	☐	☐	☐
• Feeling that you have passed your peak	☐	☐	☐	☐	☐
•Feeling burnt out, having hit rock-bottom	☐	☐	☐	☐	☐
•Decrease in beard growth	☐	☐	☐	☐	☐
•Decrease in ability/frequency to perform sexually	☐	☐	☐	☐	☐
•Decrease in the number of morning erections	☐	☐	☐	☐	☐
•Decrease in sexual desire/libido (lacking pleasure in sex, lacking desire for sexual intercourse)	☐	☐	☐	☐	☐

Please mark yes or no on the questions below:

Do you have a history of elevated or abnormal PSA: ☐ Yes ☐ No

Do you have a history of prostate cancer in the last 5 years? ☐ Yes ☐ No

Do you have a desire to have children in the future? ☐ Yes ☐ No

Date of last digital rectal exam: _____

Please list any history of prostate problems: _____

Please list any history of prior hormone use: _____

General Comments: _____

Patient Name _____ ☐ Pre ☐ Post Insertion Date _____

Patient informed Consent for Weight Loss Program

blue sky MD®

I. Procedure and Alternatives:

1. I, _____ (patient), am voluntarily enrolling in/or have enrolled in an aggressive weight management program, through Blue Sky MD. I hereby authorize Blue Sky MD and whomever they designate as assistants, to provide medical care to assist me in my weight reduction efforts, to achieve the goals of weight loss and weight maintenance. I understand that such care may include but is not limited to physical examination, laboratory screening, EKG testing, intense follow-ups, psychological therapy, instruction in behavior modification techniques, nutritional counseling, fitness counseling, vitamin supplementation, and may involve the use of appetite suppressants. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the product literature, and when indicated, in higher doses than the dose indicated in the appetite suppressant labeling.

2. I have read and understand my doctor's statements that follow:

"Medications, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosages indicated in the labeling.

"As a bariatric physician, I have found the appetite suppressants helpful for periods far in excess of 12 weeks. As a provider, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer term studies and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses.

"Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted below).
"As a bariatric physician, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time However, you must decide if you are willing to accept the risks of side effects, even if they might be serious, for the possible help the appetite suppressants use in this manner may give."

3. I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight any significant medical problems that I think may be related to my weight control program as soon as reasonably possible. I agree to disclose any past or current medical conditions or problems that may exist or would be consistent with any of the conditions or problems in the cautionary statement. I have read and I understand that the conditions and contraindications that are outlined in the cautionary statement.

4. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.

5. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an exchange eating program without the use of the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

6. Patients, who are pregnant or are trying to conceive, should not be taking prescription appetite medications. Please notify our staff or doctor should you have any missed or irregular periods. Mothers who are breastfeeding should not use prescription appetite suppressants and patients with a history of alcohol and/or drug abuse should not use appetite suppressants.

II. Risks of Proposed Treatment:

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks and in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heartbeat and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease, heart attack and stroke. Physical injury can result from such things as increased exercise and activity. GI side effects, such as constipation, diarrhea, and/or bloating, or development of gallbladder disease from rapid weight loss. These and other possible risks could, on occasion, be serious or fatal. Age may also be a factor in prescribing these medications and is at the discretion of the examining and treating physician. Phentermine has not been studied in patients older than 65 or younger than 18, therefore we cannot guarantee the safety or effectiveness of the medication in these age groups.

Some patients may not be good candidates for prescription appetite suppressant use due to various medical reasons.

III. Risks Associated with Being Overweight or Obese:

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees and feet, and many other diseases. Obesity and overweight also reduces my overall life expectancy. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am. I recognize these current risks to my health as unacceptable and wish to aggressively treat my weight by enrolling in this program.

IV. No Guarantees:

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

V. Patient's Consent:

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

I further understand that upon withdrawal from this program, I will not be entitled to a refund of any previously paid monies.

WARNING:
IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK YOUR DOCTOR NOW BEFORE SIGNING THIS CONSENT FORM.

Date: _____ Time: _____ Witness: _____

Printed Name: _____ Signature: _____

Blue Sky MD Medication Agreement

I understand and voluntarily agree.

I will keep and be on time for all my scheduled appointments with the provider and other members of the treatment team.

I will keep the medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

I will take my medication as instructed and not change the way I take it without first talking to the provider or other member of the treatment team.

I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

I will tell the provider all other medicines that I take, and let him/her know right away if I have a prescription for a new medicine.

I will use only one pharmacy to get all of my medicines.

I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped.

I consent to drug testing and counting of my pills on an as needed basis.

I consent to allow Blue Sky MD providers and staff to review any state prescription drug monitoring websites.

I understand that I may lose my right to treatment in this office if I break any part of this agreement.

Date: _____ Time: _____ Witness: _____

Printed Name: _____ Signature: _____