Myrtle Beach Diet Follow-up Form

(PLEASE PRINT)

Patient Name: _____Date: _____

DOB: _____ Email: _____

Phone: H_____ C_____ W_____

Please answer the following questions if you are not currently on medication(s) prescribed by Dr. Norman.

How long ago did you stop taking your medication(s)? _____

Is there a reason why you stopped taking your medication(s)? _____

_____

Is there a reason why you have not been back to our office? _____

_____

Have you experienced any weight gain since you stopped taking your medication(s)? _____

Have you experienced any changes in your health since you last visited our office? _____

_____

_____

When you were on the diet medication(s), did you feel that it/they worked for you? _____

_____

Have you been to see any other physician since you last visited our office? Yes / No

Are you on any new medications? Y N If yes, please list: _____

_____

_____

At Myrtle Beach Diet, we value your business and want to make it easy for you to refill your medications! Please be sure to inquire about our Mail Order Program if you live far away or have trouble getting into our office regularly. If you need someone else to pick up your medications for you, please ask for a Pre-Fill form.

Patient Signature: _____ Date:_____

Restart Patient Form

Please fill this form out legibly.

Are you currently exercising? YES NO

If YES: What activities?_____

_____

How many days per week?_____

_____

Do you have any NEW medical problems (since your last visit)? YES NO

If YES, please list & explain:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Occupation_____

Is your occupation physically demanding? YES NO

Work Address_____

Furthest Education: (circle one)

Elementary High School College

Year Completed?_____

Marital Status: (Please circle one)

- Single
- Married
- Widowed
- Divorced

Spouse's information:

Name_____

Cell Phone_____

Work Phone_____

Personal Medical History (PMHx):

- Heart Disease (CAD)
- High Blood Pressure (HBP)
- Diabetes (DM)
- Stroke (CVA)
- Cancer (CA)

_____

_____

_____

Family Medical History (FMHx):

- Heart Disease (CAD)
- High Blood Pressure (HBP)
- Diabetes (DM)
- Stroke (CVA)
- Cancer (CA)

_____

_____

_____

G____P____A____

Medications that you are currently taking:

_____

_____

_____

_____

_____

Surgeries: _____

_____

_____

Allergies: _____

_____

_____

Do you use tobacco products? YES NO

How much:_____packs/day

Do you drink alcohol? YES NO

How often:_____days/week

BEAM LDX® Medical History Questionnaire

The Myrtle Beach Diet®
Fred Paul Norman, MD
6507 N. Kings Hwy.
Myrtle Beach, SC 29572
Phone (843) 692-9494
Fax (843) 692-7474

Name:_____ , _____ , _____
Last First MI

Phone: (_____) _____-_____ Home (_____) _____-_____ Cell

Mailing Address:_____

City/State/Zip:_____ **SS#**:_____-_____-_____

DOB:_____ /_____ /_____ **Email**:

_____

Work: _____ **Phone: (_____) _____-_____**
Company

Marital Status: S M D W Spouse's Name:_____**Spouse's Cell: (_____) _____-_____**

Do you Smoke? Y / N _____ **Do you drink Alcohol? Y /N** _____
QUANTITY WHAT / HOW OFTEN

Do you have any allergies? Y/N _____ **if yes, please name** _____

Check YES if symptom is present, or if a history of the condition exists. Check NO if not.

RESPIRATORY:	YES	NO
Shortness of breath (at rest)	____	____
Shortness of breath (activity)	____	____
Night sweats	____	____
Productive cough	____	____
Bloody cough	____	____
HISTORY OF		
Tuberculosis	____	____
Pneumonia	____	____
Asthma	____	____
Pulmonary emboli	____	____
Emphysema	____	____
CARDIOVASCULAR:		
Chest pain	____	____
HISTORY OF		
High blood pressure	____	____
Heart attack	____	____
Angina	____	____
Heart failure	____	____
Heart murmur	____	____
Mitral valve prolapse	____	____
Low blood pressure	____	____
Edema	____	____
Peripheral vascular disease	____	____

GASTROINTESTINAL:	YES	NO
Nausea	____	____
Vomiting	____	____
Abdominal pain	____	____
Black stools	____	____
Rectal bleeding	____	____
Heartburn	____	____
Belching	____	____
HISTORY OF		
Constipation	____	____
Diarrhea	____	____
Hemorrhoids	____	____
Ulcer disease	____	____
Gallstones	____	____
Colitis	____	____
High cholesterol	____	____
High lipids	____	____
GENITOURINARY:		
Nighttime frequent urination	____	____
Urgency	____	____
Difficult urination	____	____
Burning on urination	____	____
Infertility	____	____
Enlarged prostate (men)	____	____
Bloody urine	____	____
Recurrent urinary infection	____	____

MORE ON BACK - - - - - - - - →

MUSCULOSKELETAL:	**YES**	**NO**
Aching muscles / joints	____	____
Low back pain	____	____
Limitations on mobility	____	____
HISTORY OF		
Arthritis	____	____
Muscle cramps	____	____
NEUROLOGICAL:		
Numbness	____	____
Dizziness	____	____
Headaches	____	____
HISTORY OF		
Epilepsy	____	____
Seizure disorder	____	____
Fainting	____	____
Visual limitations	____	____
Hearing limitations	____	____
OTHER:		
Diabetes	____	____
Gout	____	____
Thyroid	____	____
Depression	____	____
Bipolar/manic depression	____	____
Schizophrenia	____	____
Glaucoma	____	____
Anemia	____	____

FAMILY HISTORY: mother/father/brother/sister

Cancer _____
Heart disease _____
High blood pressure _____
Lung disease _____
Psychiatric disease _____

CURRENT MEDICATIONS: LIST ALL

LIST ALL PAST HOSPITALIZATIONS:

LIST ALL SURGERIES:

WOMEN - PLEASE ANSWER:

Last menses _____
Post-menopausal (y/n) _____
Last pap smear _____
Last breast exam _____
Birth Control (y/n-drug) _____
Pregnancies _____
Miscarriages _____
Abnormal female bleeding (y/n) _____
Are you breast feeding (y/n) _____

WEIGHT HISTORY:

Age of onset of weight problem_____yr.
Number of weight loss attempts over last 5 years _____
Date of last weight loss attempt ___/____/____
Method _____
Outcome _____
Lowest weight: 5 years _____
: 10 years _____
Highest weight: 5 years _____
: 10 years _____
Women Current Dress size _____
Men current waist size _____

PLEASE READ THIS CAREFULLY

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO NOTIFY DR. NORMAN OF ANY COMPLICATIONS OR UNUSUAL PROBLEMS THAT I AM HAVING WITH THIS PROGRAM AND IMMEDIATELY DISCONTINUE MEDICATIONS AND SUPPLEMENTS UNTIL DR. NORMAN REVIEWS MY SITUATION. I WLL NOTIFY DR. NORMAN IF MY HEALTH STATUS CHANGES FOR ANY REASON OR IF MY FAMILY DOCTOR PRESCRIBES MEDICATIONS OR ANY TREATMENT FOR ANY DISEASE OR ILLNESS PREVIOUSLY NOT REPORTED TO DR. NORMAN'S OFFICE ON MY PERMAMENT RECORD. I WILL INFORM MY FAMILY DOCTOR OF PRESCRIPTION MEDICATIONS I AM TAKING FROM DR. NORMAN.

I HEREBY ACKNOWLEDGE THAT I HAVE READ THE ABOVE AND WILL ASSUME FULL RESPONSIBILITY FOR RELATING MY MEDICATIONS TO DR. NORMAN. I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS TO DR. NORMAN.

X SIGNED:_____ X DATE:_____/_____/_____

MY FAMILY DOCTOR:_____ ADDRESS_____

Dr. Norman's Myrtle Beach Diet

WEIGHT LOSS ATTITUDE TEST

Answer each question by circling "Y" for Yes or "N" for No.

1. When it comes to eating, I too often feel **out of control**. Y N
2. I have tried to eat better and exercise **several** times. Y N
3. It always seems that **someone** in my life disapproves of my weight loss or expresses concern when I attempt to lose weight. Y N
4. I like and enjoy eating, or better yet—I **love** food. Y N
5. I feel that at least sometimes I should be able to "cheat" and eat too much foods that I know are bad for me. Y N
6. I do not enjoy **working out**. In fact, I don't even like to sweat! Y N
7. I have serious problems cutting back on eating and **especially** maintaining my cutbacks. Y N
8. I have trouble refusing food from others because **I do not want to hurt their feelings** by refusing the things that **they** want me to eat. Y N
9. I **reward** myself by over-eating my favorite foods. Y N
10. It isn't that I don't know what I should do to lose weight. My problem is getting myself to make the right decisions **consistently**. Y N
11. I have trouble keeping **my focus** on making changes in my eating and it seems that the harder I try, the more difficult it becomes! Y N
12. For me, eating is more of a **habit** that keeps me busy, and less about appetite or hunger. Y N
13. I feel **guilty** if I don't "clean my plate." Y N
14. I do not like fruits and vegetables Y N
15. I have a tendency to be **extreme** when it comes to dieting and overeating. In fact, it seems that I'm always either dieting or overeating. I **never** feel like I reach a middle ground among the two. Y N

COUNT THE NUMBER OF "YES" ANSWERS AND PUT YOUR TOTAL HERE: _____

What your answers indicate:

If you have **more than 5 "Y"** (Yes) answers, then there is a greater chance that you have experienced increases in excess bodyweight. Unfortunately, most Americans do not even notice these increases since they tend to develop gradually over time. Hopefully, this quiz will provide you with some very important information about your eating lifestyle and your psychological perspective on your health. At the Myrtle Beach Diet we are here to help you permanently change these negative weight loss attitudes. Please consider the results of your quiz when you meet with Dr. Norman. This will help us to provide you with the best medical assistance possible as you strive to maintain a long healthy life.

CHANGE YOUR **LIFESTYLE** NOT YOUR DIET!

This quiz also helps you to find the "hidden" parts of your personality. By identifying your own personal "Road Blocks," you increase your ability to make lifestyle changes. Some of these are also identified by **Questions #3 and #8**. If you answered yes to these questions, then you probably have one or more people in your life who are intentionally or unintentionally interfering with your weight loss efforts. Identify these people and talk to one of our nutrition specialists in order to learn different ways to overcome the negative effects they have on your health status.

Did you answer "YES" to **Questions #9 and #12?** If so, this reveals that you have a strong conditioned response to many different stimuli that trigger you to eat. Your responses can be to both positive and negative stimuli. An example of positive stimuli would be a job promotion. In this incident you might take your family out to dinner in celebration and overeat as a reward. An example of negative stimuli would be the loss of a loved one. Most people turn to eating during circumstances that are negative in nature more than those that are positive. The only way to make changes that can become long lasting is to first admit that there is a problem, and then find other activities that can take the place of eating and actively combat your personal triggers.

BEAM LDX® Medical Consent Form

I _____ authorize Dr. Fred Paul Norman and whomever they designate as their assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

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 obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

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 to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding 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.

X Date: _____ **Time:** _____

Witness: _____ **X Patient:** _____

(Or person with authority to consent for patient)

Myrtle Beach Diet Patient Contract

Successful weight loss involves lifestyle changes. Medications may facilitate weight loss by regulating appetite and metabolism but are worthless without lifestyle changes. The correlates that effect lifestyle changes are **structure, accountability, and goal setting.** We use these correlates in a contract with you to strive for a successful outcome and prevent the ineffective prescribing of medications.

Structure:

I agree to abide by a low glycemic index diet as described in my information package and educate myself as to the glycemic index of every carbohydrate I eat. I will strive to keep 90% of my carbohydrates under a rating of 60 in the weight loss phase of my diet. I will seek a glycemic level from Dr. Norman that will be necessary for the maintenance phase of my diet.

Glycemic Index Levels: 0-59 = low octane
60-99 = medium octane
> 100 = high octane

I understand the 1 month induction phase (**Level III**) is a low carbohydrate detoxification meal plan reducing carbohydrates from 100 grams/day to 50 grams/day over a two week period.

I understand that a meal constitutes 3 palm sized servings as a measure of caloric intake.

I understand that this is not a high fat diet (Atkins) but moderate fat intake is acceptable.

I understand that a protein drink (of 15 grams) with less than 4 grams carbohydrate is mandatory if I skip a meal due to habit or an anorexiant medication.

I agree to increase my activity as prescribed in my information package to include incidental, aerobic, and resistance activities as prescribed by the staff.

Accountability:

I agree to keep a daily diary of food and activity during my weight loss phase and, if instructed to do so, when I experience recidivism (weight regain, or fall back to old habits or reach a plateau).

I agree to weigh myself weekly and provide these weights to the staff of MBD.

I agree to check my blood pressure weekly and provide these readings to the staff of MBD.

I agree to fill out an information sheet of side effects on every prescription refill and call the MBD if I encounter any adverse side effects which cause significant discomfort. I will discontinue any prescribed medication and call MBD if any side effects occur that interfere with my daily activities or well being.

Goal Setting:

I understand that The MBD short term goal is to lose 5% of my initial body weight in the first 3 months and The MBD long term goal is 10% of my initial body weight.

I will endeavor to construct additional goals with the MBD staff that will facilitate my permanent lifestyle transition. These goals will include eating, exercise, and lifestyle changes that we mutually agree on subsequent visits.

I understand that my ability to continue to receive prescription medications will depend on my compliance with these stipulations.

I understand that my hormone balance and other prescription medications may affect my weight loss success.

X Signed _____ X Date _____

Witnessed_____