

# The Center for Medical Weight Loss at Sayebrook, LLC

Phone 843-293-8444 Fax 843-293-8455

Karen L. Mahood, DO  
Edward R. McCarthy, DO  
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106 Lansford Court, Ste 200  
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www.healthandbeautyofsayebrook.com

## Compound Authorization for Release of Information

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

The Center for Medical Weight Loss at Sayebrook, LLC is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

<b>Entity to Receive Information</b> <i>Check each person/entity that you approve to receive information.</i>	<b>Description of information to be released.</b> <i>Check each that can be given to person/entity on the left in the same section.</i>
<input type="checkbox"/> Voice Mail/Answering Machine	<input type="checkbox"/> Results of lab tests/ radiology <input type="checkbox"/> Status of medication refill <input type="checkbox"/> Other _____
<input type="checkbox"/> Spouse (provide name) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____
<input type="checkbox"/> Parent (provide name) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____
<input type="checkbox"/> Other (provide name) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical as follows: _____

### Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

**I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.**

*This authorization shall be in effect until revoked by the patient.*

\_\_\_\_\_  
Signature of Patient or Personal Representative

Date \_\_\_\_\_

Description of Personal Representative's Authority \_\_\_\_\_

**Necessary documentation to be kept on file.**

# The Center for Medical Weight Loss at Sayebrook, LLC

## PERSONAL HEALTH HISTORY

Name \_\_\_\_\_ Date \_\_\_\_\_

### PAST MEDICAL HISTORY

High Blood Pressure [Y][N]      Diabetes [Y][N]      Heart Attack [Y][N]  
 Thyroid Disease [Y][N]      Anemia [Y][N]      Heart Disease [Y][N]  
 High Cholesterol [Y][N]      Asthma [Y][N]      Depression [Y][N]  
 Hospitalization [Y][N] Why \_\_\_\_\_  
 Other Illness [Y][N] List \_\_\_\_\_

### PAST SURGERY

Appendix [Y][N]      Other Surgeries [Y][N] \_\_\_\_\_  
 Tonsils [Y][N] \_\_\_\_\_  
 C-Section [Y][N] \_\_\_\_\_  
 Gallbladder [Y][N] \_\_\_\_\_  
 Hysterectomy [Y][N] \_\_\_\_\_

### CURRENT MEDICATIONS

Medication Name	Dose	When Taken	Refills Needed
			[Y][N]
			[Y][N]
			[Y][N]
			[Y][N]
			[Y][N]

Medication Allergies [Y][N] \_\_\_\_\_

### FAMILY HISTORY

Heart Disease [Y][N]      High Blood Pressure [Y][N]      Diabetes [Y][N]  
 Stroke [Y][N]      Cancer [Y][N]      Depression [Y][N]

### WORK HISTORY

Current occupation \_\_\_\_\_  
 History of exposure to chemicals, fumes, or asbestos \_\_\_\_\_  
 Any job related injury [Y][N]  
 Are you disabled [Y][N] Why? \_\_\_\_\_

### SOCIAL HISTORY

Smoke [Y][N] How much? \_\_\_\_\_ packs/day      Started \_\_\_\_\_ years ago      Quit \_\_\_\_\_  
 Alcohol [Y][N] How many drinks? \_\_\_\_\_ per day or week (circle one)  
 Illegal Drugs [Y][N]  
 History of Sexually Transmitted Disease [Y][N]  
 Do you think you have any risk of AIDS [Y][N]

## REVIEW OF SYSTEMS

### Respiratory Tract

Chronic Cough [Y][N] Cough Blood [Y][N] Short of Breath [Y][N]  
Sinus Trouble [Y][N] Allergy Shots [Y][N] Chest Pain [Y][N]

### Heart and Blood Vessels

Chest Pain [Y][N] Prior Heart Attack [Y][N] Leg Pain with Walking [Y][N]  
Palpitations [Y][N] Fluid in Legs [Y][N]

### Gastrointestinal Tract

Heartburn [Y][N] Ulcers [Y][N] Hiatal Hernia [Y][N]  
Chronic Nausea [Y][N] Cramping [Y][N] Poor Appetite [Y][N]  
Chronic Diarrhea [Y][N] Blood in Stool [Y][N] Pain in Abdomen [Y][N]  
Change in Stool [Y][N]

### Skin and Nails

Chronic Rash [Y][N] New or Changing Moles [Y][N] Frequent sun exposure [Y][N]

### Neurologic

Frequent Headache [Y][N] Migraines [Y][N] Numbness [Y][N]  
Fainting [Y][N] Double vision [Y][N] Seizures in Past [Y][N]

### Skeletal System

Joint Pain [Y][N] Broken Bones [Y][N] Sprained Joints [Y][N]  
Back Pain [Y][N] Arthritis [Y][N]

### Questions for MEN

Painful Urination [Y][N] Difficult Urination [Y][N] Blood in Urine [Y][N]  
Penis Discharge [Y][N] Nighttime Urination [Y][N] Sexual Difficulty [Y][N]

### Questions for Women

Painful Urination [Y][N] Difficult Urination [Y][N] Painful Menses [Y][N]  
Irregular Menses [Y][N] Birth Control Pills [Y][N] Vaginal Discharge [Y][N]  
Hot Flashes [Y][N] Sexual Difficulty [Y][N] Number of Pregnancies \_\_\_\_\_

Number of Children \_\_\_\_\_ Date of Last PAP \_\_\_\_\_

Age at First Menses \_\_\_\_\_ Date of Last Menses \_\_\_\_\_

### General Questions

Difficulty Sleeping [Y][N] Loss of Enjoyment in Life [Y][N] Change in Appetite [Y][N]  
Always Tired [Y][N] Always Hot or Cold [Y][N] Poor Concentration [Y][N]  
Weight loss [Y][N] Weight Gain [Y][N]

## ADDITIONAL INFORMATION

Any important information not asked above?

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### *Patient Information*

Acct# \_\_\_\_\_

Date \_\_\_\_\_ Social Security \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Mailing Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Physical Address \_\_\_\_\_ Apt # \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Birthday \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_ Employer \_\_\_\_\_

Work Address \_\_\_\_\_ Work Phone \_\_\_\_\_

Email Address \_\_\_\_\_

### Marital Status

Single  
 Married  
 Divorced  
 Separated  
 Widowed

### Student

Full Time  
 Part-time

### Employment

Full time  
 Part-time  
 Not employed

### *Emergency Contact*

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

How did you hear about this practice?

***\*\*Please present a valid ID to the receptionist.\*\****

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**AUTHORIZATION TO RELEASE INFORMATION**

I, \_\_\_\_\_, \_\_\_\_\_  
(name) (date of birth)  
\_\_\_\_\_ hereby authorize release of my medical  
(social security number)  
records from:

Physician or Medical Facility \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ to the attention of

\_\_\_ Edward R. McCarthy, DO \_\_\_ Jonathan D. Bornfreund, DO \_\_\_ Karen L. Mahood, DO

Description of the information to be released: (check all that apply)

***MOST RECENT***

\_\_\_ Labs \_\_\_\_\_ EKG

***\*\*\*ONLY SEND MOST RECENT LABS & EKG\*\*\****

Patient information is need for:

\_\_\_ Continuing Medical Care \_\_\_\_\_ Personal Use

\_\_\_ Other \_\_\_\_\_

- I understand that I may inspect or copy the protected health information described by this authorization.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations.
- I understand that I may revoke or terminate this authorization by submitting a written revocation to The Center for Medical Weight Loss at SayeBrook, LLC.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***This authorization shall be in effect for one year from date signed.***

Witness Signature: \_\_\_\_\_

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## Weight Control Expectations Questionnaire

How much weight do you expect to lose? \_\_\_\_\_  
Each week? \_\_\_\_\_ Each month? \_\_\_\_\_

How will you react if you do not lose your anticipated amount of weight?  
\_\_\_\_\_

How will you react if you do not lose weight quickly?  
\_\_\_\_\_

If your weight loss slows down or even completely stops for a while, will you understand the difference between fat loss and water loss?  
\_\_\_\_\_

What size clothes do you expect to wear when you reach your goal weight? \_\_\_\_\_

What do you expect from us (your medical counselors)? Be specific:  
\_\_\_\_\_

When you reach your goal weight, do you expect to be doing anything you are not doing now? Describe in detail:  
\_\_\_\_\_

When you reach your goal weight, do you expect to STOP doing anything you ARE doing now? Describe in detail:  
\_\_\_\_\_

Will you be able to handle compliments about how you look when you reach your goal weight? \_\_\_\_\_

Will your relationship with significant others be threatened when you reach your goal weight? \_\_\_\_\_

How will family and friends respond to the "new" you?  
\_\_\_\_\_

Do you expect to get a better job? \_\_\_\_\_

Will you be expected to perform better at work or home? \_\_\_\_\_

Will you feel comfortable with altered responses from others? \_\_\_\_\_

Will you be more sociable than you are now? \_\_\_\_\_

Will you have to assume any new responsibilities? Please describe:  
\_\_\_\_\_

What will you do to maintain your goal weight?  
\_\_\_\_\_

Will you continue to watch your food intake? \_\_\_\_\_ Exercise? \_\_\_\_\_

Will you continue with professional medical monitoring? For what length of time? \_\_\_\_\_

Please describe in detail any expectations other than those listed above:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Email address: \_\_\_\_\_

By signing this form, I understand that I may receive email communication from The Center for Medical Weight Loss at Sayebrook, LLC related to my weight program. I also understand that I may elect to stop receiving such emails at any time.