Please fill out both sides *Today's Date: Day _ Month _ _ Year _____*

Last name _____ First name _____ Sex: _____
Health number _ _ _ _ _ _ _ _ _ _ version code _ _ Date of Birth: Day _ _ Month _ _ _ Year _ _ _ _
Ethnic origin:_____ Occupation (optional): _____ Contact phone number: _____
Drug allergy: _____ Food allergy: _____
Do you smoke? Yes / No Do you consume alcohol regularly? Yes / No How many drinks per week? _____
Are you vegetarian? Yes/No Do you eat fish? Yes/No Do you eat egg? Yes/No Do you drink milk? Yes/No
Name of Family Doctor: _____ Name of Specialist: _____

	Medications	**Dosage**	**Frequency**
1.			
2.			
3.			
4.			
5.			
6.			

Vitamin and supplements: _____

Please write down all the foods that you consume in a typical day or yesterday:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
What kind of beverage did you consume?_____

To be eligible to enroll in Dr Poon's Metabolic Diet Program, you must be: ***Obese*** (BMI>30), and suffering from ***one or more*** of the following conditions.

Please check what is applicable to you:

□ Diabetes: how long you been diabetic? _____ year(s) or had history of diabetes during pregnancy
□ Are you on insulin? If yes, how many years have you been taking insulin? _____year(s)
□ Family history of diabetes If yes, who has diabetes? _____
□ Hypertension (high blood pressure)
□ High cholesterol (High LDL and/or low HDL cholesterol)
□ High triglycerides (fat in the blood)
□ Polycystic ovarian syndrome and/or infertility
□ Snores and/or Sleep apnea (positive sleep study)
□ Arthritis, low back pain, fibromyalgia Area of pain? _____
□ Hiatus hernia with reflux
□ Hernia repaired or to be repaired pending weight reduction
□ Fatty liver If you have fatty liver, was ultrasound done? _____ Did you have abnormal blood work _____
□ Breast cancer, prostate cancer, stroke or coronary heart disease in yourself or occurring *prematurely* (<55 years old) in an *immediate* family member
□ Stress eating or emotional eating
□ Varicose veins
□ Cancer survivor Type of cancer? _____ Was surgery needed? _____
□ List of surgery done_____

Consent and Agreement to Treat

By signing my name below, I certify that I am

1. suffering from medical condition(s) related to my obesity and require weight loss in order to regain my health and have been recommended by my doctor/specialist to seek diet counseling
2. going to seek my own family doctor's opinion for conditions that are ***not*** related to this diet program. I understand that the doctors in this clinic will not examine or give opinions on conditions not related to my nutrition
3. aware that physicians of this clinic will check my urine and blood periodically, as needed, to monitor my progress and health condition
4. giving consent to physicians of this clinic to communicate with my family doctor and/or specialist regarding my health
5. not going to duplicate any part of the books, handouts or teaching materials (copyright)
6. aware that I do not have to purchase any book, supplement, or food products. Any purchase is done on a voluntary basis. Any associate programs offered at the clinics are all optional
7. aware that there is no charge on the first visit. If I wish to continue with the diet, there is a onetime administration fee of $20 which covers the first copy of phase 1, 2, 3 handouts and all subsequent counseling handouts. Do not lose these handouts because replacement handouts are $1 per page. I am allowed to make copies for my own use but not for distribution (copyright)
8. aware that the physiotherapy, sleep clinic, and exercise programs are run by a third party not related to Dr. Poon's Metabolic Diet Program and that participation is on a voluntary basis
9. going to give the office a *24-hour notice* in person, telephone message or email if I have to change or cancel my appointment, otherwise a $36 fine for no-show must be paid before another appointment is booked. There is no exception except for extreme emergency and at the discretion of the doctor
10. not going to ask physicians and staff members for over-the-phone or email consultation, reports, advice or medication repeats (medical/legal issues). I can book an urgent appointment to see any doctor here
11. aware that the first consultation is ***not*** an automatic acceptance to the program. It will be up to the supervising physician to accept or decline me as a patient (according to my weight, medical conditions, and commitment). I understand that if I do not follow the diet program, the supervising doctor has the right to discharge me at any stage of the diet program
12. aware that this is not a weight loss clinic but a program to help me to fight my weight related diseases through dietary counseling and education
13. aware that I will be assessed by either Dr. Pat Poon or one of his associates. I might not be seeing the same doctor at each visit
14. aware that I have to pay a fee of $10 if I just wish to be weighed without an appointment
15. aware that the doctor of the clinic will try to keep the booking schedule as close as possible. However, it is inevitable to have delay. If I did the weight-in but does not wish to wait to see the doctor, a fee of $46 will be charged to me
16. ready to make changes in my lifestyle and not to return to my old eating habit
17. provided with ample time to read this consent form and have my questions answered
18. giving consent to this clinic to use my medical and weight data (without mentioning my name) in scientific research papers and communications. Your name will not be used
19. verbal abuse, in person, telephone and email to the staff or the doctor is an automatic discharge from the program and from any of our clinics

Please list the type of diet(s) that you had attempted in the past:_____

Signed on this date: Day_____ Month_____Year_____

Signature: _____ Witness signature: _____