mochi HEALTH

Tel:
Fax:

Date:

Patient Name: **Date of Birth:**

MRN:

Single Encounter History

(Jun 10, 2024 10:43PM GMT+0) - -

S- Patient is a 32 y/o female w/ BMI of 40.2 and weight of 220 lb presenting for initial weight management appointment. At present, goals include being at a healthier weight and reducing DM/CV risk. Allergy: none

PMH: none, neg gallbladder/liver/pancreatitis

Psych: anxiety

AOM: None in the past / None Present

Other Rx: anti-depressant escitalopram

Prior Wt. Loss: 60 lb while on a ketogenic diet but gained weight back

Teenage weight 165 lb

Max Adult Weight 230 lb and OW as a child yes

Fam Hx: Mother - overweight/obese

Sibs - overweight/obese

ROS:

Cardiopulmonary:neg

GI: heartburn

GU: Neg

Other: Neg

Social: exercises regularly by cycling, walking, weight-lifting 2 times per week for 60 minutes per session, performs housework daily and has a supportive family

Etoh: None/Social/No Binge

Tob/Vape: None

Other Substance: None

O-Virtual Google Meets

A/P:

1. Obesity-Due to chronic positive energy balance /BMI=

- Patient AACE intake, PMH and weight loss Hx reviewed and discussed.
- Available therapeutic and lifestyle change discussed.
- Patient wishes to start medication therapy and adjust as needed.
- Async recheck 4 weeks or PRN
- Informed decision discussion carried out the patient knows at present this medication is only indicated for diabetes management and also understands are using this as an "off label" indication and she wishes to start this Rx.
- We review significant side effects, contraindications as well as alternatives.
- It is mutually agreed that the Rx will be sent to the listed pharmacy
- No family history of Medullary Thyroid Cancer or MEN2.
- There is no active hepatobiliary disease or symptoms.
- There is no history of pancreatitis
- No pregnancy planned nor is there a suspected pregnancy noted.
- Pregnancy precludes weight loss treatment and or medication therefore contraceptive therapy is reviewed.
- Initial goal of 5-10% BM reduction is set to reduce CV and DM risk.

- she would like to have a PA submitted for all branded medications

- she is amenable to allowing for prior authorizations to be sent to insurance to ensure maximal coverage for mediations and is amenable substituting brand with compound formulations
- patient consents to remote medical visit today and notified at all medical concerns will be kept confidential
- member identity was confirmed with name and date of birth and patient location confirmed in the state where I hold a valid license to practice

Completed Intake Form

Who is your primary care physician?

Which types of medication are you taking?

name **- Anti-depressant/Anti-anxiety**

Do you have any allergies/known allergies?

text **- No**

noAllergies **- No**

Past Labs

files

If yes, were there any abnormalities in your labs? Please describe below **- No**

Have you had any labs done in the last two years? **- Yes**

Is there a medication you're particularly interested in?

name **- Whichever my provider recommends!**

Beds

During your episodes of excessive overeating, how often did you feel disgusted with yourself or guilty afterwards? **- never**

Do you feel distressed about your episodes of excessive overeating? **- No**

During your episodes of excessive overeating, how often did you continue eating even though you were not hungry? **- never**

During your episodes of excessive overeating, how often did you feel like you had no control over your eating (e.g. not being able to stop eating, feel compelled to eat, or going back and forth for more food)? **- never**

During your episodes of excessive eating, how often were you embarrassed by how much you ate? **- never**

Stop bang

fatigue **- No**

loudSnore **- No**

stopBreath **- No**

highBloodPressure **- No**

GAD/PHQ Form

Feeling afraid as if something awful might happen **- Not at all**

Feeling nervous, anxious or on edge **- Not at all**

Feeling tired or having little energy **- Several days**

Trouble relaxing **- Several days**

Being so restless that it's hard to sit still **- Several days**

Not being able to stop or control worrying **- Not at all**

I feel down, depressed, or hopeless **- Not at all**

Becoming easily annoyed or irritable **- Not at all**

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? **- not-difficult**

Poor appetite or overeating **- Not at all**

Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual **- Not at all**

Trouble concentrating on things, such as reading the newspaper or watching television **- Not at all**

Worrying too much about different things **- Not at all**

Trouble falling or staying asleep or sleeping too much **- Not at all**

Feeling bad about yourself - or that you are a failure or have let yourself or your family down **- Not at all**

Little interest or pleasure in doing things **- Not at all**

Weight History

Were you successful? **- Yes**

Have you ever consulted with a registered dietitian? **- No**

If yes, how much weight did you lose? **- 60**

What is the highest weight you have had in your life? **- 230**

Have you ever participated in a weight loss program? **- No**

Have any of your close relatives been overweight or had obesity? Check all that apply

- **mother**

- siblings

Have you ever been treated by a doctor for your weight? **- No**

Were you overweight as a child? **- Yes**

What was your weight in high school? **- 165**

Weight Treatment History

When? **- nill**

Program **- Diet Center**

Length of Time **- nill**

Weight Loss **- 0**

When? **- nill**

Program **- HMR**

Length of Time **- nill**

Weight Loss **- 0**

When? **- nill**

Program **- Jenny Craig**

Length of Time **- nill**

Weight Loss **- 0**

When? **- nill**

Program **- Lindora**

Length of Time **- nill**

Weight Loss **- 0**

When? **- nill**

Program **- Medi-Fast**

Length of Time **- nill**

Weight Loss **- 0**

When? **- nill**

Program **- Nutri-System**

Length of Time **- nill**

Weight Loss **- 0**

When? **- nill**

Program **- Opti-Fast**

Length of Time **- nill**

Weight Loss **- 0**

When? **- nill**

Program **- Pro-Car**

Length of Time **- nill**

Weight Loss **- 0**

When? **- nill**

Program **- Weight Watchers**

Length of Time **- nill**

Weight Loss **- 0**

When? **- nill**

Program **- Other**

Length of Time **- nill**

Weight Loss **- 0**

Bariatric Meds History

Medication **- Phentermine (e.g., Adipex)**

Was it effective? **- No**

When did you take it? (list years)

Did you have side effects that made you stop taking it? (If so, list side effect) **- nill**

Medication **- Tenuate (diethylpropion)**

Was it effective? **- No**

When did you take it? (list years)

Did you have side effects that made you stop taking it? (If so, list side effect) **- nill**

Medication **- Contrave (naltrexone/bupropion)**

Was it effective? **- No**

When did you take it? (list years)

Did you have side effects that made you stop taking it? (If so, list side effect) **- nill**

Medication **- Qsymia (phentermine/topiramate)**

Was it effective? **- No**

When did you take it? (list years)

Did you have side effects that made you stop taking it? (If so, list side effect) **- nill**

Medication **- Saxenda (liraglutide for weight loss)**

Was it effective? **- No**

When did you take it? (list years)

Did you have side effects that made you stop taking it? (If so, list side effect) **- nill**

Medication **- Xenical (prescription orlistat)**

Was it effective? **- No**

When did you take it? (list years)

Did you have side effects that made you stop taking it? (If so, list side effect) **- nill**

Medication **- Alli (over the counter orlistat)**

Was it effective? **- No**

When did you take it? (list years)

Did you have side effects that made you stop taking it? (If so, list side effect) **- nill**

Medication **- Topamax (topiramate)**

Was it effective? **- No**

When did you take it? (list years)

Did you have side effects that made you stop taking it? (If so, list side effect) **- nill**

Medication **- Glucophage (metformin)**

Was it effective? **- No**

When did you take it? (list years)

Did you have side effects that made you stop taking it? (If so, list side effect) **- nill**

Medication **- Victoza (liraglutide for type 2 diabetes)**

Was it effective? **- No**

When did you take it? (list years)

Did you have side effects that made you stop taking it? (If so, list side effect) **- nill**

Medication **- Belviq (lorcaserin)**

Was it effective? **- No**

When did you take it? (list years)

Did you have side effects that made you stop taking it? (If so, list side effect) **- nill**

Medication **- Phen/Fen or fenfluramine**

Was it effective? **- No**

When did you take it? (list years)

Did you have side effects that made you stop taking it? (If so, list side effect) **- nill**

Medication **- Meridia (sibutramine)**

Was it effective? **- No**

When did you take it? (list years)

Did you have side effects that made you stop taking it? (If so, list side effect) **- nill**

Medication **- Herbal**

Was it effective? **- No**

When did you take it? (list years)

Did you have side effects that made you stop taking it? (If so, list side effect) **- nill**

Medication **- Other**

Was it effective? **- No**

When did you take it? (list years)

Did you have side effects that made you stop taking it? (If so, list side effect) **- nill**

Surgery

Are you currently interested in considering bariatric surgery? **- No**

Have you ever consulted a surgeon regarding bariatric surgery? **- No**

Dietary Habits

Place (home, work,car, restaurant,take-out) Typical Foods **- nill**

Meal/Snack **- Breakfast**

Time of Day **- nill**

Place (home, work,car, restaurant,take-out) Typical Foods **- nill**

Meal/Snack **- Morning snack**

Time of Day **- nill**

Place (home, work,car, restaurant,take-out) Typical Foods **- nill**

Meal/Snack **- Lunch**

Time of Day **- nill**

Place (home, work,car, restaurant,take-out) Typical Foods **- nill**

Meal/Snack **- Afternoon snack**

Time of Day **- nill**

Place (home, work,car, restaurant,take-out) Typical Foods **- nill**

Meal/Snack **- Dinner**

Time of Day **- nill**

Place (home, work,car, restaurant,take-out) Typical Foods **- nill**

Meal/Snack **- Evening snack**

Time of Day **- nill**

Place (home, work,car, restaurant,take-out) Typical Foods **- nill**

Meal/Snack **- Light night snack**

Time of Day **- nill**

Place (home, work,car, restaurant,take-out) Typical Foods **- nill**

Meal/Snack **- Grazing (eating small amounts frequently)**

Time of Day **- nill**

Physical Activities

Do you do house work? **- Yes**

If yes, what type of work? **- nill**

Do you walk to work/school? **- no**

How many hours per day do you watch television? **- 4**

Do you work outside the home? **- No**

Kind of excercise **- Cycling, walking, weights**

How many times per week? **- 2**

How many minutes per session? **- 60**

How far? **- nill**

Do you exercise regularly? **- Yes**

How often do you do housework? **- Daily**

Social support

Does your family support your efforts to have a healthier lifestyle? **- Yes**

Do you see a counselor of any kind (e.g., therapist, religious leader, addiction counselor, psychologist, psychiatrist)? **- No**

Do you belong to any support groups? (e.g. Weight Watchers, Overeaters Anonymous, Alcoholics Anonymous, Alanon, etc.)? **- No**

Endocrine

Do you have dry mouth? **- No**

Have you been told that you have prediabetes? **- No**

Do you have excessive thirst? **- No**

Do you have type 1 diabetes? **- No**

Do you have type 2 diabetes? **- No**

Do you have history of hypothyroidism (underactive thyroid)? **- No**

Do you have excessive urination? **- No**

Do you have a history of hyperthyroidism (overactive thyroid)? **- No**

Have you or anyone in your family had medullary thyroid cancer? **- No**

Women

Do you have acne? **- No**

Do you have increased facial hair? **- No**

Have you been diagnosed with infertility or been told you’re infertile? **- No**

Do you have irregular periods? **- No**

Men

Lung and Breathing Disorders

Do you have a history of COPD (chronic obstructive pulmonary disease)? **- No**

Do you snore? **- No**

Do you have a history of asthma? **- No**

Do you wheeze? **- No**

Have you been diagnosed with sleep apnea (severe snoring that interferes with your sleep)? **- No**

Do you get short of breath when walking? **- No**

Cardiac

Have you ever been diagnosed with congestive heart failure (CHF)? **- No**

Have you ever been diagnosed with angina? **- No**

Do you ever have chest pain? **- No**

Do your feet swell? **- No**

Have you ever been diagnosed with an arrhythmia (irregular heart beat)? **- No**

Have you ever had a heart attack? **- No**

Have you ever been told you have a heart murmur? **- No**

Do you ever have palpitations (racing heart)? **- No**

Do you get short of breath when laying down? **- No**

Do you take medication for high cholesterol? **- No**

Have you been diagnosed with heart valve disease? **- No**

Do you take medication for high blood pressure? **- No**

Urinary

Do you ever have blood in your urine? **- No**

Do you have trouble holding your urine? **- No**

Do you have history of kidney stones? **- No**

Do you experience excessive urination (urinate more than normal)? **- No**

heartValveDisease **- No**

Eye

Do you have a history of glaucoma? **- No**

Do you have blurry vision? **- No**

Do you have diabetic retinopathy (diabetes-related eye disease)? **- No**

Diabetes history

prediabetes **- No**

hyperthyroidism **- No**

Gestational diabetes **- No**

Family type 2 diabetes **- No**

Gastrointestinal

Have you ever been diagnosed with GERD (gastroesophageal reflux disease)? **- No**

Do you frequently have nausea? **- No**

Do you frequently have diarrhea? **- No**

Do you ever have heartburn? **- Yes**

Have you had gallstones? **- No**

Have you ever been diagnosed with liver disease? **- No**

Have you ever been diagnosed with pancreatitis? **- No**

Do you have abdominal pain? **- No**

Have you been diagnosed with gastroparesis? **- No**

Do you vomit frequently? **- No**

intestineRenoved **- No**

liverDiseaseType **- nill**

Have you had your gallbladder removed? **- No**

Psychiatric

Have you ever been diagnosed with ADHD (attention deficit hyperactivity disorder)? **- No**

Have you ever been diagnosed with anxiety? **- Yes**

Have you ever been diagnosed with bipolar disorder? **- No**

Have you ever been diagnosed with depression? **- No**

Do you have memory loss? **- No**

Do you have trouble sleeping? **- No**

Do you drink more than 2 alcoholic beverages per day? **- No**

Do you take pain medication or opiates on a regular basis? **- No**

Do you avoid social interaction because of your weight? **- No**

Does being overweight cause you to feel depressed? **- No**

Have you ever felt discriminated against because of your weight? **- No**

Have you ever taken medication for depression or anxiety? **- Yes**

Oncology

Have you ever had a mammogram? **- No**

Have you ever had a colonoscopy? **- No**

When was the last time **- nill**

Have you ever been diagnosed with cancer? **- No**

When was the last time **- nill**

What type(s) **- nill**

Obstetrics systems

nursing **- No**

pregnant **- No**

infertility **- No**

familyPlanning **- No**

Neurologic

Have you ever had a stroke? **- No**

Do you have a hand tremor, or does your hand shake when you hold it out? **- No**

Have you ever had migraine headaches? **- No**

Have you ever had a seizure? **- No**

Do you have tingling in your fingers or feet? **- No**

Do you take medication to prevent migraines? **- No**

Have you been diagnosed with chronic kidney disease (CKD) or diabetic nephropathy? **- No**

Joint Diseases

Do you have pain in your hips? **- No**

Do you have chronic back pain? **- No**

Do you have pain in your knees? **- No**

Do you have a history of arthritis? **- No**

Do you take medication for joint or back pain? **- No**

Do you have trouble walking or exercising due to joint pain? **- No**

Have you had a joint replacement (e.g., hip or knee surgery)? **- No**

Genetic Screening

IM SLEEPY

scoff

Food Insecurity

Created at

Updated at

Deleted at **- _**

Glp1 medication history

Intake history form id **- _**

Gad phq form id **- _**

Aace 1 form id **- _**

Aace 2 form id **- _**

Diabetes history form id **- _**

Patient ros form id **- _**

Food insecurity form id **- _**

Scoff form id **- _**

Im sleepy form id **- _**

complete **- Yes**

Genetic screening form id **- _**

Peds ros form id **- _**

Weight history form id **- _**