Weight Management Center

"Weight Loss Made Simple"

PATIENT INFORMATION

Please Print Clearly and Fill Out Completely

Today's Date: _____ Preferred Language: _____

Patient Name: _____ _____ _____
Last *First* *Middle*

Height: _____ Date of Birth: _____ Desired Weight: _____ Current Weight: _____

Age: _____ Gender: ☐ Male ☐ Female Ethnicity: _____

Physical Address (No P.O. Box #): _____
Street

_____
City *State* *Zip Code*

Mailing Address: _____
Street

_____
City *State* *Zip Code*

_____ _____ _____
Social Security Number *Driver's License Number* *Email Address*

(_____)_____ (_____)_____ (_____)_____
Home Phone Number *Cell Phone Number* *Business Phone Number*

*Preferred Primary Contact: ☐Home ☐Cell ☐Business ☐Standard Mail ☐Email

*Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

_____ _____ (_____)_____
Occupation *Employer's Name* *Employer's Phone Number*

Emergency Contact Information

Name: _____

Relationship: _____ Phone Number: (_____)_____

How Did You Hear About Us?

Friend/Referral: _____ Radio: _____

Post Card/Direct Mail: _____ Billboard/Sign: _____

Internet/Website: _____ Newspaper: _____ Other: _____

Let's Just Imagine MD Weight Management Center * 6243 Fairmont Pkwy, Suite 203B * Pasadena, TX 77505
Phone: 281-487-0812 * Fax: 713-946-7210

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Patient Release Form

1. I understand that the injections provided by **WMC** contain **Sulfa** and **Lidocaine**. I understand that it is my responsibility to inform the WMC Staff, including the physician(s), if I am allergic to **Sulfa** or **Lidocaine/Caine Drugs**. I understand that I must see an WMC physician before receiving injections.
2. I understand that it is my responsibility to inform the **WMC** Staff, including the physician(s) if I am currently taking Coumadin. I understand that there are risks involved with taking Coumadin and receiving the **WMC** injections. I understand that I must see an **WMC** physician before receiving injections.
3. By reviewing any medical information, the **Weight Management Centers' Physician(s)** will determine if medication will help in the facilitation of weight loss. I understand that it is my responsibility to have **my own physician** conduct regular physical examinations for me, including any and all suggested testing by **my own physician** to ensure that I have no medical conditions that would constitute a contradiction to me taking medication prescribed for me by **my own physician**. I agree that should I suffer any adverse effects while taking any prescription medication, I will immediately stop taking this medication and contact **my own physician**.
4. I understand and agree that any information provide to **Weight Management Center** may be seen by its employees and its agents and this information will constitute a medical record.
5. I understand and acknowledge that the type of medication that may be prescribed to me has been approved by the FDA **(Food and Drug Administration)**. I also understand that the supplements and vitamin injections are not FDA approved and are taken at my own discretion and under physician supervision.
6. I understand and agree that the review of my medical information by the **Weight Management Center's Physician(s)** is in no way intended as a means to diagnose any medical condition and does not substitute the requirement for me to obtain my own medical advice from **my own primary medical physician**.
7. I understand and acknowledge that the **Weight Management Centers' Physician(s)** is only reviewing my medical information as I related to them and the staff. I agree and acknowledge that I have informed the **Weight management Centers' Physician(s)** of any and all medical conditions that I am aware of. The **Weight Management Center's Physician(s)** is only determining if I am a candidate for this weight loss program.
8. I acknowledge and consent that the prescription of one of the FDA approved appetite suppressant medications is based upon **FDA regulations, manufacturer recommendations, State Board of Medical Examiner recommendations** and the **Weight Management Center s' Physician(s)'** medical judgment.
9. If I still have concerns or doubts about the medications I may be prescribed, I will contact **my own personal physician**, prior to taking this medication to get more information.
10. I hereby confirm that I am eighteen (18) years of age or older and I am fully competent to make my own health care decisions. I am fully aware of the potential side effects and/or problems associated with prescription medication and understand that it is a **violation of the law** to falsify any information on my medical questionnaire or other medical records for the purpose of obtaining prescription medication. I agree to truthfully and to the best of my knowledge answer all the questions on my medical questionnaire I agree that if I fail in any way to fully furnish my complete and accurate medical history or I become aware of any changes in my physical or medical condition in the future and fail to notify **Weight Management Centers'** or their **physician(s)** of these changes, then I am solely responsible for any and all adverse effects that I may suffer from taking or continuing to take such prescribed medication.
11. I agree that **Weight Management Center** or any physician employed by **Weight management Center** shall not be held liable for any liability, claim, loss, damage or expense of any kind or nature caused directly or indirectly by the prescribing of approved FDA medication.
12. I understand that my vital statistics will be taken at each visit. I understand that it is my responsibility to inform the WMC staff of any medical history/conditions that prohibit conventional blood pressure applications.

I have read and understand all of the above referenced patient acknowledgements and agree to each and every one of the foregoing terms. I also understand that due to the nature of the medications, they are not returnable.

Patient Name _____ Date Signed _____
(Please Print)

Patient's Signature _____

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PERSONAL COMMITMENT STATEMENT

Any successful weight-loss program requires you to be fully committed to changing your lifestyles.

By formally agreeing to this contract, you confirm your commitment to your weight loss goal of _____ pounds, which is essential for achieving success.

I, _____, on this date _____, am ready to take control of my life and my health by starting a realistic weight-loss program (that may include a reduced-calorie diet, increased physical activity, and an appetite suppressant/&/or nutritional supplements that can aid in weight loss.

I realize that I get frustrated easily with diets and weight loss programs, and that I let this frustration defeat my efforts. I also realize that there are serious health risks that are associated with being overweight. I'm fully willing to change my lifestyle so that I can improve my health and well-being.

I am fully committed to my success and can't wait to get started!

Patient's Signature _____ Date _____

_____ _____
Witness Date

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NOTICE OF PRIVACY POLICIES AND PRACTICES

I have received a copy of the Notice of Privacy Practices from Weight Management Center which disclosed how my medical information may be used and disclosed.

Signature of Patient or Personal Representative	**Name of Patient or Personal Representative**
Description of Personal Representative Authority	**Date**

PERSONS AUTHORIZED TO RECEIVE INFORMATION:

Health information Advanced Weight Loss Clinic collects and receives about you may be disclosed to:

- ☐ **Patient Only** _____
- ☐ **Spouse/Significant other** _____
- ☐ **Mother/Father/Parents** _____
- ☐ **Son/Daughter/Children** _____
- ☐ **Other** _____
- ☐ **OK to leave messages at home phone number**_____
- ☐ **Additional Instructions** _____

The authorization shall be effective for a maximum of one year or:

- ☐ **Until I state otherwise**
- ☐ **Date** _____

I may revoke or terminate this authorization at any time by submitting a written request to Advanced Weight Loss Clinic, Attention Privacy Officer.

Signature_____ **Date**_____

Office Use Only

I attempted to obtain the patient's signature on this Privacy Notice Acknowledgement, but was unable to do so as documented below.

Date _____ Employee Name _____ Reason_____

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Initial Physical Exam / SOAP

Pt. Name: _____ **Date of Birth**: _____ **Today's Date**: _____

Medication Allergies: _____

Please Complete the Following:

Weight Gain Began: Recent Years _____ After Childbirth _____ Lifelong _____

Dieting Attempt History: Multiple _____ None: _____ Prior Weight Loss Prescription _____
Prior use of Rx appetite suppressant: (type/duration/effectiveness/side effects)

Current Diet: Daily Calorie Intake _____ Current Goal Weight _____

Current Exercise: Frequency _____ Activity _____

Current Medical History: _____

Glaucoma _____ Thyroid Disorder _____ Cardiac Abnormality _____ MVP _____ Hypertension _____

Eating/Mental Disorder/Substance Abuse History: _____

Current Medications:_____

For Physician Use Only

Room #_____

_____ Pt. desires weight loss. History from _____

_____ Pt. denies pregnancy/intentions to become pregnant/current breastfeeding. HCG/Urine Test_____

Objective

General: Obese _____ Overweight _____ NAD _____ Other _____

VS: Ht. _____ Wt. _____ BMI _____ BP_____/_____ Pulse _____ Waist Circ. _____

HEENT: No Thyroid Abn _____ No Lymph Node Abn _____ No Exophthalmose _____PG Test_____

CV: RRR _____ No Tachy _____ No Murmur _____ Other _____

Lungs: CTA/BBS _____ Other _____ **Counseling**: (Diet, Exercise, Duration of Rx)

Abdomen: NDNT _____ Other _____

Extremities: No CCE _____ Other _____

Assessment/Plan

_____ Overweight/Obese – Will initiate diet and exercise changes as detailed.

_____ Patient understands risks/benefits of all aspects of this weight loss plan.

_____ Instruct to take blood pressure daily while taking anorectic medications.

_____ If BP>145/90 or pulse is greater than 90, hold anorectic medication.

_____ Will not start anorectic medication due to _____

Rx: _____ **Follow-up in one month** Goal wt. loss / 1 month: _____

_____N.P/M.D./P.A.

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Cautionary Statement

****If you are currently taking Coumadin you must see physician before receiving injections****
If you are allergic to Sulfa Drugs or Lidocaine/Caine Drugs, please let the physician know.

You ***should not*** use medication such as
Adipex (*Phentermine*) or **Bontril** (*Phendimetrazine*) if the following apply:

Heart Disease:	People with **cardiovascular disease** ***should only use*** the medications mentioned above under doctor's supervision.
Hypertension:	People with **elevated blood pressure** ***should not use*** the medications mentioned above without doctor supervision.
Glaucoma:	People with **glaucoma** *(elevated pressure in the eye)* ***should not use*** the medications mentioned above without doctor supervision.
Extrapyramidal Disorders:	People with **extrapyramidal disorders** *(disease characterized involuntarily movement, changes in muscle tone and abnormal posture)* ***should not use*** the medications mentioned above without doctor supervision. Extrapyramidal disorders include: Tardive dyskinesia, Chorea, Athetosis and Parkinson's disease.
Thyroid Disease:	People with **hyperthyroidism** *(overactive thyroid)* ***should not use*** the medications mentioned above without doctor supervision.
Easily Overexcited:	People who experience **this condition** ***should not use*** the medications mentioned above without doctor supervision.
History of Alcohol Abuse:	People who experience **this condition** ***should not use*** the medications mentioned above without doctor supervision.
Pregnant Women:	**Women in this condition** ***should not use*** the medications mentioned above.
Breast-Feeding Mothers:	**Breast-feeding mothers** ***should not use*** the medications mentioned above.
Anti-depressants:	Anti-depressants are **contraindicated** ***should not use*** the medications mentioned above unless approved by doctor.
Leber's Disease:	People with **this disease** ***should not get*** the B12 injections.

I fully understand the counter indications noted and also the medical complications that can be caused by the medications listed above. I also understand that if I take these medications, they may cause over-sedation or drowsiness, and if this occurs, I should not drive or operate dangerous machinery. I also understand that the medications mentioned above should not be taken with **tranquilizers**, **barbiturates**, **alcohol** or **anti-depressants**.

Patient Name _____ Date Signed_____
(Please Print)

Patient's Signature _____

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Medical Hx:

Please complete the following information for your consultation with the doctor.

Do you have or experience any of the following:
(Please Check)

1. Hypertension	**YES ☐ NO ☐**
2. Coronary Artery Disease (Heart Disease)	**YES ☐ NO ☐**
3. Mitral Valve Prolapse	**YES ☐ NO ☐**
4. Thyroid Problems	**YES ☐ NO ☐**
5. Depression	**YES ☐ NO ☐**
6. Anxiety	**YES ☐ NO ☐**
7. Glaucoma	**YES ☐ NO ☐**
8. Seizure Disorder	**YES ☐ NO ☐**
9. Plans for pregnancy (In near future)	**YES ☐ NO ☐**

Patient Name _____ Date Signed_____
(Please Print)

Patient's Signature _____

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Appetite Suppressant Disqualifying Criteria

- **History of Glaucoma**(need clearance letter from ophthalmologist, not optometrist)
- **Hyperthyroidism**
- **Hypothyroidism** (not on a stable supplementation medication)
- **Mitral Valve Prolapse/Regurgitation or other Valvular Disease**
- **Atrial Fibrillation or other Cardiac Arrhythmia**
- **Concurrent use of MAOI medication**
- **Systolic Blood Pressure >145**
- **Diastolic Blood Pressure >90**
- **Calorie intake <1200/day**
- **Use of appetite suppressant medication for >6 months out of a 12 month period**
- **Body Mass Index (BMI) <25**
- **Age <16 or >80 years old**
- **History of Pulmonary Hypertension**
- **Documented prior Cardiovascular or Neurologic adverse reactions to Appetite Suppressant medications**
- **Concurrent use of other stimulants (i.e. Used to treat ADD/ADHD)**
- **Pregnancy or Planning Pregnancy**
- **Breast Feeding**
- **History of Substance Abuse**
- **Less than approximately four pounds of weight loss per month** (i.e. Patient must demonstrate progress and medication efficacy)

I acknowledge that I have read and understand the disqualifying criteria listed above. I understand that this list is not all inclusive, and that the clearance to use the prescribed appetite suppressant remains reliant on the discretion of the physician.

Patient Name _____
(Please Print)

Patient's Signature _____ **Date Signed_____**

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