AMERICAL WEIGHT CLINIC

Set Yourself Free. Gain Control & Lose The Weight.

PATIENT INFORMATION SHEET (please print)

Today's Date _____

Patient's Name: _____ Birthdate _____ Age _____
First MI Last

Address: _____ Soc.Sec.# _____
and Street City State Zip

Telephone # Home:_____, Work:_____ Occupation:_____

Employer: _____ Address: _____ Phone: _____

Spouse Name: _____ Occupation: _____

Emergency Contact: _____ Phone _____

How did you learn about our office?_____

Have you tried other weight control programs?_____

****

I understand that the start up fee is _____, and is all inclusive for the first four weeks. Thereafter the biweekly fee is _____, or a special discounted fee of _____ for four (4) consecutive weeks. There will be an extra charge for above standard dosages of medications. Vitamin B12 (cyanocobalamin) injections are available at a cost of $5.00 each and $20 for lipotropic B-12 shots.

Credit cards, debit cards, check or cash is readily accepted.

PLEASE UNDERSTAND THAT THERE IS A $20.00 CHARGE FOR RETURNED CHECKS

A large number of studies have proven a much greater rate of successful weight loss among people who come regularly for weigh-ins, medications and counseling. Please do your best to come in regularly. If you are unable to keep a scheduled return appointment, please call the clinic promptly, and we can reschedule you for a different time and/or date.

SIGNED _____

AMERI CAL WEIGHT CLINIC

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Patient Request for Weight Loss Treatment

1. I have been unsuccessful at losing weight or maintaining weight loss by decreasing my food intake and increasing my exercise. I believe my excess weight has had or will have a negative impact on my health and would like to add medical therapy as part of my weight management program.
2. I understand that the risks associated with the use of a prescription appetite suppressant medication in weight reduction and weight management is low when used for three months or less. However, the risks when medications are used for more than three months or in combination have not been studied as comprehensively. therefore, there may be risks associated with the long-term use of appetite suppressants.
3. I understand that I must make a commitment to the lifestyle changes of a low fat, low calorie diet and regular exercise, if permanent weight loss is to occur. I am willing to try to make these lifestyle changes.
4. I understand that if I fail to lose at least 10 pounds or 10% of my initial body weight in the initial three months, or if I share my medication with others, that I may not be a candidate for further medical treatment.
5. I have discussed the above information with the medical staff of Ameri-Cal Weight Clinic and understand that there are alternative therapies available.
6. After reading and understanding the above information, I would like to add medical therapy to a plan of low fat, low calorie diet and regular exercise for weight loss and weight maintenance.

Name (print)_____ Signature _____

Witness (print) _____ Signature _____

Physician (print) _____ Signature _____

Date:_____

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WEIGHT LOSS PROGRAM INFORMED CONSENT FORM

I,_____ authorize Dr. William Brown, M.D. and whomever he designates has his assistants, to help me in my weight reduction efforts. I understand that this program will consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the combined use of the appetite suppressant medications phentermine, phendimetrizine, diethylpropion, sibutramine, and the fat blocking medication orlistat, and the peripheral anticholinergic/antispasmodic/mild sedative Donnatal. The first six medications have been listed by there generic name. Each has one or more brand names and are identified as follows:

phentermine: Adipex, Anoxine, Dapex, Fastin, Ionamin, Obe-nix, Obiphen, Parmine, Phentrol, Rolaphent, Unicelles, and Wilpowr.

phendimetrazine: Adipost, Anorex, Bacarate, Bontril, Bontril Slow-Release, PDM, Delcozine, Dital,

diethylpropion: Tenuate, Tenuate Dospan, Tepanil.

I further understand that these appetite suppressants 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 alone and in combination safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in product literature.

I also 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 disturbance, weakness, tiredness, psychological problems, high blood pressure, rapid heart beat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining over weight or obese are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, gall bladder disease, 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 is 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, as your doctor now before signing this consent form.

Date _____ Time _____

Witness _____ Patient _____

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HISTORY

Today's Date: _____

Name: _____ D.O.B._____ Age_____

Chief Complaint (reason for seeking help here): _____

Medications being taken & reason:_____

_____

Name of PMD (personal M.D.)_____

Current Medical Problems? (please list) _____

_____

FAMILY HISTORY

		LIVING	DECEASED		
	Age	State of health	Cause of death	Age at death	Overweight
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brothers	_____	_____	_____	_____	_____
Sisters	_____	_____	_____	_____	_____

Has any immediate family member had:

High blood pressure_____

Who?_____

Heart disease _____

Who?_____

Diabetes _____

Who? _____

Asthma _____

Who? _____

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SOCIAL HISTORY

Smoke? _____ How much _____ Alcohol? _____ How much _____

Height _____ Present weight _____ Desired weight _____

Highest weight _____ At what age? _____

Lowest weight (age 18 - present) _____ At what age? _____ Have you ever been on a special diet or weight loss program? _____ What kind? _____

PAST HISTORY

Answer the following questions with yes or no and date or age of onset and current status.

Drug Allergies: Yes _____ No _____ To what? _____

Food Allergies: Yes _____ No _____ To what? _____

Surgery: Yes _____ No _____ List, with dates_____

_____

Diabetes _____ Hepatitis/Jaundice_____

Rheumatic fever _____ Low blood sugar _____

HEENT: Headaches or dizziness _____ Fainting _____ Hearing problems _____

Vision problems _____ Glaucoma _____

C-V-R: High blood pressure _____ Heart problems _____

Chest pain _____ Lung problems _____

Shortness of breath _____ Swelling of feet or ankles _____

G-I: Nausea or vomiting _____ Indigestion or heartburn _____

Ulcer _____ Gallbladder problems _____ Constipation _____

Diarrhea _____ Other stomach or colon problems _____

Women: Birth control pills _____ Regular periods _____ Date of last period _____

Last GYN exam _____ Problems? _____ Pregnancies? children? _____

B & J: Arthritis or joint problems _____ Gout _____

N-PSY: Trouble with nerves or depression _____

History of anorexia _____ Bulimia _____

HEM: Anemia _____ Transfusions _____

Endocrinology: Thyroid problems _____

Signature _____ Name (print) _____ Date _____