Weight Loss New Patient Intake Form

Name: (Last)_______________________________(First)___________________________________(MI)_________

Social Security#:_________________________Date of Birth:__________________________Sex: M/F

Street Address:____Apt/Suite:________

City:____State:___________________________Zip_______________

Home Phone:___________________________________Cell Phone:_______________________________________

Email Address:____

Personal Medical History:

Allergies:____

____

Current Medication/Supplements/Vitamins:

____ ____

____ ____

____ ____

____ ____

List all previous Surgeries/Hospitalizations:

____ ____

____ ____

____ ____

For Women: Last menstrual cycle:_______________________Trying to become pregnant? Y/N

Birth Control Type:____

Have you ever had the following?

Weakness/Fatigue	Y	N	Kidney problems	Y	N
Recent weight loss	Y	N	Liver Problems/Fatty Liver	Y	N
Diabetes or Hypoglycemia	Y	N	Headaches	Y	N
Dizziness/Fainting	Y	N	Cancer	Y	N
Asthma/Respiratory problems	Y	N	Sleep Apnea/Obesity Hypoventilation	Y	N

Shortness of breath	Y	N	Urinary Incontinence	Y	N
Thyroid disorder	Y	N	Skin Infections (Boils)	Y	N
Acid Reflux/Ulcers/GERD	Y	N	Candidiasis/Yeast Infections	Y	N
Depression/Anxiety	Y	N	Glaucoma/Increased Eye Pressure	Y	N
High Blood Pressure	Y	N	Seizures/Epilepsy	Y	N
Metabolic Syndrome	Y	N	Heart Attack/Stroke	Y	N
Osteoarthritis/Rheumatoid Arthritis	Y	N	Heart Murmur/Mitral Valve Prolapse	Y	N
Elevated Cholesterol	Y	N	Irregular Heart Rate/Palpitation	Y	N
Polycystic Ovarian Syndrome	Y	N	Cardiovascular/Coronary Artery Disease	Y	N
Compression Fractures	Y	N	Chest Pain	Y	N
Varicose Veins	Y	N	Blood Clot/Clotting Disorder	Y	N
Lymphedema	Y	N	Pulmonary Hypertension	Y	N

Other:____

____

I understand that HcgOfJax.com will provide me with a HIPAA notice of privacy practice if requested. I also acknowledge that the information on this medical form is true to the best of my ability. Also, I understand that if I have any adverse reactions to any medications and/or injections I receive that it is my responsibility to contact HcgOfJax.com to make them aware. I also understand that if I am signing up for a multi-month discount program and I am required to stop due to medical conditions or personal reasons, any refund will be based on clinics posted fees. Also, I understand that the multi-month programs must be used within 3 months of the program. For example, if you sign up for a three (3) month program, all of the visits must be used within three (3) months.

I am requesting treatment for a condition that affects me. I am reading and making this agreement while in full possession of my faculties and am not under the influence of any substance which might impair my judgment. I understand that I am responsible for any medication and will not ask for any early refill. I also understand that the prescription is my responsibility after each visit. Any prescription that is lost, stolen or destroyed will not be replaced. I will not seek the same or similar medication or treatment at another facility until speaking with my doctor at HcgOfJax.com. I understand that HcgOfJax.com. is utilizing e-forces and will be looking up each controlled medication I might be taking each time I make an appointment. If I fail to disclose medications I'm taking, I understand that I risk being discharged as a patient. I give consent to HcgOfJax.com and all its agents to make report to otherwise cooperate with any law enforcement officials or regulatory agencies in any investigation which may arise as a result of or related to my receiving prescriptions as a patient of HcgOfJax.com or if HcgOfJax.com or its agents suspect illegal activity. I waive any and all rights of privacy and privilege in this regard and these authorities may be given full access to my records held by HcgOfJax.com without order of clerk of court. I further accept full responsibility for any sickness, injury or untoward event

which may happen to me or someone else as a result of taking any medications prescribed at HcgOfJax.com. I also understand that if I become pregnant, or if I am suspicious that I am pregnant, I will notify the staff of HcgOfJax.com. The medication is contraindicated for pregnant or breastfeeding patients. I further accept that any medications may cause harm to my embryo/fetus/baby and hold HcgOfJax.com and its employees harmless.

I understand that HcgOfJax.com has a $25.00 missed appointment fee if I do not give a 24-hour notice.

I understand that no agreement can anticipate all events in medical treatment which may arise and that for myself and my heirs, I will hold harmless HcgOfJax.com and its employees.

Signature:____Date:____________________________

Weight-Loss Consumer Bill of Rights (Required by FL. Statue 501.0575)

- The weight-loss consumer bill of rights shall consist of the following provisions:
    1. Warning: Rapid weight loss may cause serious health problems. Rapid weight loss is more the 1-1/2 to 2 pounds per week or weight loss of more than 1% of body weight per week after the second week of participation in the weight loss program.
    2. Consult your personal physician before starting any weight loss program.
    3. Only permanent lifestyle changes, such as making healthful food choices and increasing physical activity, promote long-term weight loss.
    4. Qualifications of this provider are available upon request.
- You have the right to:
    1. Ask questions about the potential health risks of the program and the nutritional content, psychological support and educational comments.
    2. Receive an itemized statement of the estimated price of the weight loss program, including extra products, services, supplements, examinations and laboratory tests.
    3. Know the actual or estimated duration of the program.
    4. Know the name, address and qualifications of the physician, dietitian or nutritionist who has received and approved the weight loss program according to Florida statue 468.5055(1)(1).

Informed Consent for Phentermine

Phentermine HCL (Appetite Suppressant-Oral)

Uses: This medication is used as an appetite suppressant. It is used in conjunction with an overall diet and exercise plan to reduce weight.

How To Take This Medication: Take on an empty stomach, once daily, 30-60 minutes before breakfast or 1—2 hours after breakfast. The tablet may be broken or cut in half. Do not crush or chew the tablet. This medication may cause sleeplessness, so avoid taking late in the day. Start with ½ tablet for 1 week, then if no side effects, increase to 1 tablet daily.

Side Effects: Dry mouth, sleeplessness, irritability, upset stomach or constipation may occur the first few

days as your body adjusts to the medication. If these side effects persist or become bothersome, inform your healthcare provider.

Precautions: Tell your healthcare provider your complete medical history especially if you have high blood pressure, cardiovascular disease, an over-active thyroid, glaucoma, diabetes or emotional problems. This medication is not to be used by women who are pregnant or breastfeeding. Consult with your healthcare provider if you think you may be pregnant or before breastfeeding. Pregnancy prevention measures should be used while taking this medication. Alcohol can increase unwanted side effects of dizziness. Limit all alcohol use while taking this medication. This drug is not recommended for use in children. Consult your healthcare provider or pharmacist for further information. Please let us know of any upcoming surgeries you may have, you will need to stop the medication at least 14 days prior to your surgery.

Drug Interactions: Inform your healthcare provider about all the medications you use (prescription and non-prescription) especially if you take high blood pressure medications, MAO inhibitors, anti-depressants, pain medications, sleeping pills, anxiety medications or any other weight loss medications. Avoid "stimulant" drugs that may increase your heart rate or blood pressure such as decongestants or **caffeine**. Decongestants are commonly found in over the counter cough and cold medicines.

Notes: Appetite suppressants are not a substitute for a proper diet. For maximum results, this must be used in conjunction with a diet and exercise program. Do not share medication with others. There is lack of scientific data regarding the potential danger of long term use combination weight loss treatment.

Missed dose: If you miss a dose, do not double dose the next dose. Instead, skip the missed dose and resume your usual dosing schedule.

Storage: Store at room temperature away from sunlight and moisture. Keep this and all medications out of the reach of children.

Patient Signature:____ Date:______________________

Physician Signature:_______________________________________ Date:______________________