Personal Information

Last name:_____ **First Name:**_____ **Middle Name:** _____

Date of Birth:_____ **Sex:** _____

Address:

_____

Street **City** **State** **ZIP**

Home Phone:_____ **Work Phone:**_____ **Cell:** _____

Email:_____ **Marital Status:**_____ **Maiden name:** _____

Spouse name:_____ **Tel:** _____

Emergency Contact:_____ **Tel:**_____ **Relationship:** _____

How did you hear about us?

☐ **Relative/Friend:** _____

Please provide name and if possible DOB

☐ **Radio:** _____

Please provide station (93.9, 102.3, 104.1, 107.9)

☐ **Internet:** _____

Please provide site (i.e. weight loss forum, Yelp, Facebook, website)

☐ **Other:** _____

Please provide details (Former Patient, etc.)

Information and Assignment of Benefits

I authorize the release of medical information to my primary care physician, referring physician, or consults if needed. I understand that payment is required for all services at the time they are rendered. Please note that Right Weight Clinics will not present a bill to any insurance company for its services. Right Weight will provide you a receipt for your visit and will not complete any specific forms that the insurance companies provide.

I certify that the information I have reported above is correct. I had the opportunity to ask questions regarding this issue. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing.

Signature:_____ **Date:** _____

RIGHT WEIGHT
PHYSICIAN DIRECTED WEIGHTLOSS

WEIGHT LOSS CONSENT FORM

BY SIGNING BELOW, I ACKNOWELDGE THAT I HAVE READ AND AGREE TO THE WEIGHT LOSS PROGAM DESCRIBED IN THIS INFORMED CONSENT. I understand that my program may consist of a balanced deficit diet, injections, a regular exercise program, instruction in behavior modification techniques, and involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be use for durations exceeding those recommended in the medication package insert. I understand that any medical treatment using medications there are certain risks associated that were mentioned in this consent but most importantly there are many benefits associated with weight loss.

I understand that weight loss improves obesity related conditions such as: High blood pressure, High cholesterol, Sleep apnea, Arthritis, Diabetes, Increased energy level, reduces aches and pains, improves mobility, improves breathing, helps you sleep better and wake more rested, Prevention of angina, chest pains caused by decreased oxygen to the heart, Decreased your risk of sudden death from heart disease or stroke, Improved blood sugar levels. I understand that these risks may be modest if I am not significantly overweight but that these risks increase considerably the more overweight I am. I understand that appetite suppressants have been taken safely by millions of people, but as with any medications there is a possibility of side effects or an adverse reaction. Risks of this program may include but are not limited to common symptoms like Depression, Drowsiness, Increased blood pressure, Irritability. Less common to rare symptoms like Blurred vision, Confusion, Diarrhea, Dizziness, Dry mouth, Headache, Irregular Heartbeat, Vomiting, Stomach pain, Tiredness, Heart palpitations, Chest pain, Shortness of breath, Rapid weight loss may also be associated with some medical problems but not limited to physical such as dizziness, hair loss or gall bladder disease. The program provides medical supervision to minimize the risks associated with rapid weight loss.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic; lifelong condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I understand the possible rare complications of SC/IM injection are abscess, cellulitis, tissue necrosis, granuloma, muscle fibrosis, contractures, hematoma and injury to blood vessels, bones and peripheral nerves.

I understand that appetite suppressants should not be used in conjunction with cocaine, caffeine, medicine for colds, fluoxetine, medicine for asthma or breathing problems, etc. I will inform my doctor of all prescriptions and over the counter medications I am taking.

I understand that children under the age of 17 and adults over the age of 65, pregnant, or breast feeding women, people with significant health problems like, heart disease, hypertension, cardiovascular disease, history of alcohol abuse, history of drug abuse, kidney disease, diabetes, psychiatric disorders, brain disease are NOT recommended to use appetite suppressants and should consult with their primary care doctors before participating in the program.

Prescription appetite suppressants are controlled drugs with significant regulations regarding their dispensing. I understand that once I receive a prescription for such medication, it will not be replaced or refilled except in compliance with regulations mandated by federal and state drug dispensing policies and guidelines. Once I leave the office with the controlled medication, I understand that I am fully responsible to comply with the usage of the drug as labeled. If I lose the prescription or the medication is accidently disposed, I have no expectation of getting a new prescription without an office visit at an appropriate interval for a refill. There will be no exceptions to these restrictions.

The appetite suppressants Phentermine could cause the patient to have a positive drug test with amphetamines.

I understand that I, have to keep this and all medications out of children's reach, store away from heat or damp places and direct light, do NOT keep outdated medications past the expiration date.

I understand that if a prescription for an appetite suppressant is issued that I can get if filled at an outside pharmacy of my choice, but I choose to get the prescription dispensed at Right Weight Clinics LLC as it is more convenient for me.

By signing below, I acknowledge that I have read and fully understand this consent form, and I realize that I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor and/or his staff regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

Patient:_____ **Patient name/Guardian signature:**_____ **Date:** _____

RIGHT WEIGHT
PHYSICIAN DIRECTED WEIGHTLOSS

Last Name:_____First Name:_____DOB: _____

Medical Condition Write NO if none	Current Medication Write NO if none	Drug Allergies Write No if none	Type of Reaction	Hospitalization/Surgery Date	Reason

Are you currently or in last 2 weeks taken any of the following drugs? (Circle Yes or No)

SNRI's			SSRI's			MAOI's		
Atomoxetine (Strattera)	YES	No	Fluoxetine (Prozac)	YES	No	Rasagiline (Azilect)	YES	No
Desvenlafaxine (Pristiq, Khedezla)	YES	No	Sertraline (Zoloft)	YES	No	Selegine (Eldepryl, Zelapar)	YES	No
Duloxetine (Cymbalta, Irenka)	YES	No	Paroxetine (Paxil)	YES	No	Isocarboxazid (Marplan)	YES	No
Levomilnacipran (Fetzima)	YES	No	Escitalopram (Lexapro)	YES	No	Phenelzine (Nardil)	YES	No
Milnacipran (Savella)	YES	No	Fluvoxamine (Luvox)	YES	No	Tranylcypromine (Parnete)	YES	No
Tramadol (Ultran)	YES	No	Citalopram (Celexa)	YES	No			
Venlafaxine (Effexor XR)	YES	No	Volazodone (viibrid)	YES	No			
	YES	No	Vortioxetine (Brintellix)	YES	No			

Medical History - This information is required to determine if Phentermine is contraindicated.

Please CIRCLE Yes or No to all medical conditions that you have been diagnosed NOW or In PAST:

Congestive Heart Failure	YES	NO	Glaucoma If YES, Angle?	YES Closed or Open	NO	Dizziness/Fainting	YES	NO
Heart Murmur	YES	NO	Thyroid Disease	YES	NO	Chest Pain	YES	NO
Cardiovascular disease	YES	NO	Liver Disease	YES	NO	Heart Palpitations	YES	NO
Other Heart Conditions	YES	NO	Kidney Disease	YES	NO	Shortness of Breath	YES	NO
Hypertension	YES	NO	History of Rheumatic Fever	YES	NO	Migraines/ Headaches	YES	NO
Stroke	YES	NO	Seizure Disorder	YES	NO	Insomnia	YES	NO
Depression	YES	NO	Other Psychiatric Disorder	YES	NO	Sexual Dysfunction	YES	NO

Any Drug Addictions	YES	NO	If Yes, What Drugs and When last Used -	Any addiction to Alcohol	YES	NO

Women Only Pregnant? YES/NO Nursing? YES/NO

Social History

Coffee/ other caffeine	Type/Cup Daily	
Current Alcohol use	Type	
	Amount	

STAFF USE ONLY **

Weight:	Height:	BMI: BFM:	Pulse: BP:
GW:	HW:	ECG:	( ) Patient is aware starting phentermine at higher dosages can cause increase in side effects. MA:

Patient Signature:_____Todays Date:_____Cell#:_____

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