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: _____

and Street City State Zip

Telephone # Home/Cell:_____ Work:_____Occupation: _____

Employer:_____Address:_____Phone: _____

Emergency Contact:_____Phone _____

How did you learn about our office?_____

Appetite Suppressant Program

I understand that the start up fee is $190.00, and is all inclusive for the first four weeks. Thereafter the biweekly fee is $95.00 or a special discounted fee of $180.00 for four (4) consecutive weeks. This fee includes filling the medication prescription. There will be an extra charge for above standard dosages of medications.

GLP-1 Program

$170 per month. This program includes unlimited access to the medical staff for follow-up visits and counseling as well as maintaining a valid prescription. The fee does not include filling the prescription. Lab fees (in-office): HbA1c $30 (rechecked every 3 mo) and blood glucose testing is $10.

B12 Vitamins

Vitamin B12 (cyanocobalamin) injections are available at a cost of $5.00 each and $20 for lipotropic B-12 shots. *(For patients coming in for shots only and not on the weight program, Vit B-12 shots are $10.00 each and $25.00 each for Lipotropic B-12 shots)*

Credit cards, debit cards, check or cash is readily accepted. CHARGE FOR RETURNED CHECKS is $20.00

SIGNATURE _____

Email address:

_____

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.

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.

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 as 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, or glucagon like peptide hormone receptor agonist (GLP-1).

Each has one or more brand names and are identified as follows:

Medication	Brand Name
Phentermine (PTM)	Adipex, Anoxine, Dapex, Fastin, Ionamin, Obe-nix, Obiphen, Parmine, Phentrol, Rolaphent, Unicelles, and Wilpowr
Phendimetrazine (PDM)	Adipost, Anorex, Bacarate, Bontril, Bontril Slow-Release, PDM, Delcozine, Dital,
Diethylpropion (DEP)	Tenuate, Tenuate Dospan, Tepanil
Glucagon like peptide (GLP-1):	Tirzepatide (Mounjaro), Semaglutide (Ozempic, Wegovy, Rybelsus), Liraglutide (Saxenda)

- 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.
- *Note: The GLP-1 medication does not cause cancer, but it should not be used if the patient has a personal or family history of medullary thyroid cell cancer, multiple endocrine neoplasia syndrome, or a history of pancreatitis or pancreatic cancer.*
- 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 heartbeat, and heart irregularities.* These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight 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 this may increase with additional weight gain.
- 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, 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 understand 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.

Date_____Time _____

Witness_____Patient _____

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HISTORY

Today's Date: _____

Name: _____ D.O.B._____ Age_____

Chief Complaint (reason for seeking help here): _____

Current medications being taken & reason:_____

_____

I have used weight loss meds in the past (list here): _____

Name of PMD (personal M.D.)_____

Current Medical Problems? (please list) _____

_____

FAMILY HISTORY

	Age	Living State of health	Deceased Cause of death	Age at death	Overweight
Father					
Mother					
Brother(s)					
Sister(s)					

Has any immediate family member(s) (Parents, sibling(s) had:

Medical History		List who
High blood pressure	Yes No	
Heart disease	Yes No	
Diabetes	Yes No	
Kidney Disease	Yes No	
Pancreatitis	Yes No	
Thyroid Medullary Cancer	Yes No	
Asthma	Yes No	

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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? _____

Women:
Are you pregnant?
Yes / No

Breastfeeding?
Yes / No

MEDICAL HISTORY

Drug Allergies: Yes _____ No_____ To what? _____

Food Allergies: Yes _____ No _____ To what? _____

Surgery: Yes _____ No _____ List, with dates_____

Medical History				Date or Age of onset *If applicable*	Current Status
Endocrinology:		Yes	No		
Diabetes		Yes	No		
	Low blood sugar	Yes	No		
	Thyroid problems	Yes	No		
	Thyroid medullary cancer	Yes	No		
	Kidney Disease	Yes	No		
	Pancreatitis	Yes	No		
HEENT:	Headaches	Yes	No		
	Fainting	Yes	No		
	Dizziness	Yes	No		
	Hearing problems	Yes	No		
	Glaucoma	Yes	No		
	Retinopathy	Yes	No		
C-V-R:	High blood pressure	Yes	No		
	Heart problems	Yes	No		
	Chest pain	Yes	No		
	Lung problems	Yes	No		
	Shortness of breath	Yes	No		
	Asthma	Yes	No		
	Swelling of feet or ankles	Yes	No		
	h/o Rheumatic fever	Yes	No		
G-I:	Nausea or vomiting	Yes	No		
	Indigestion or heartburn	Yes	No		
	Ulcer	Yes	No		
	Gallbladder problems	Yes	No		
	Hepatitis / Jaundice	Yes	No		
	Diarrhea	Yes	No		
	Constipation	Yes	No		
	Other stomach or colon problems	Yes	No		
Bone & Joints:	Arthritis	Yes	No		
	Other Joint problems	Yes	No		
		Yes	No		
HEM:	Anemia	Yes	No		
	Transfusions	Yes	No		
Women:	Birth control pills	Yes	No		
	Regular periods	Yes	No	Date of last period _____	
				Last GYN exam _____	
	Children	Yes	No	How many _____	

Signature _____ Print _____ Date _____