



**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.

Credit cards, debit cards, check or cash is readily accepted. FSA / HSA are also accepted.

*CHARGE FOR RETURNED CHECKS is \$20.00*

Patient (print) \_\_\_\_\_ Signature \_\_\_\_\_

Provider (print) \_\_\_\_\_ Signature \_\_\_\_\_

Date: \_\_\_\_\_

## 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, phendimetrazine, diethylpropion, or glucagon like peptide hormone receptor agonist (GLP-1/GIP)*.

**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, Rolapent, 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): (GLP-1 + GIP):	<b>Semaglutide</b> (Ozempic, Wegovy, Rybelsus), <b>Liraglutide</b> (Saxenda) <b>Tirzepatide</b> (Mounjaro, Zepbound)

- 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 understand that the GLP-1 medication is compounded from a compounding pharmacy adhering to the highest FDA standards.
- *Note: The GLP-1/ GIP medication 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 \_\_\_\_\_

(Ameri-Cal Provider)

## HISTORY

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Birthdate \_\_\_\_\_ 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 PCP (primary Doctor): \_\_\_\_\_

Current Medical Problems? (please list) \_\_\_\_\_

Surgery: Yes \_\_\_\_\_ No \_\_\_\_\_ List, with dates \_\_\_\_\_

Drug allergies: Yes \_\_\_\_\_ No \_\_\_\_\_ List \_\_\_\_\_

Food allergies: Yes \_\_\_\_\_ No \_\_\_\_\_ List \_\_\_\_\_

Height \_\_\_\_\_ Present weight \_\_\_\_\_ Desired weight \_\_\_\_\_

Highest weight \_\_\_\_\_ At what age? \_\_\_\_\_ Lowest weight (age 18 - present) \_\_\_\_\_ At what age? \_\_\_\_\_

Smoke? \_\_\_\_\_ How much \_\_\_\_\_ Drink? \_\_\_\_\_ How much \_\_\_\_\_

## FAMILY HISTORY

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

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

<b>Medical History</b>		<b>List who</b>
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	

<b>Medical History</b>		<b>Age of onset</b>	<b>Medical History</b>		<b>Age of onset</b>
<b>Endocrinology:</b> Diabetes Low blood sugar Thyroid problems Thyroid medullary cancer Kidney Disease Pancreatitis	Yes No Yes No Yes No Yes No Yes No		<b>G-I:</b> Nausea or vomiting Indigestion / heartburn Ulcer Gallbladder problems Hepatitis / Jaundice Diarrhea Constipation	Yes No Yes No Yes No Yes No Yes No Yes No	
<b>HEENT:</b> Headaches Fainting Dizziness Hearing problems Glaucoma Retinopathy	Yes No Yes No Yes No Yes No Yes No Yes No		<b>Bone &amp; Joints:</b> Arthritis Osteoporosis Other Joint problems <b>HEM:</b> Anemia Transfusions	Yes No Yes No Yes No Yes No Yes No	
<b>C-V-R:</b> High blood pressure Heart problems Chest pain Lung problems Shortness of breath Asthma Swelling of feet or ankles Rheumatic fever	Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No		<b>Women:</b> Birth Control pills Regular Periods Children # _____ Last period _____  Are you pregnant Are you breastfeeding	Yes No Yes No    Yes No Yes No	

Signature \_\_\_\_\_ Print \_\_\_\_\_ Date \_\_\_\_\_