WEIGHT LOSS PATIENT INTAKE FORM

Name:		
Street Address:		
City:	Postal Code:	
Phone: (home)	(Cell)	(Work)
Email Address:		
Would you like to receive South Florida Injury and convenient Care emails regarding appointment Information? Yes ☐ No ☐		
Would you like to receive South Florida Injury and convenient Care text regarding appointment Information? Yes ☐ No ☐		
Gender *(circle)*: M F	Date of Birth:	
Family Doctor:		
Preferred Pharmacy:	Phone Number:	
How did you discover this clinic? *(please circle)*	Family Doctor | Specialist | Friend/Family | Website | Facebook | Attorney: _____ | Other *(please specify)*:	

CHIEF COMPLAINT:

_____

_____

_____

SOCIAL HISTORY:

___ Smoker ___ Non-Smoker ___ Drink Alcohol How much? _____

___ Does not Drink Alcohol ___ Does not take Drugs ___ Takes Drugs

MEDICAL HISTORY:

Do you have any of the following?

Diabetes?	Y	N
Heart Trouble?	Y	N
Epilepsy?	Y	N
High Blood pressure	Y	N
Circulation problems?	Y	N
Osteoporosis?	Y	N

Bowel/Bladder Problems?	Y	N
AIDS/HIV positive?	Y	N
Do you smoke?	Y	N
Have you ever had cancer?	Y	N
Have you ever experienced dizziness or blackouts?	Y	N
Sudden weight loss?	Y	N
Breathing problems?	Y	N
Are you pregnant?	Y	N
Recent surgery?	Y	N
Arthritis?	Y	N

Describe any other health problems:

_____

_____

List of Past Surgeries

_____

_____

List any allergies

_____

_____

List all medications you are taking

_____

_____

PHENTERMINE WEIGHT LOSS PROGRAM

INFORMED CONSENT

I request the use of Phentermine, along with strict dietary restrictions for the purpose of weight loss. I understand that as part of the program, I will be given a limited physical, orientation to the program with supporting materials and I will be instructed on how to administer Phentermine myself. I understand that initial blood tests may be necessary to rule out any conditions that would disqualify me from the program. I will obtain these from my own physician or have them ordered through Dr. Hebron White. I understand there is no guarantee for the effectiveness of Phentermine. I agree that I am and will be under the care of another medical provider for all other conditions. Dr. Hebron White can work in conjunction with, but cannot replace, my regular primary care physicians, such as general practitioners or other specialists in family medicine or internal medicine. I understand Dr. Hebron White can only prescribe Phentermine and medication necessary for this treatment and all other health matters should be through my regular physician(s).

Prior to my treatment, I have fully disclosed any medical conditions or diseases such as history of gallbladder disease, diabetes, autoimmune diseases, HIV, heart disease, liver disease, kidney disease, uncontrolled high blood pressure, seizure disorders, blood disorder (anemia, thalassemia, hemophilia, etc.) emphysema or asthma, and any history of stroke or cancer. These contraindications have been fully discussed with me. Further contraindications are outlined below. If I fail to disclose any medical condition that I have, I release the doctor and facility from any liability associated with this procedure.

Initials: _____

Contraindications and Warnings –

Patients with the following should not use Phentermine:

- An allergy to Phentermine
- Those who have taken a monoamine oxidase inhibitor (MAO) within the last 14 days
- Have advanced arteriosclerosis, cardiovascular disease, moderate to severe hypertension, hyperthyroidism, or glaucoma
- Are in an agitated state or have a history of drug or alcohol abuse
- Women who are nursing, pregnant, or plan on becoming pregnant

Patients with the following should take special precautions and consult their doctor before using Phentermine:

- Allergies to medicines, foods, or other substances
- Those who have diabetes may need a larger dose of insulin while taking phentermine
- Have a brain or spinal cord disorder, hardening of the arteries, high blood pressure, diabetes, or high cholesterol or lipid levels

Side Effects –

While Phentermine is generally free of negative side effects, there is the possibility of the following:

- Dry mouth
- Unpleasant taste
- Heartburn
- Skin Rash or Itching
- Diarrhea
- Constipation
- Stomach Pain
- Lactic acidosis
- Nausea/ Vomiting
- Fatigue
- Hypertension
- Insomnia or Restlessness

Less common side effects include:

- Convulsions (Seizures)
- Panic attacks
- Tremors or shaking
- Erectile Dysfunction
- Fever
- Fainting
- Depression
- Hallucinations
- Overactive reflexes

I understand Phentermine treatments may involve these risks and other unknown risks: Initials: _____

I understand that use of Phentermine is absolutely contraindicated during pregnancy and breastfeeding. I understand that it is my responsibility to inform Dr. Hebron White if I am pregnant, if I am trying to become pregnant or if I become pregnant during the course of these treatments. Initials:_____

I agree to immediately report any problems that might occur to my medical provider during the treatment program. I further understand that not complying with the dosage recommendations and dietary restrictions could increase risks and alter my results from the program. If I do not follow these recommendations and restrictions, I agree to release the doctor and facility from any liability arising as a result of this. Initials: _____

I understand that I may quit the program at any time. While adverse side effects or complications are not expected, in the event that an illness does occur, I understand that I need to contact Dr. Hebron White immediately. If I experience an emergency situation, I understand that I need to go to an emergency facility. Initials: _____

I understand that if there are any changes in my medical history or there are any changes in my medications or any other changes relevant to this procedure, I will advise Dr. Hebron White at that time.

PHOTOGRAPHS: I give permission for photographs of the treated area(s) to be used by South Florida injury Convenient Care for information kept in my file, and/or teaching purposes, and/or promotional purposes. Complete patient confidentiality will be maintained at all times. Initials: _____

I have read and fully understand the above terms. All my questions have been addressed to my satisfaction. I agree to release the doctor and the facility from any liability associated with this procedure. In the event a dispute arises over the outcome of the procedure, I consent solely to arbitration as a legal means of settlement.

Patient's Name Printed: _____

Patient's Signature: _____ Date: _____

Provider's Name Printed:

Provider's Signature: _____ Date: _____

Weight-Loss Consumer Bill of Rights & Patient Acknowledgement of The Weight-Loss Consumer Bill of Rights

WARNING: RAPID WEIGHT LOSS MAY CAUSE SERIOUS HEALTH PROBLEMS. RAPID WEIGHT LOSS IS WEIGHT LOSS OF MORE THAN 11/2 POUNDS TO 2 POUNDS PER WEEK OR WEIGHT LOSS OF MORE THAN 1 PERCENT OF BODY WEIGHT PER WEEK AFTER THE SECOND WEEK OF PARTICIPATION IN A WEIGHT-LOSS PROGRAM.

CONSULT YOUR PERSONAL PHYSICIAN BEFORE STARTING ANY WEIGHT-LOSS PROGRAM.

ONLY PERMANENT LIFESTYLE CHANGES, SUCH AS MAKING HEALTHFUL FOOD CHOICES AND INCREASING PHYSICAL ACTIVITY, PROMOTE LONG-TERM WEIGHT LOSS.

QUALIFICATIONS OF THIS PROVIDER ARE AVAILABLE UPON REQUEST.

YOU HAVE A RIGHT TO:

1. ASK QUESTIONS ABOUT THE POTENTIAL HEALTH RISKS OF THIS PROGRAM AND ITS NUTRITIONAL CONTENT, PSYCHOLOGICAL SUPPORT, AND EDUCATIONAL COMPONENTS.

2. RECEIVE AN ITEMIZED STATEMENT OF THE ACTUAL OR 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 DIETITIAN OR NUTRITIONIST WHO HAS REVIEWED AND APPROVED THE WEIGHT-LOSS PROGRAM

_____ _____

Print Patient's Name Date

I, _____, acknowledge that I have either received a copy
(Signature of Patient or Parent or Legal Guardian)

of this office's Weight-Loss Consumer Bill of Rights or that this office's Weight-Loss bill of rights was made available to me to receive.

Hebron B. White, MD

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Bradenton, Florida 34205
Tel: 941-744-0040
Fax: 941-259-0189

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To our patients taking Phentermine:

Thank you for trusting us with your health. We want to make medicine as convenient and affordable as possible for you. If you have any concerns or questions please let us know how we can better take care of you. With our medical weight loss program, we use Phentermine as a strong appetite suppressant. This medication is safe and very effective when used appropriately. I want to go over some common side effects of the medication and how to treat them while you are taking the medicine:

Insomnia: Take 50 mg Benadryl before going to bed. A good workout during the day will also help you sleep better.

Dry mouth: Drink more water, breathe through your nose, use room vaporizer/humidifier, chew gum and maintain oral hygiene.

Constipation: Take over the counter MiraLAX or Magnesium citrate if you have not had a bowel movement in several days.

If you develop chest pain, rapid or irregular heartbeat, shortness of breath or a rash stop taking the medication immediately and seek medical attention.

Sincerely,

H.B. White M.D.

South Florida Injury and Convenient Care

Medical director