Pensacola Physical Medicine, Inc.

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Patient Name_____ **Date**_____

Address: _____ **Date of Birth**_____

Age_____ **Primary Care Physician:** _____ **Date of last physical/ labs**_____

Email Address: _____ **Primary Phone Number:** _____

Emergency Contact & Phone Number: _____

Medical History: Have you had the following diseases or conditions? If Yes, please write year of diagnosis

Disease/Condition	No	Yes	Date
High Blood Pressure			
Heart Disease (heart attacks, heart failure)			
Stroke			
High Cholesterol			
Glaucoma			
Uncontrolled Asthma			
Emphysema			
Thyroid Disease (Hyperthyroidism Hypothyroidism)			
Neurological Disorder			
Seizure/Epilepsy			
Anorexia/Bulimia			
Anxiety/Depression			
Drug/Alcohol Abuse			
Kidney Disease			
Liver Disease			
Anemia or other blood disorder			
Blood Clotting Disorder			
Diabetes			
Cancer			
HIV			
Autoimmune Disorder			
Pregnant			
Breastfeeding			

List Any Allergies to Medications

Daily Medications and Supplements

Name	Daily Dosage

Hospitalizations/Surgeries

Year	Reason

LMP: _____

Pregnancies

Year	Complications?

Tobacco Use: Yes or No: (if Yes) How Much_____ How long_____
Alcohol: Yes or No: (if Yes) How Much _____/Day or Week
Illicit Drug Use: Yes or No (if Yes) Type _____

Phentermine Weight Loss Program Informed Consent

Please read and initial each sentence after you review:

1. I have presented to the clinic for a consultation for weight loss management using Phentermine (if I qualify) along with an individualized diet and exercise plan. *Initial___*
2. Prior to treatment, I have fully disclosed any medical condition(s) in which Phentermine would not be a safe choice for my weight loss program. *Initial___*
3. These medical conditions have been provided to me in the weight loss package which has been reviewed by the clinician. *Initial___*
4. I understand that if I fail to disclose any medical condition(s), I release the facility which is known as Pensacola Physical Medicine, Dr. Barbara Wade, Misty Johnson DNP, FNP, & Dr. Smith from all liability. *Initial___*
5. I have been fully informed of the benefits & risks of taking Phentermine. I understand that there is no guarantee for the effectiveness of Phentermine. *Initial___*
6. I understand that the treatment received by the clinician at Pensacola Physical Medicine CANNOT replace my regular primary care physician nor any specialists where I may be a current patient. *Initial___*
7. I understand that I must have current labs that are no older than 6 months. *Initial___*
8. I agree to sign a record of release of these labs from my primary care provider. *Initial___*
9. I understand that labs can be drawn at Pensacola Physical Medicine if I do not have a current provider. *Initial___*
10. I understand that it is MANDATORY to return to the clinic 2 WEEKS after administration of Phentermine and failure to return to the clinic with automatically withdraw me from the program *Initial___*
11. I understand that I may quit the program at any time. While side effects or complications are not expected, in the event that an illness does occur, I understand that I need to contact the clinic immediately or if urgent, go to the nearest ER/call 911. *Initial___*
12. I have read and understand the above terms. All questions have been fully addressed to my satisfaction. *Initial___*

_____	_____	_____
Patient Signature	Provider Signature	Date

Phentermine Weight Loss Program Patient Information

Contraindications and Warnings:

Patients with the following should NOT use Phentermine:

1. An allergy to Phentermine
2. Those who have taken a monoamine oxidase inhibitor (MAO) within the last 14 days
3. Diagnosed with any of the following:
    a. Advanced arteriosclerosis
    b. Cardiovascular disease (Heart Disease)
    c. Moderate to severe hypertension uncontrolled
    d. Hyperthyroidism
    e. Glaucoma
    f. Liver Disease
    g. Kidney Disease
    h. Cancer
    i. Seizures or any Neurological Disorders
    j. Uncontrolled Depression and/or Anxiety
    k. HIV or Autoimmune Diseases
    l. Bleeding Disorders
    m. Uncontrolled Asthma
    n. Emphysema
    o. Drug and/or Alcohol Abuse
    p. Stroke
    q. Pregnancy or planning to become pregnant
    r. Breastfeeding

Pensacola Physical Medicine strongly encourages you to consult with your primary care physician regarding initiation of our weight loss program. Our goal is for a successful outcome and your health is very important to our clinic.

PATIENT REGISTRATION AND PRIVACY INFORMATION

1.) I request Pensacola Physical Medicine to assist me in my weight reduction efforts.
2.) I am aware that the F.D.A. recommends that Phentermine should to be used as an appetite suppressant on a short-term basis along with a comprehensive weight loss program.
3.) I understand it is my responsibility to follow the instructions carefully and to report any significant medical problems that may be related to my weight control program as soon as possible.
4.) I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.
5.) I understand this authorization is given with the knowledge that the use of the appetite suppressants involves some side effects. The more common include dry mouth, constipation, or nervousness, elevated blood pressure and heart rate.
6.) 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.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Conduct normal healthcare operations such as quality assessment and improvement activities

Patient Name: _____ Date: _____

Signature: _____

Provider Signature: _____

Lisa Della Ratta DNP, FNP-BC