New Patient Weight Loss Packet

Todays Date: _____

Patient Information:

Patient Last Name: _____ Patient First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Number: _____ Cell Number: _____

Work Number: _____ Date of Birth: _____ Age: _____

Height: _____ Weight: _____ Social Security Number: _____

Married / Single / Divorce / Widowed

Preferred Pharmacy:
Name: _____

Address: _____

Phone/Fax: _____

Gynecologic History:
Pregnancies Number: _____ Dates: _____

Last Menstrual: _____ Duration: _____

Are you regular? Y / N Do you have a history of Polycystic Ovarian Syndrome? Y /N

Are you on birth control: Y / N What Kind? _____

Medications:
List all Medications you are currently taking [supplements / prescribed / over the counter]
_____
_____
_____

Medical History:

Sleep Apnea	____ Self _____ Family	Hypothyroidism	____ Self _____ Family
Snoring	____ Self _____ Family	Hypogonadism	____ Self _____ Family
Anxiety	____ Self _____ Family	Kidnesy Disease	____ Self _____ Family
Depression	____ Self _____ Family	Obesity	____ Self _____ Family
Liver Disease	____ Self _____ Family	Heart Disease	____ Self _____ Family
Hypertension	____ Self _____ Family	Stroke	____ Self _____ Family
Infertility	____ Self _____ Family	High Cholesterol	____ Self _____ Family
Anemia	____ Self _____ Family	HIV Positive	____ Self _____ Family
Diabetes 1	____ Self _____ Family	Blood Disorder	____ Self _____ Family
Diabetes 2	____ Self _____ Family	Prostate Cancer	____ Self _____ Family
Thyroid Cancer	____ Self _____ Family	Prostate Enlargement	____ Self _____ Family
Thyroid Enlargement	____ Self _____ Family	Breast Cancer	____ Self _____ Family
Peripheral Arterial Disease	____ Self _____ Family	Reproductive / Fertility Disorder	____ Self _____ Family
Chronic Lymph Node Enlargement	____ Self _____ Family	Prior Testosterone Replacement / Exposure	____ Self _____ Family

Smoking Tabacco Use	_____ None	_____ Occasional	_____ Frequent	_____ Daily
Opioid or Pain Mediciation Use	_____ None	_____ Occasional	_____ Frequent	_____ Daily
Alcohol Use	_____ None	_____ Occasional	_____ Frequent	_____ Daily
Recreational Drugs Use	_____ None	_____ Occasional	_____ Frequent	_____ Daily
Caffeine Use	_____ None	_____ Occasional	_____ Frequent	_____ Daily

List of Past Medical History / Current Medical Issues / Past Surgeries:

_____

_____

List of Other Family Medical History:

_____

_____

Have you had a comprehensive physical exam in the last 12 months? Y / N

Do you have any Seizures? Y / N

If yes when was your last seizure?

_____

Do you have history of heart trouble? Y / N

Do you have history of blood clots? Y / N

Do you have a history of prostate putridity / gland tumor? Y / N

Lipo allergy to Sulfa drugs: Bactrim / Septra / Eryzela / Glyburide

Weight Loss Specific Questions:

What program are you looking at doing today?

- **Growth Hormone Peptides:** is a compound that stimulates the pituitary gland to produce growth hormones. At night, during your body's natural cycle of growth hormone production, Sermorelin stimulates the pituitary gland during REM sleep. The pituitary gland produces growth hormones which repair tissue, bones, nerves, and more. GHRP2 also acts as an appetite suppressant allowing for increased weight loss.
- **HCG 23:** is a subcutaneous injection that has been safely used to enhance and accelerate weight loss for over 60 years. This hormone allows the body to mobilize fat and use it as energy. Research suggests given in low doses weight loss of a ½ pound per day when accompanied by a low caloric intake. It is given upon awakening once a day for 23 - 45 days, depending on the individual's medical history and weight management goals.
- **Phentermine:** is a medication for chronic weight management. It is for people with overweight and weight-related complications or obesity. It is meant to be used together with a lifestyle therapy regimen involving a reduced calorie diet and increased physical activity. Generally, a patient needs to have a BMI >25.

Human Growth Hormone Peptide

Risks vs Benefits of HGH Peptide Therapy and understand that this treatment is elective. I have been made aware that the following are possible adverse events/reactions:

- I understand that therapy may awaken laten cancers, may promote metabolic disorders such as diabetes and may exacerbate the decline of other endocrine functions by changing and/or distorting essential hormonal interactions.
- I understand that HCH benefits may take 4-8 weeks to take effect. If no positive effects are noted at this point, I will have serial blood draws to measure effectiveness prior to continuing treatment.
- I understand how to draw and administer HGH peptide and agree to take the exact dose prescribed by my provider.
- I understand the other side effects include: Injection site reactions (such as pain, swelling, or redness), headache, flushing, difficulty swallowing, dizziness, hyperactivity, sleepiness, hives, nausea, vomiting, change in taste, pale skin, or tightness in chest. If any of these reactions occur, medication should be discounted immediately, and I will seek appropriate medical attention.

Patient Informed Consent for Medical Weight Loss with use of Phentermine

I hereby authorize Titan T- Center & Weight Loss to assist me in my weight reduction efforts. I understand that my treatment program consists of a balance diet, a regular exercise program, instruction in behavior modification techniques, meeting with a registered dietician, and the use of appetite suppressant medication Phentermine. I also understand that regular medical visits will be necessary while on the medication and that Phentermine must be used with caution and under direct supervision of Titan T – Center & Weight Loss.

Risk of Proposed Treatment: I understand that any medical treatment may involve risks as well as proposed benefits of weight loss. I understand that this authorization is given with the knowledge that the use of Phentermine involves risks. Risks of Phentermine include but are not limited to nervousness, diarrhea, constipation, sleeplessness, headache, tremor, fever, fainting, dry mouth, rash, change in libido, difficulty urinating,

shortness of breath, swelling of feet or ankles, tiredness, dizziness, temporary memory loss, weakness, allergic reactions, psychological imbalances, hallucination, stomach cramps, high blood pressure, palpitation, arrhythmias, rapid heart rate, and gall stones. Although seen only in rare cases, pulmonary hypertension, or heart valve disease may develop. These latter two conditions are serious and can be fatal. In case of serious side effects, stop taking the Phentermine and see immediate medical assistance. In Addition, Phentermine can be addictive and should not be used with a history of drug dependence. I also understand that there are certain health risks associated with remaining overweight or obese including high blood pressure, diabetes, heart attack, heart disease, arthritis of the joints, sleep apnea, and sudden death.

I further understand that phentermine should not be used by people who suffer from heart disease, glaucoma, history of a stroke, liver or kidney disease, those with history of drug dependency, alcoholism, psychotic illness, uncontrolled hypertension, advanced atherosclerosis, thyroid over-activity, people are on MAOI's, serotonin migraine medications, or lithium.

While taking Phentermine avoid taking the following medication:

Decongestant medication, {Sudafed/pseudoephedrine, Tylenol sinus, Claritin D, Zyrtec D, Allegra D}, stimulate medications, high doses of caffeine, other weight loss medication, ephedrine MAO inhibitions and alcohol.

Patient Responsibility: As the patient, I understand it is my responsibility to follow instructions carefully, and to report to Titan T-Center & Weight Loss any significant medical problems that I think may be related to my weight control program as soon as possible. I agree to notify Titan T – Center & Weight Loss of any medical problems that I may have, or any results of labs/tests ordered and reviewed by any other physician. I further acknowledge that I enter this program in full knowledge and understanding that no physician, provider, or staff of the weight loss physician has prior knowledge as to whether I would or would not have adverse effect since each individual has a different biological and chemical make-up. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight reduction and weight maintenance. I understand that a balanced caloric counting program combined with regular exercise without the use of Phentermine may likely prove successful if followed, even thought I would be hungrier than without the suppressant.

Phentermine may result in lethargy or depression with abrupt discontinuation, and I understand that during the program, medications will be discontinued if:

- I become pregnant, try to become pregnant, or suspect that I am pregnant.
- I develop a contraindication or serious side effect of the medication.
- I do not comply with medical requirements, i.e., visits, med doses, etc.
- I fail to lose and/or maintain weight appropriately.
- I have a planned surgery. Medications are to be stopped at least 2 weeks prior to any surgical procedure requiring general anesthesia.

Woman Only: I understand Phentermine should not be taken during pregnancy, due to the change of damage to the fetus. This has been explained to me fully, and I am aware of the risks involved. To the best of my knowledge, I am not pregnant. I am aware of the precautions that should be taken to avoid pregnancy while I am on the medication. If I become pregnant, I will advise both Titan T- Center & Weight Loss and my OB/GYN immediately. In addition, Phentermine is not to be used while breast feeding.

NO GAURANTEE: I UNDERSTAND THAT MUCH OF THE SUCCESS OF THE PROGRAM WILL DEPEND ON MY EFFORT, AND THAT THERE IS NO GUARANTEE THAT THE PROGRAM WILL BE SUCESSFUL. I UNDERSTAND THAT I WILL HAVE TO CONTINUE WITH SENSIBLE AND NUTRITIONAL EATING HABITS AND REGULAR EXERCISE ALL OF MY LIFE, IF I AM TO BE SUCESSFUL LONG TERM.

Patient Consent/Waiver: I have read and fully understand this document and authorize and accept the proposed care regardless of the risks. I affirm that my questions have been satisfactorily answered at this time. I realize that I should not sign this form if all items are not understood by me or if my questions have not been answered to my satisfaction. I hereby release Titan T-Center & Weight loss from any liability associated and connected with my participation in this weight loss program. I accept the risks as discussed above, in hopes of obtaining desired beneficial results of weight loss treatment.

WARNING: If you have any questions as to the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask the physician of Titan T-Center & Weight Loss now before signing this consent form. To conclude, by signing this document you are agreeing to the risks associated with Phentermine, and any of the weight loss programs offered by Titan T-Center & Weight Loss. You are agreeing that to be successful in your weight loss goals you must alter your lifestyle and adapt healthy eating and exercise patterns. You are agreeing that you are not pregnant or breast feeding. You are agreeing that you understand Phentermine may be addictive. You are agreeing that you must notify Titan T-Center and Weight Loss of any medical conditions current or that develop while taking any of the medications prescribed and you are agreeing that this document has been adequately explained to you and that you understand the documents in its entirety.

Patient Name: _____

Patient Signature: _____ **Date:** _____