



Patient Reported

Height: _____

Weight: _____

Date: ____/____/____

Primary Care Physician: _____

First Name: _____

Last Name: _____

Date of Birth: ____/____/____

Sex F/M: _____

Occupation _____

Address: _____

City: _____

State: _____

Zip Code: _____

Primary Phone #: _____ — _____ — _____

Secondary Phone: _____ — _____ — _____

Email Address: _____

May we call/leave message/email with appointment reminders? Yes/No _____

Please Do Not Fill Out Below Line ———For Office Use Only

Current Prescriptions: _____, _____, _____
_____, _____, _____

Allergies: _____

Height: _____

Weight: _____

BMI: _____

Waist Measurement: _____

Intake Notes: _____

Blood Pressure : _____

Pulse: _____

Heart: _____

Thyroid: _____

Lungs: _____

Doctor's Notes: _____

Doctor's Signature: _____

RX Label: _____



Medical History

Legal Name: _____
(As It Appears On Your State Or Government Issued ID)

Date of Birth: ____/____/____ Age: ____ Sex M/F: ____

Driver's License # _____ Issuing State: _____

Name of Primary Care Physician: _____

Address of Primary Care Physician: _____

Check any of the following illnesses or medical conditions that you currently have or have had in the past:

- | | |
|---|--|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Bulimia |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Anorexia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Alcohol/Drug Addiction | <input type="checkbox"/> Prostate Problems |

Check any of the following illnesses or medical conditions that are in your family history.

- | | |
|--|----------------|
| <input type="checkbox"/> Stroke | Relative _____ |
| <input type="checkbox"/> Heart Disease | Relative _____ |
| <input type="checkbox"/> High Blood Pressure | Relative _____ |
| <input type="checkbox"/> Diabetes | Relative _____ |
| <input type="checkbox"/> Obesity | Relative _____ |



Are you pregnant? _____ Are you nursing? _____ Do you Smoke? _____

Patient Signature _____ Date ____/____/____



Medication List

Please list all medications or drugs you are currently taking as prescribed by a dentist or doctor:

_____, _____, _____, _____,
_____, _____, _____, _____.

Birth Control Statement

Diet medications can be potentially harmful to a fetus. It is imperative to use extreme caution with a certain form of birth control.

Are you currently using any form of birth control? Yes/No _____

If yes, please list the form of birth control used: _____

Have you ever taken an FDA approved appetite suppressant? Yes/No _____

If yes, please list the medication(s) taken: _____

Date last taken: ____/____/_____

Do you have any allergies/reactions to any medication or food items? Yes/No _____

If yes, please list medication(s) or food item(s) with a brief explanation of the allergy/reacton:

Full Legal Signature: _____

Date: ____/____/_____



Dear New Patient,

Thank you for allowing Eastern Shore Medical Weight Loss the opportunity to assist you with your weight loss goals. Please feel free to ask any of our staff any questions you may have regarding your weight loss program. We want to make it our top priority to make you feel as empowered as possible. Please understand that we do not claim that an enormous amount of weight will be lost in a short amount of time. The FDA approved medications that our doctor(s) prescribe for you are compounded to help reduce your appetite, speed up your metabolism, and give you energy. We recommend, as a way to maximize your weight loss efforts, that you make a change in the types of foods you are eating, lowering your portion sizes, eliminating sugary drinks and starting an exercise program under the direction of your primary care physician.

The general nature and purpose of Eastern Shore Medical Weight Loss is to offer an overview of dietary education supplemented with FDA approved appetite suppressants, prescribed by our State Licensed Physician, for the treatment of weight loss.

Alabama State Law requires that we inform you of the nature of our program, including the risks associated with the medication prescribed for treatment, and to obtain your consent for such treatment. The following document titled *Medication Side Effect Acknowledgement*, will list possible side effect. Please read the acknowledgement carefully and ask any questions you may have. Further, we recommend that you consult your primary care physician regarding this program and its effect on any medications you may be taking.

Eastern Shore Medical Weight Loss
28588 Highway 98
Unit 7
Daphne, AL 36526



Medication Side Effect Acknowledgement

The FDA approved medications prescribed by our doctor's at Eastern Shore Medical Weight Loss are meant to be used as an oral appetite suppressant in conjunction with an overall change in diet and increase in exercise to reduce weight.

Some side effects known to be associated with these medications are:

Dry mouth, nervousness, headache, insomnia, heart palpitations, impotence and lack of libido. These medications are not recommended for individuals with hypertension, hyperthyroidism, glaucoma, cardiovascular disease and advanced arteriosclerosis.

I acknowledge that I have read and have been informed of the nature of this weight loss program and the side effects associated with the medication that may be prescribed to me. I also acknowledge that this consent shall remain valid until revoked by me in writing. I further affirm that I understand that once the medication is purchased, by law I cannot return it for any reason. I understand that if I request to have the medication destroyed, and in return want to try another medication, I will be charged for the doctor visit and the medication as a normal doctor visit.

Full Legal Signature: _____

Date: ____/____/____



Refill Appointment Acknowledgement

I understand that after my initial appointment and upon the approval of the doctor(s) at Eastern Shore Medical Weight Loss Clinic, it is my responsibility to make a refill appointment.

I understand that I cannot walk into the clinic at anytime to receive a refill prescription. I further understand that I must make an appointment for clinic day (Friday) and that I must see a doctor at each appointment.

I understand that the cost of each visit will be determined by the medication prescribed at that visit as there are different costs associated with FDA approved medications available.

(Example: If you are prescribed Phentermine every month then your cost would be the same every month but, if you request an alternative medication the price may not be the same as Phentermine). Exceptions to the cost of the medication may include a \$10 referral discount or a special offer.

Full Legal Signature: _____

Date: ____/____/____

Please Let Us Know How You Heard About Us

Friend/Relative

Please write the name of the person that referred you so that they receive a \$10.00 discount off their next visit: _____

You'll receive this same discount if you refer a new patient and they give your name. Please remember this discount is only applied to your next visit if the patient you referred came into the clinic and was seen by our doctor.

Google /Website

Facebook Page

Other —Please Specify _____