Weight Loss History

Name: _____ Date of Birth:_____ Age:___ Date:_____

Name that you prefer to be called:_____

Address:_____
(Street #) *(City)* *(State)* *(Zip)*

Home Phone:_____ Cell Phone:_____ Sex: M/F

Email:_____ Who is your Physician:_____

Where do you work?_____

Name/# Emergency Contact_____

Dietary & Exercise History

What weight loss programs/techniques/diets have you tried?_____

What was your weight when you graduated high school?_____

What do you attribute your weight gain to?_____

Do you exercise? What type? How often?_____

Do you eat a balanced & healthy diet? Y/N

Do you eat 3 meals/day? Y/N Do you graze throughout the day? Y/N

Are you a night time Eater? Y/N Are you a binge eater? Y/N

Do you skip meals? Y/N Do you eat before you sleep? Y/N

Why do you want to lose weight?_____

How Did you Hear about our Weight Loss Program?

☐ *Already a Client* ☐ *Radio Ad* ☐ *Referred By:*_____

☐ *Billboard* ☐ *Website*

☐ Newspaper Ad ☐ *Walk-in/Sign*

Medical History

Do you have or have you had?	YES	NO	Do you have or have you had?	YES	NO
Fatigue			Heart Palpitations		
Heart Disease			Heart Fluttering		
Sleep Disorders			Chest Pain		
Asthma			High Cholesterol		
Thyroid disorder Hypo or Hyper (low/high)			Cancer Type? _____		
Depression			Anemia		
Anxiety			Gallstones		
BiPolar Disorder			Dizzy Spells		
Psychiatric Illness			Heart Murmur		
Memory Loss			Diarrhea		
Diabetes			Constipation		
High Blood Pressure			Sleep Apnea		
DVT/ Pulmonary Embolism			Swelling of legs/ankles		
History of Heart Attack			COPD		
History of Coronary Artery Disease			Seizures		
Migraine Headaches			Bulimia		
Kidney Disease			Anorexia		
Liver Disease			Kidney Stones		
Hepatitis			Shortness of Breath		
Polycystic Ovarian Syndrome			Stomach Ulcers		

Do you have a history of Alcohol/Drug Dependence? Yes or No

Do you have a family history of cardiac disease, sudden death, cancer, high blood pressure, diabetes, psychiatric illness? Yes or No

If yes, who (mother, father, sister, brother, aunt, uncle …) _____

Notice of Personal Health Information Practices (HIPAA Privacy Notice)

Dr. Marc S. Scheiner is committed to treating information about you and your health responsibly. The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule gives individuals the right to be informed of the privacy practices of their health plans and of their health care providers, as well as to be informed of their individual results with respect to their protected health information. Health care providers are required to provide a notice of these practices. By signing here you are agreeing that you have received or have been given the opportunity to review our Notice of Privacy Practices. You are further giving your consent to Dr. Scheiner to provide your physician with information regarding the treatment you receive by Dr. Scheiner

Name_____ Signature _____ Date _____

Lipotropic MIC – B12 Injections Informed Consent

Vitamin injections maintain good health and have been shown to be beneficial in helping to: Reduce stress, fatigue, improve memory and cardiovascular health, and maintain a good body weight. It can also assist the body in converting proteins, fats and carbohydrates into energy and is necessary for healthy skin and eyes.

Vitamin injections are better absorbed by the body since they go directly into the blood stream. Alternatives to vitamin injections are oral vitamins, B12 patch, lozenges, liquid drops, and nasal spray.

1. Risks: I understand there is a risk of mild diarrhea, upset stomach, nausea, a feeling of pain and a warm sensation at the site of the injection, a feeling, or a sense, of being swollen over the entire body, headache and joint pain.

2. If any of these side effects become severe or troublesome, I will contact my physician immediately.

3. I understand that although rare, vitamin injections can result in serious side effects. Although this is relatively rare occurrence, anyone taking vitamin injections should be aware of the possibility. Uncommon side effects include:

- rapid heartbeat
- chest pain
- flushed face
- muscle cramps and weakness
- difficulty breathing and swallowing
- dizziness
- confusion
- tight feelings in the chest
- hives, skin rashes
- shortness of breath when there is no physical exertion and unusual wheezing, and
- coughing.

4. Before starting Vitamin injections, I will make sure to tell my Physician if I am pregnant, lactating, or have any of the following conditions

- Leber's disease
- Kidney disease
- Liver disease
- An infection
- Iron deficiency
- Folic acid deficiency
- Receving any treatment that has an effect on bone marrow
- Taking any medication that has an effect on bone marrow
- An allergy to cobalt or any other medication, vitamin, dye, food or preservative.

5. I understand that certain herbal products, vitamins, minerals, nutritional supplements, prescription and non-prescription medications may result in side effects when the interact with the vitamin injection.

6. I understand that I will be receiving a B12 vitamin injection or a Vitamin and Amino Acid injection consisting of Vitamin B12, methionine, inosital, and choline. This injection is commonly referred to as a lipotropic injection or a MIC-B12 "fat burner" injection.

By signing below, I acknowledge that I have read the foregoing informed consent and agree to the Vitamin treatment with its associated risks. I hereby give consent to perform this and all subsequent injections with the above understood. I hereby release the doctor, the person injecting the vitamins, and the facility from liability associated with this procedure.

Patient signature: _____ *Date:* _____

Patient Informed Consent for Medical Weight Loss with the use of Phentermine

I hereby authorize Dr. Marc Scheiner to assist me in my weight reduction efforts. I understand that my treatment program consists of a balanced diet, a regular exercise program, instruction in behavior modification techniques, meeting with a registered dietician, and the use of the 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 Dr. Marc Scheiner.

Risk of Proposed Treatment: I understand that any medical treatment may involve *risks* as well the proposed *benefits* of weight loss. I understand that this authorization is given with the knowledge that the use of Phentermine involves risk. 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, hallucinations, stomach cramps, high blood pressure, palpitations, 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 seek immediate 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 and 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 athereosclerosis, thyroid over-activity, people who are on MAOI's, serotonin migraine medications, or lithium.

While taking Phentermine avoid taking the following medications: Decongestant medications (Sudafed/Pseudoephedrine, Tylenol Sinus, Clariten D, Zyrtec D, and Allegra D), Stimulant medications, high doses of caffeine, other weight loss medications, ephedrine MAO inhibitions and alcohol.

Patient responsibility: As the patient, I understand it is my responsibility to follow instructions carefully, and to report to Dr. Scheiner any significant medical problems that I think may be related to my weight control program as soon as possible. I agree to notify Dr. Scheiner 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 into 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 effects due to the fact that 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 loss. I understand my continuing to receive Phentermine will be dependent on my progress in 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 though I would be hungrier than without the suppressant.

I am also in full understanding that Phentermine will be used no longer than 3 consecutive months. After 3 months of use, the medication will be discontinued. If I and Dr. Scheiner agree to use the medication longer than 3 months or if my BMI has decreased below the Federal Drug Administration's recommended value, I will be using the medication in an off-label manner.

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

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

Women Only: I understand Phentermine should not be taken during pregnancy, due to the chance 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 Dr. Scheiner and my OB/GYN immediately. In addition, Phentermine is not to be used while breast feeding.

NO GUARANTEEE: 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 SUCCESSFUL. I UNDERSTAND THAT I WILL HAVE TO CONTINUE WITH SENSIBLE AND NUTRITIONAL EATING HABITS AND REGULAR EXERCISE ALL MY LIFE, IF I AM TO BE SUCCESSFUL LONG-TERM.

Patient Consent/Waiver: I have read and fully understand this document and authorize and accept the proposed care regardless of the risk. 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 questions have not been answered to my satisfaction. I hereby release Dr. Marc Scheiner and Cecil Dermatology, LLC, from any liability associated and connected with my participation in this weight loss program. I accept the risks as discussed above, in hope of obtaining desired beneficial results of weight loss treatment. I understand it is my responsibility to give Dr. Scheiner the name of my primary care physician where labs and/or EKG can be obtained for follow through and interpretation, if need be.

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 Dr. Scheiner now before signing this consent form. To conclude, by signing this document you are agreeing to the risks associated with Phentermine. You are agreeing that to be successful in your weight loss goals you must alter your lifestyle and adopt healthy eating and exercise patterns. You are agreeing that you understand Phentermine may be addictive. You are agreeing that you must notify Dr. Scheiner of any medical conditions current or that develop while taking Phentermine. You are agreeing that this document has been adequately explained to you and that you understand the document in its entirety.

Patient Signature: _____ Date: _____

Provider Declaration: I have explained the contents of this document to the patient and have answered all the patient's related questions. To the best of my knowledge, I feel that patient has been adequately informed concerning the benefits and risk associated with the use of Phentermine, the benefits and risks associated with alternative therapies, and the risks concerning an overweight status. After being adequately informed, the patient has consented.

Provider Signature: _____ Date: _____

Medical Dispensing Form

I have been informed by Dr. Marc Scheiner that I am being prescribed the medication Phentermine, Phendimetrazine, Diethylpropion and/or Semaglutide.

I may fill my prescription at a pharmacy or at Dr. Marc Scheiner's office.

If I choose to have the medication dispensed by Dr. Marc Scheiner, I am indicating that a pharmacy is not conveniently available to me and that the determination that a pharmacy is not conveniently available to me was made solely by me.

The reason that a pharmacy is not conveniently available to me is:

- □ Daily activities, such as childcare and work, limit my time to go to a pharmacy
- □ My pharmacy hours are not convenient
- □ I do not have transportation
- □ Other: _____

Name (printed): _____

Name (signed): _____ Date: _____

Diet & Exercise Disclaimer

By signing below, I attest that I have tried to make changes to my diet and increase my amount of exercise for at least 6 months, without weight loss success.

Signature: _____ Date: _____

There will be a $10 fee added to your follow up appointment, should you not show up for your appointment. Kindly provide us with a 24 hour cancellation notice to avoid this fee. Thank you for your understanding.

Signature: _____ Date: _____