Physlim

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Patient information

Date: Name: How did you hear about us?

Address: City, State Zip:

Home Phone: Cell Phone: Email:

Preferred Contact: Birthday:

Email Phone

Primary Care Physician: Phone Number:

Occupation: Company: Phone Number:

Emergency Contact

Name: Relationship: Phone:

Medical History

List of Medications:

Surgeries: Dates:

List Allergies to Medication:

Have you ever taken an Appetite Suppressant before? When?

Yes No

What has been your maximum lifetime (non-pregnant) weight? When?

Men

Last Digital Rectal Exam/ Prostate Exam:

Are you and your spouse trying to conceive?
Yes No

Do you experience any of the following?
Prostate problems Impotence/ Erectile Dysfunction Other:_____

Women

Are you Pregnant?
Yes No

Are you trying to get pregnant?
Yes No

Number of Pregnancies _____
Number of Children _____

Are you currently experiencing (Circle all that apply)
Pre-menopausal Menopausal Post-Menopausal

Vaginal Discharge?
Yes No

I currently have or have had in the past (Circle all that apply)
Irregular Menstruation Heavy Flow Light Flow No Flow Clots Cramps Irritability Breast Tenderness

Gastrointestinal

Do you experience any of the following? (Circle all that apply)
Belching Heartburn Bloating Pain Acid Reflux Gas Bad Breath Other: _____

Irregular Bowel Movements Constipation Diarrhea Loose Stools Undigested Food in Stool

Burning Sensation Hemorrhoids Anal Itching Other: _____

Other

How is your overall temperature? (Circle One)
Hot Cold Normal

Perspiration (Circle all that apply)
Spontaneous Sweating Night Sweats Profuse Sweating Absence of Sweating

Thirst (Circle all that apply)
Thirsty No Thirst Thirst for Cold Beverages Thirst for warm Beverages

Appetite (Circle One)
Normal Increased Decreased

Family Health History

List illnesses that have occurred within your family:
Mother:

_____

Father:

_____

Siblings:

_____

Grandparents:

_____

Other Blood Relatives:

_____

Please include any of the following that apply: Diabetes, high blood pressure, stroke, cancer, heart disease kidney disease, liver disease, alcoholism, etc.

I, _____, understand that Phentermine (Adipex), and Phendiametrazine are controlled substances, and therefore my name and date of birth will be searched on the Georgia Prescription Drug Monitoring Program website to endure I am not having either of these medications filled by other prescribers or offices.

Please list ALL addresses you have lived at in the past 12 months:

1.) _____
street address city state zip code

2.) _____
street address city state zip code

3.) _____
street address city state zip code

_____
Patient Signature Date

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Weight Loss Program Consent Form

I _____ authorize Dr. Spurlock, PhySlim LLC, and whomever they designate as their assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

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. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.
I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.
If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

_____ _____

Patient Signature Date

Have you had any of the following medical conditions?
(Check only those that apply)

- Allergies
- Arthritis
- Asthma
- Anemia
- Tendency to Bleed
- High Blood Pressure
- Low Blood Pressure
- Celiac Disease
- Cancer
- Depression
- Diabetes
- Dizziness
- Eczema
- Fainting/seizures/ Epilepsy
- Frequent Colds
- Glaucoma
- Hay Fever/ Seasonal Allergies
- Headaches/ Migraines
- Heart Attack Date:
- Heart Disease
- Heart Failure
- Heart Surgery (Pacemaker)
- Stroke Date:
- High Cholesterol
- Hypotension
- Hypertension
- Hypothyroid
- Hyperthyroid
- Hepatitis A, B, C, D, E (Circle)
- HIV/ AIDS
- Herpes
- Kidney Disease
- Liver Disease
- Tuberculosis
- Weight loss
- Weight gain
- Other: _____

Lifestyle- Please circle all activities that

Exercise Alcohol Vegetarian Diet Meditation Marijuana Soft Drinks Narcotics

Coffee (cups/day_____) Smoking (pks/day_____) Caffeine (cups/days_____)

Energy

How is your energy? Please circle. Low 1 2 3 4 5 6 7 8 9 10 High
Do you fatigue easily? Yes No

Emotional

Do you experience any of the following? (Circle all that apply)
Anxiety Depression Panic Attacks Nervousness
Do you feel like you experience any of the following emotions excessively? (Circle all that apply)
Anger Fear Worry Grief Joy

Sleep

How many hours per night do you sleep? _____
I have difficulties with (Circle all that apply)
Falling Asleep Staying Asleep Waking Early (Time_____) Dream-Disturbed Sleep