The Weight Clinic

Please, at your initial consultation, let the doctor know if you have any of the following conditions:

Uncontrolled blood pressure

*

Chest pain = Angina

*

History of Heart Attack or heart disease

*

History of Stroke

*

Mitral Valve Prolapse

*

Glaucoma

*

Pregnancy

*

Hyperthyroidism

*

Hypoglycemic

Patient Information Form

Patient Name: (Last)_____ (First)_____(MI)
Name you prefer to be called_____
Patient Address:_____
City:_____State:_____Zip:_____
Home Phone:_____Cellular ber:_____
Birthdate:_____Age:_____Sex_____
Country of Birth:_____Country of Parents Birth:_____
E-Mail Address_____
Patient Employer:_____Occupation_____
Employer Address:_____
City:_____State_____Zip_____
Work Phone Number:_____Extension____
Social Security Number_____Drivers License #_____

In Case of Emergency:
Name:_____Relationship_____Phone_____
Patient's Spouse_____Phone_____
Family's
Physician_____Phone_____
Referred by:_____

Financial Policy:
Thank you for selecting Dr. Summers for your health care needs. We are honored to be of service to you. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, Mastercard, Debits and Cash.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements

_____ _____
Patient's Signature Date

The Weight Clinic
462 McQueen Smith Road South
Prattville, Alabama 36066
(334) 358-9262

New Patient Questionnaire

This medical history and physical exam are for our purposes at Dr. Summers Weight Clinic and in no way replace you care and exams with your health care provider.

NAME: _____

DOB: _____

AGE: _____

HT: _____

WEIGHT: _____

Please circle your answer to these questions, if your answer is yes, please explain and then sign below:

Are you pregnant, breastfeeding or planning to get pregnant soon? Yes ___ No ___
(Appetite suppressant medication should not be taken while pregnant, breastfeeding or attempting to conceive as the risks to the fetus and fertility are unknown, but potentially serious or life threatening. Serious adverse reactions can occur in nursing infants.)

Do you have a history of Depression, Panic Disorder, Anxiety Disorder, Nervousness or fear of medications? Yes___ No___

Are you currently on any type of anti-depressant medication? Yes___ No___

Do you currently have or had a history of the following?

Heart disease? (Irregular heart beat, palpitations, chest pain, shortness of breath, heart murmur, mitral valve prolapse, arrhythmia, pacemaker or defibrillator.) Yes___ No__
High blood pressure? Yes___ No___
High cholesterol? Yes___ No___
Headaches or migraines? Yes___ No___
Anorexia or Bulimia or? Yes___ No___
Glaucoma? Yes___ No___
By-Pass Surgery? Yes___ No___
Advance kidney or liver disease? Yes___ No ___
Have you ever or currently undergoing drug addition treatment?
Have you ever had a bad reaction to stimulant drugs? Yes___ No___
Do you have thyroid problems? Yes___ No___
Do you have diabetes, type 1 or 2 ? Yes___ No___
Have you been treated for Hypoglycemia?
Do you feel "wired" or uncomfortable on caffeine or Sudafed? Yes___ No___
Have you ever been treated for seizures or epilepsy? Yes___ No___
Have you ever tested positive or had treatment for TB? Yes___ No___
Have you ever tested positive for Aids? Yes___ No___

Please list ALL drug allergies, including prescription, herbal and over-the-counter medications.

Please list ALL medications and dosage you are taking, including prescription, herbal and over-the-counter medications.

Please list ALL diet medications you have used:

Is there any ADDITIONAL INFORMATION regarding your medical history you would like us to know?

"I declare to the best of my knowledge this information is complete and true. I agree to Dr. Summers Weight Clinic providers believing it to be TRUE, shall rely and act upon it in making medical decisions about my weight loss treatment."

Patient's signature _____

Date:_____

Provider Signature_____

THE WEIGHT CLINIC
462 McQueen Smith Road South
Prattville, Alabama 36066
Phone: (334) 358-9262

Medication Side Effects

At The Weight Clinic, we strive to help our patients lose weight. Besides diet and exercise advice and the use of dietary supplements, we also may prescribe certain medications called "stimulant" drugs to help our patients lose weight. These stimulant medications called phentermine, work in the body's central nervous system by increasing your metabolism and decreasing your hunger drive to help you lose weight.

These medications have been prescribed for short term weight loss therapy for many decades and are considered relatively safe for most people. Certain medical conditions and medications can increase the risk of reactions or side-effects while using these drugs, so it is important to tell our clinician and doctors about all your other medical conditions and medications you take.

The majority of patients taking stimulant medications for weight loss never have any problems with the stimulant medication itself, but some people do. Therefore, it's important to tell you about what some of those reactions or side-effects could be when considering this form of weight loss treatment. Most side effects are mild (although some can be unpleasant) and usually improve or go away completely as your body adjusts to the medication.

Some reactions or side-effects to stimulants could be:

- Increased anxiety, jittery, edgy, restlessness or nervousness.
- Feeling lightheaded, drowsy or dizzy
- Headaches
- Irregular or increased heart beat or high blood pressure
- Feeling hot, increased sweating, excessive thirst or dry mouth
- Constipation, diarrhea, trouble sleeping and others.

Stimulant drugs are considered "controlled substances" and are monitored by the DEA and should be safe-guarded against theft or loss. Taking these medications too often or in too large quantity and longer than prescribed, can lead to addiction or, in worse-case situations, an overdose. Rarely, serious and even fatal outcomes have been reported. Symptoms of an overdose can include confusion, convulsions, hallucinations, and coma.

Even if not overdosed, rarely some people can have serious reactions to the medications that could be life threatening. So, if you ever experience any of the following symptoms, call your doctor, dial 911, or go to the nearest ER for evaluation: Some symptoms are:

- Chest discomfort, shortness of breath or difficulty breathing
- Swelling in the feet or lower legs
- Irregular heartbeat, fast heart rate, or large increase in blood pressure

Because these are most often prescribed in weight loss medical clinics nationally, we feel they are safe for most patients, but they are not for everyone. At The Weight Clinic, we strive to inform and treat you with the utmost care and courtesy. We want you to be well and lose weight with or without medication. Please know our performing focused medical history, examination, and lab test review is part of that, but sometimes even those exams may not be able to tell us who will have a rare reaction to these medications.

Should you have any questions about these medications or their side effects and risks, please ask our clinician. Please sign that you have read and understand this information.

Patient Name:_____
(print)

Patient Signature_____

Date:_____

Summers Weight Loss Clinic

Important Treatment Information

1. I understand to only take the prescribed dosage of oral medication that I am given and I will not give the medication to another person
2. I will notify this office of ANY and ALL changes of prescribed and over the counter medications I am taking including strength and dose
3. I will update this office whenever I have a new diagnosis or new medical issue I am being treated for by all other medical offices I receive care from. This includes psychiatric or emotional disorders as well as any new Medications when prescribed elsewhere
4. I understand I will receive my weight management participation treatment for the sole purpose of the weight management program. All medical staffs' directives and treatments should not be regarded as are from a primary care physician.
5. I understand my medical history, examination at Summers Weight Clinic are strictly to evaluate my qualification as a candidate for this weight management program and that I may need further tests and or treatments from my primary care physician.
6. I understand any additional health issues not directly related to the medical weight management program will need to be addressed by my primary care provider in a timely manner, including abnormal exam or lab test findings
7. I understand that if Dr. Summers has approved me for this medical weight management treatment, I could still have a medication reaction, allergy, or side effect that can't always be predetermined, even after a medical exam
8. I understand I will be given information on side-effects and risks of taking stimulant medications like adipex and it is important I read the information and ask any questions before taking the medications or supplements in this medical weight management program
9. I understand all injections have inherent risk which may include, but not be limited to bruising, bleeding, injection at site and allergic reaction.

I have read, understood and agreed to all the items above.

Patients
Signature:_____