Fairmont Weight Loss Clinic

4416 Fairmont Pkwy Ste 108 Pasadena, TX 77504 Ph: 281-487-0402

Medical History Questionnaire

First / Last Name (Nompre/ Apellido)	Date of Birth (Fecha de Nacimiento) Age (Edad) Gender
Address(Direccion)	Home Phone # (Numero de Casa) Cell Phone # (Numero de Celular)
City/State/Zip (Cuidad/Estado/Codigo Postal)	Email (Correo Electronico)

How were you referred to our clinic?/ ¿Como fue referido a la clinica?: _____

Mark the participating factors that pertain to you. / ¿Cual le pertenece a usted?

Inactivity/Inactividad____Overeating/Come Demasiado____Sedentary Job/Trabajo Sedentario____Injury/Lesion____
Childbirth/Parto____Stress/Estrés____Depression/Depresión____Smoker/Fuma____Drinker/Toma_____

Mark the following conditions that pertain to you / Marque que condiciones apliacan para usted:

Medical History / Historia Medica
Asthma/Asmaticó____Cervical Cancer/Cancer Cervical___Depression/Depresión ____Bi-polar Disorder/ Desorden Bipolar___
Diabetes/Diabetes_____ Hypertension/Hipertenso_____ Infertility/Infertilidad_____ Menopause/Menopausia_____ Anxiety/Anciedad____
Obesity/Obesidad____ Thyroid Problems/Problema de Tiroides____ Other/Otro_____

Past Surgical History / Historia De Cirugia
Back Surgery/ Cirujia De Espalda____ Breast Augmentation/Aumento de Busto ____ C- Section/Cesarea____
Gall Bladder/Vesicula Biliar_____ Gastric Stapling/Engrapado Gastrico_____ Hernia/Hernia _____ Hysterectomy/Histerectomía ____
Laparoscopy/Laparoscopia _____ Liposuction/Liposucción _____ Thyroid_____ Removal/Eliminación de Tiroides_____Tubaligation/Ligadura de Trompas____ Other/Otro_____

Family History/ Historia De Familia
Cancer/Cáncer_____ Depression/Depresión_____ Diabetes/Diabetes_____ Heart Disease/Problemas del Corazón ____
Obesity/Obesidad_____Hypertension/hipertensión_____Stroke/Isquemia Cerebral(Apoplejia) ____ Other_____

Is there a certain diet that you follow? Explain. ¿Esta haciendo alguna dieta? Explique.
_____

Do you excersise? Specify. ¿Hace algun tipo de ejercicio? Explique.
_____

Are you currently taking any medications? If yes, please list medication and dosage.
¿Esta tomando algun medicamento? Si o No, Por favor note medicamento y dosis.
_____

Are you allergic to any Medications? YES / NO If so, please specify: _____
¿Es alergico algun Medicamento? SI / NO Explique: _____

Are you breast feeding? YES / NO ¿Esta dando pecho? SI / NO
When was your last Menstrual Cycle? _____ ¿Cuando fue se ultima Menstruacion?_____

Patient Informed Consent for Appetite Suppressants

I. Procedure & Alternatives:

I,_____ authorize ***Sherolyn Simmons, MD*** to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of appetite suppressants for more than 6 months and when indicated in higher doses than the dose indicated in the appetite suppressant labeling.

I have read and understand my physician's statements that follow:

- "Medications, including the appetite suppressants, have labeling worked out between the markers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter term studies (up to 6 months) using the dosages indicated in the labeling.
- "As a Bariatric Physician, I have found the appetite suppressants helpful for periods far in excess of 6 months, and at times in larger doses than those suggested in the labeling. As a physician, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer term studies and recommendations of university of university based investigators. Based on these, I have chosen, when indicated, to used the appetite suppressants for longer periods of time and at times, in increased doses.
- "Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted below).
- "As a Bariatric physician, I believe the probability of such side effects is out weighed by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses. How ever, you must decide if you are willing to accept the risks of the side effects, even if they might be serious for the possible help the appetite suppressants use in this manner may give."

I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.
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 the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an exchange eating program without the use of the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

II. Risks of Proposed Treatment:

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 6 months and in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common side effects include: nervousness, sleeplessness, and headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heart beat and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and alveolar heart disease. These and other possible risks could, on occasion, be serious or fatal.

III. Risks Associated with Being Overweight or Obese:

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to hypertension to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

IV. No Guarantees:

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 I will have to continue watching my weight all of my life if I am to be successful.

V. Patient's Consent:

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, or any questions I have concerning them, have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding other treatments not involving the appetite suppressants.

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 NOW BEFORE SIGNING THIS CONSENT FORM.

_____ _____

Patient Signature (Firma) Date (Fecha)

VI. PHYSICIAN DECLARATION:

I have explained the consents of this document to the patient and have answered all the patient's related questions, and, to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use if the appetite suppressants, the benefits and risks associated with alternative therapies and the risks of continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving the appetite suppressants in the manner indicated above.

_____

Sherolyn Simmons, MD

Weight Loss Program Consent Form

I _____ authorize ***Sherolyn Simmons, MD*** 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; any may involve 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 privates 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 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 these 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 YOUR LAB WORK IS TESTED ABNORMAL, *SHEROLYN SIMMONS, MD* WILL RECOMMEND YOU TO STOP TAKING THE MEDICATION UNTIL YOU CONSULT WITH YOUR PRIMARY PHYSICIAN. WE ARE NOT HELD RESPONSIBLE IF YOUR LAB WORK IS TESTED ABNORMAL, WE HAVE PROVIDED OUR SERVICES 100%, THEREFORE, THERE ARE NO REFUNDS!

SI SU EXAMEN DE TIROIDES REGRESA ANORMAL, *SHEROLYN SIMMONS, MD* PODRIA SUGESTIONAR QUE DEJE DE TOMAR EL MEDICAMENTO, USTED TIENE QUE CONSULTAR CON SU MEDICO ANTES DE CONTINUAR CON EL MEDICAMENTO. NO HAY REMBOLSO SI SU EXAMEN DE TIROIDE RESULTA ANORMAL, NOSOTROS LE DIMOS EL 100% EN NUESTROS SERVICIOS!

_____ _____

Patient Signature (Firma del Paciente) Date (Fecha)

Dear Patient,

Be aware that the price we are quoting you is for generic Phentermine 37.5mg tablets. Most patients have great results with this medication. However, if you are unable tolerate it or it does not work for you, we will gladly issue you a new prescription. Unfortunately, this new medication will be at an additional cost. If you have a special request for a different medication like (Tenuate 75mg or Bontril 150mg), this may also cost more than the quoted price. If for any reason your medication is stolen or lost we would not give you another prescription. **WE ARE NOT RESPONSIBLE FOR ANY STOLEN OR LOST MEDICATION!!!!**

Estimado(a) Paciente,

Para su información le estamos cotizando es para las tabletas genéricas de Phentermine 37.5mg. La mayoría de los pacientes tienen grandes resultados con este medicamento. Sin embargo, si no puede tolerar el medicamento o no funciona para usted, recetaremos un nuevo medicamento. Desafortunadamente, este nuevo medicamento tendrá un costo adicional. Si tiene un pedido especial como (Tenuate 75mg, Bontril 150mg), esto puede tener un costo adicional al cotizado. EN CASO DE PERDIDA O EXTRAVIÓ DEL MEDICAMENTO POR CUALQUIER MOTIVO, NO PODREMOS DAR UNA RECETA PARA REMPLAZARLO!

Thank you
Fairmont Weight Loss Clinic Management

_____ _____
Signature/ Firma *Date/ Fecha*

For Fairmont Weight Loss Clinic and all its staff, your safety is very important, for that reason our MD set the following safety protocol for all our new and follow up patients. All new and restarting patients will receive an e-script for seven days after consulting with the PA and after seven days the patient will return to the clinic where the MA will check their blood pressure, heart rate and weight, then the patient will have to consult either with the MD or the APN in order to receive their rest of the prescription, there will be no exceptions any staff member cannot issue a prescription without previous consultation, the patient shall not exceed more than two weeks for the check up and consultation appointment or a $25.00 fee will be issued. If the thyroid results are abnormal the patient will be required to consult with their Primary Care Physician in order to address the problem and get medicated and then the patient will continue with the program after showing proof of treatment for the thyroid problem, we will not issue a refund if the patient fails to do so. If the patient has a hypertension condition and is considered a candidate for the medication he/she will be given a Blood Pressure Log where they have to record the readings as directed by the PA, failure to do so will make the patient not a candidate for the medication and for refund, if the patient is not a candidate due to Blood Pressure they will not be charged.

The MD or APN have designated for second consultation the following days and time Mondays from 3:00 to 6:00 PM, Tuesdays from 10:30 AM to 1:30 PM and from 3:00 to 6:00 PM and Thursdays from 4:00 to 6:00PM. Please be sure to make your follow up appointment.

_____ _____
Signature Date

Para Fairmont Weight Loss Clinic y todo su personal, su seguridad es muy importante, es por eso que nuestro director medico ha establecido el siguiente protocolo de seguridad para todos nuestros pacientes nuevos y de reinicio. Todos los pacientes nuevos y reinicio recibiran un e-script para 14 dias de medicamento que deberan tomar de acuerdo a las instrucciones dadas durante la consulta con el Asistente del Doctor (PA), después de siete dias, el paciente debera regresar al al clinica donde la MA tomara su presion arterial, la frecuencia cardiaca y el peso, a continuación, tendra que consultar con el Director Medico o con la enfermera titulada (APN) con el fin de recibir su resto de la receta, no habra ninguna excepcion, ningun miembro del personal no puede ordenar medicamentos a la farmacia sin examen anterior y consulta, el paciente no excedra de mas de dos semanas para su consulta con el Director Medico, o se la hara cargo de $25.00. Si los resultados del examen de tiroides muestran un resultado anormal, sera necesario para el paciente consultar con su medico de atención primaria a fin de abordar el problema y obtener medicados para tratar el problema de tiroides, el PT va poder continuar con el programa después de que pruebe que esta bajo tratamiento medico para su problema de tiroides, no emitiremos un reembolso alguno si el paciente es incapaz de hacerlo. Si el paciente tiene presion arterial alta y no es considerado candidato para el medicamento supresor de apetito a el o ella se le dara un hoja para anotar su presion arterial de acuerdo a las intrucciones del asistente del doctor (PA), de no hacerlo el paciente sera considerado no candidato al programa debido a problemas de presion arterial y no recibe ningun servicio o producto, no se le cobrara nada

El Medico o APN han designado para segunda consulta solamente los Lunes de 3:00 a 6:00 PM, Martes de 10:30 AM a 1:30 PM y de 3:00 a 6:00 PM y los Jueves de 4:00 a 6:00 PM. Favor de hacer su cita para consulta.

_____ _____
Firma Fecha