MEDICI
URGENT CARE & WELLNESS CENTER

Medical Weight Loss Patient Information & Consent Form

Today's Date:	Last Name:	First Name:

Date of Birth:	Age:	Gender: Male / Female	Preferred Name:

Street Address:	City:	State:	Zip Code:

Cell Phone:	Email:
Relationship Status: Single / Married / Divorced / Widowed	Occupation:

In Case of Emergency

Name:	Relationship:
Cell Phone Number:	Alternate Phone Number:

How Did You Hear About Us?

Social Media / Google / Friend/Family / Other ____

Main Concern for Seeking Medical Weight Loss

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Medical Problems

☐ Heart Disease	☐ High Blood Pressure	☐ Prior Stroke	☐ Diabetes
☐ Heart Arrhythmia	☐ Prior Heart Surgery	☐ Sleep Apnea	☐ Back/Joint Pain

Other:

Current Medications/Vitamins/Supplements/Herbs

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____

____

ALLERGIES:

Describe Your Daily Diet

____

____

Patient Name: ____

Habits
Cigarettes Yes / No How many per day ____________ How many years ________________
Alcohol Yes / No How many per day/week _____________
Cravings ☐ Sugar/sweets ☐ Salty food

Women's Issues/ Gynecological Issues
Are you pregnant? Yes / No Date of last period ____________ Number of pregnancies __________
Number of births ________ Number of miscarriages/abortions _______
Age of menopause ________ Menopausal symptoms ____

By signing below, I authorize the providers at MEDICI Urgent Care & Wellness Center to help me with my weight reduction efforts. I understand the success of my weight loss depends upon my effort and there are no guarantees of weight loss or how long I will maintain any weight lost during the course of my weight management program. Obesity can be a chronic condition that may require permanent changes in behavior including dietary and exercise habits to be treated successfully.

My weight loss program may include a reduced-calorie diet, exercise program, appetite suppressant medications, and instruction on behavior modification. I understand that any weight loss regimen may involve risks as well as benefits. I also understand there are significant risks to being overweight or obese. Risks of the weight loss program may include, but are not limited to, fatigue, headaches, trouble sleeping, dry mouth, diarrhea, constipation, anxiety/depression, elevated blood pressure, heart rhythm irregularities, and, although very rarely, death. Risks associated with remaining overweight or obese may include elevated blood pressure, diabetes, heart disease, heart attacks, strokes, cancer, sleep apnea, and sudden death.

My weight loss program may include FDA-approved appetite suppressant medications. These medications may be given for a longer period of time than recommended for appetite-suppressant labeling. I understand that I should NOT become pregnant while taking these medications.

My weight loss program may include formulations and vitamin products which have not been evaluated by the FDA. In keeping with government regulations, we make no therapeutic or medical claims to these products.

I understand that I will have labs done at least every 3 months and an EKG done every 6 months. I also agree to have see a cardiologist and have a stress test done after 6 months on my medications.

I am aware of the costs associated with my medical weight loss program and that I may use insurance to help cover the costs of my labs and EKG.

I have read and fully understand this consent form. I realize that I should not sign this form if I do not understand all items. My questions will be answered to my complete satisfaction.

Signature: ____ Date: __________________