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WEIGHT LOSS

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REALISTIC MEDICAL WEIGHTLOSS CLINIC

Weight Loss Questionnaire

Name: _____ **Date:** _____

1. How long have you considered yourself to be overweight? _____

2. Have you been in any other weight loss programs? If so, name and date
   _____

Symptoms:

1.	Have you experienced any chest pain during exercise or exertion?	Yes	No
2.	Have you experienced any changes in your vision?	Yes	No
3.	Have you experienced any changes in your hearing?	Yes	No
4.	Have you experienced any changes in your bowel habits?	Yes	No
5.	Have you experienced any loss of control with bladder and/or bowel?	Yes	No
6.	Do you have any difficulty sleeping?	Yes	No

Medical History:

1.	Do you have a history of high blood pressure/ hypertension?	Yes	No
2.	Do you have a history of heart disease?	Yes	No
3.	Do you have a history of Diabetes or high blood sugar?	Yes	No
4.	Have you ever had a stroke?	Yes	No
5.	Do you have a history of kidney disease?	Yes	No
6.	Have you tested positive for HIV or been diagnosed with AIDS?	Yes	No
7.	Do you have any history of lung disease? Circle One: Pulmonary Hypertension, Asthma, Emphysema or Bronchitis	Yes	No
8.	Do you have a history of thyroid disease or abnormal reading?	Yes	No
9.	Have you experienced any depression or anxiety?	Yes	No
10.	Have you had any surgeries? If yes, what type of procedure and date?	Yes	No

_____

11. Have you ever been hospitalized? If yes, explain

_____

Medications:

1. Do you have any medication allergies? Yes No
   If so, which ones?

   _____

2. Do you take birth control or oral contraceptives? Yes No
3. Please list any current medications that you are taking

   _____
   _____
   _____

4. Please list any over the counter medications and nutritional supplements that you are currently taking

   _____
   _____
   _____

Wellness:

1. Do you exercise on a regular basis? Yes No
2. How many full meals do you eat a day? _____
3. Have you gained or lost 10 pounds or more in the past 3 months Yes No
4. Have you gone through menopause? If so, what age? _____ Yes No
5. Do you use any tobacco products such as cigarettes, cigars, or pipes? Yes No

Physician: _____M.D./N. P
Date: _____

B12 Lipotropic Shot & B12 Myoden Shot Consent Form

Realistic Medical Clinic uses pharmaceutical B12 Lipotropic and B12 Myoden combination, clinically proven to help accelerate metabolism and burn fat. They are used to enhance your current weight loss efforts i.e. following a healthy diet plan, drinking plenty of water and exercising.

How do B12 Lipotropic injections work?

Lipotropic is a fancy word for three amino acids (methionine, inositol, and choline) essential for the health of your liver. Your liver is the organ responsible for removing fat and toxins from our body, so if it is healthier it will work better for you. B12 can give you an energy boost, which helps you burn calories. The amino acids in the B12 Lipotropic shots are compound that enhance liver function and increase the flow of fats and bile from the liver and gallbladder. By definition, a lipotropic substance decreases the deposit, or speeds up the removal of fat within the liver. **The key amino acids "Lipotropics" used to make these shots are as following:**

B12 Myoden Injection Include: **B1, B2, B3, B5, B6, B12, and Vitamin C**

Vitamin B12 (*Hydrocbalamin*) is essential for helping to form new, healthy cells in the body. It also boosts energy, helping increase activity levels.

Choline supports the health of the liver in its processing and excretion of chemical waste products within the body. Moreover, it is required for the transport and metabolism of the endocrine, cardiovascular and liver systems.

Methionine an amino acid important for the main bodily functions. It acts as a lipotropic agent to prevent excess fat buildup in the liver and the body, is helpful in relieving, or preventing fatigue and may be useful in some cases of allergy because it reduces histamine release.

Inositol a nutrient belonging to the B vitamins complex, is closely associated with choline. It aids in the metabolism of fats and helps reduce blood cholesterol. Inositol participates in action of serotonin, a neurotransmitter known to control mood and appetite.

Myoden is a formulated to boost metabolism and increase cellular energy (ATP). It is an all-natural substance that is an intermediate in cellular metabolism. It is also a key component in certain reactions necessary for proper fat and carbohydrate metabolism. Research has indicated that low levels of ATP may predispose people to be overweight and suffer from loss of energy.

Acetyl L – Carnitine an amino acid (a building block for proteins) that is naturally produced in the body. It helps the body produce energy, carries fatty acids into the cell so they can be burned as fuel, and assists in the reduction of belly fat.

Acknowledgement and Informed Consent

1. The nature and purpose of the injection, possible alternative methods of treatment, risks involved, possible consequences, and the possibility of complications have been explained to me.
2. Each patient responds differently to medicine and may respond differently from one treatment to the next. As with all medicines, results are temporary, and regular dosing is necessary. The length of time the injectable medication lasts varies in each patient. No guarantee can be made with regard to the result or length of time it lasts.
3. I understand that there are some risks with any treatment. The following is the list of possible risks with injection: pain or bruising of the skin injections site, scarring of the skin (unlikely), and possible skin infection- a possibility any time the skin is broken, even with sterile needles.
4. I have been given the opportunity to have all my questions answered.

I, _____, have read and understand the ingredients of the injection being administered to me and I consent to treatment.

_____ _____

Signature **Date**

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, the undersigned, consent to the use or disclosure of my protected health information for diagnosing, providing treatment to me, obtaining payment for my healthcare bills and/or to conduct health care operations of **Realistic Medical Clinic**. I understand that diagnosis or treatment of me may be conditioned upon my consent as evidence by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. I also understand that **Realistic Medical Clinic** is not required to agree to the restrictions that I request.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Realistic Medical Clinic** has taken action in reliance on this consent. I also understand that if I revoke this consent, **Realistic Medical Clinic** has the right to refuse to provide further treatment.

I understand I have a right to review **Realistic Medical Clinic's** Notice of Privacy practices prior to signing this document; which have been provided to me.

Realistic Medical Clinic reserves the right to change the privacy practices that are described in the Notice of Privacy agreement. I may obtain a revised copy of agreement by calling the office and requesting a copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Responsible Party: _____

Date: _____

(when patient is not competent or capable to give consent, the signature of a parent, guardian, healthcare agent (proxy) or another representative is required)

CONSENT FOR WEIGHT LOSS PROGRAM AND INJECTIONS

I, the undersigned, consent to being seen at **Realistic Medical Clinic** for the treatment of weight loss and receiving Vitamin B12 and Lipotropic injections. I have been informed by the staff of the side effects these injections may cause; which may include pain at the injection site, flushed face, feeling warmth in body, mild itching, and mild stomach cramps. I consent that I am in no way allergic to cobalt or any B-complex vitamins that the staff at **Realistic Medical Clinic** may administer. I consent that I have no history of cardiovascular disease, being pregnant, breast feeding, hyperthyroidism, epilepsy, glaucoma, and do not take the medications Nardil and Parnate. I understand that Adipex-P, Phentermine, Didrex, Bontril and other stimulant diet medications have the potential to elevate blood pressure and cause cardiac and pulmonary complications. I have been informed that taking an appetite suppressant may have side effects which may include: chest pain, insomnia, heart palpitations, elevated blood pressure, dry mouth and constipation. I understand that receiving a prescription for the appetite suppressant and for the diuretic (water pills) is under the discretion of the physician. I have been made aware of all above statements by the staff at **Realistic Medical Clinic** and I am aware that the physician may discontinue treatment at anytime for not complying with directions or due to risk factors.

1. The nature and purpose of the injection, possible alternative methods of treatment, risks involved, possible consequences, and the possibility of complications have been explained to me.
2. Each patient responds differently to medicine and may respond differently from one treatment to the next. As with all medicines, results are temporary, and regular dosing is necessary. The length of time the injectable medication lasts varies in each patient. No guarantee can be made with regard to the result or length of time it lasts.
3. I understand that there are some risks with any treatment. The following is the list of possible risks with injection: pain or bruising of the skin injections site, scarring of the skin (unlikely), and possible skin infection- a possibility any time the skin is broken, even with sterile needles.
4. I have been given the opportunity to have all my questions answered.

I, _____, have read and understand the ingredients of the injection being administered to me and I consent to treatment.

Signature of Patient or Responsible Party: _____

Date: _____