WEIGHTLOSS PROGRAM CONSENT FORM

I, _____, (patient/guardian) do hereby authorize A Nu You, to assist me with weight reduction. I fully understand that this program shall consist of a reduction in caloric intake, regular exercise and behavioral lifestyle changes and my treatment may include the use of appetite suppressants and injections. I further understand that in order to continue to receive appetite suppressants, I must have regular follow up and show continued weight loss.

Regarding the use of appetite suppressants, as with any prescription medication, I understand that there are potential risks involved. Side effects may include nervousness, constipation, insomnia, headaches, dry mouth, weakness, fatigue, medication allergy, increased blood pressure and increased or irregular heart rate. I understand that these and other risks could be serious or in rare cases life threatening. **Initial: _____**

I understand that if I develop side effects from the medication, I will discontinue taking the medication and notify A Nu You immediately and in the event the problem is severe, I will go to the nearest Emergency room for immediate care. I do not have a history of alcohol abuse, drug abuse, schizophrenia, manic-depressive illness, or eating disorder, since these conditions constitute a contraindication to the use of appetite suppressants. **Initial: _____**

I agree not to take any other weight loss medications, other than those prescribed by Keva Galdamez, NP and further agree to inform the A Nu You of ANY changes in my medication or medical history. **Initial: _____**

I understand that I can be successful without the use of appetite suppressants or injections as long as I am following a reduced calorie nutrition plan and increasing my activity level, however the use of such medications and injections may significantly help with my weight loss progress. I understand the risks associated with being overweight or obese include the possibility of high blood pressure, diabetes, heart disease, stroke, cancer, arthritis and pain of the joints, gallbladder disease and even sudden death.

Initial: _____

I understand that Bariatric Physicians have found appetite suppressants helpful for periods longer than those suggested in the medication labeling and at times in larger doses. Keva Galdamez, NP is not required to use the medications as the labeling suggests but does use it as a source of information along with his own experience, the experiences of her colleagues, as well as recent studies and recommendations of investigators and professional societies. **Initial: _____**

I understand that there is no guarantee that this program will work for me. I understand that I must follow the program as directed in order to achieve weight loss. By consenting to treatment, I agree to pay, in full, for all visits and charges incurred at each visit. **Initial: _____**

By signing below, I certify that I have read and fully understand this consent form and understand the risks and benefits associated with my treatment for weight loss.

Patient Signature: _____ **Date: _____**

New Patient Registration

PLEASE PRINT AND COMPLETE IN FULL

Patient's Legal Name: _____
First Middle Last

Birthdate: _____ **Gender:** Male_____Female_____
MM/DD/YYYY

Address: _____

Home Phone Number: ____-____-_____ **Cell Phone Number:** ____-____-_____

Work Phone Number: ___-____-_____ **Email Address:** _____

Parent/Guardian Name (if under 18): _____

Emergency Contact Name: _____**Phone Number:** _____

Relation to Patient: _____

Do you have any allergies? Please list: _____

Preferred Pharmacy: _____

Medications/supplements

Name	Dose	Directions

I am…	Married	Never Married	Divorced	Widow/Widower	Other:
My tobacco use is…	Current	Former	Never		Quitting
My current alcohol use is…	None	Occasional	Weekly	Daily	A Problem
My current recreational substance use is…	None	Type:		Frequency:	
I have had a problem with drug or alcohol addiction in the past…	No	Yes	Which?		

My **Most Important Reasons** for wanting to *Change My Health Climate* are:

I decided to come to A Nu You to help me with my weight because:

_____

My weight one year ago was _____lb.

The MOST I ever weighed (non-pregnant) was _____lb.

I began to gain weight because: _____

My worst food habit is_____

I have done the following **weight loss programs** before:

Program	Year	Result

I have used weight loss medication before: YES NO If yes, which? _____
I am currently using weight loss products: YES NO If yes, which? _____

The person(s) closest to me support my intentions to do this program: YES NO UNSURE

Long term, I would like to maintain my weight at _____lbs. *(This is my "New Climate" weight)*

I would like to be at my "New Climate" weight in _____ months

My Past Health History

My regular doctor is: _____

Town: _____

Communication in healthcare is important in order for you to receive the most comprehensive care possible.
Would you like us to communicate with your regular doctor about your care here at A Nu You? YES / NO

At this time my overall health is (circle): Excellent Good Fair Poor

Previous or Current Health **Conditions I have had** include: (check all that apply to you)

☐	High Blood Pressure	☐	Depression	☐	Sleep Apnea	☐	Thyroid Problems
☐	Diabetes	☐	Anxiety	☐	Asthma	☐	Gout
☐	Heart Disease	☐	PTSD	☐	COPD	☐	Arthritis
☐	Kidney Disease	☐	Binge Eating Disorder	☐	Acid Reflux	☐	Fibromyalgia
☐	Chronic Leg Swelling	☐	Anorexia Nervosa	☐	Irritable Bowel/Colitis	☐	Osteoporosis
☐	Bleeding Disorder	☐	Bulimia	☐	Fatty Liver	☐	Urinary Incontinence
☐	Blood Clot	☐	ADHD/ADD	☐	Crohn's Disease	☐	Polycystic Ovaries
☐	Anemia	☐	Bipolar Illness	☐	Ulcerative Colitis	☐	Menopause
☐	Cancer	☐	Alcohol/Drug abuse	☐	Liver/Gallbladder Disease	☐	Other
☐	Eczema	☐	Headache/Migraine	☐	Stomach Ulcers		

Surgeries I have EVER had include:

Type	**Date**	**Type**	**Date**
1.		4.	
2.		5.	
3.		6.	

Hospitalizations, and/or Serious Injuries I have EVER had include:

Reason	Hospital Name	Date
1.		
2.		
3.		

I am **allergic** to, or do not tolerate the following medicines:

None *(circle if appropriate)*	2.
1.	3.

Over The Counter **Medications and/or Supplements/Vitamins** I CURRENTLY take are:

Medication Name	Dose and Frequency	Medication Name	Dose and Frequency
1.		4.	
2.		5.	
3.		6.	

My **Family's Health** History (circle brother or sister as appropriate; check all that apply)

Disease	**Father** Age: Living: Y N	**Mother** Age: Living: Y N	**Brother/Sister** Age: Living: Y N	**Brother/Sister** Age: Living: Y N	**Brother/Sister** Age: Living: Y N	**Brother/Sister** Age: Living: Y N
Heart Attack/Stroke						
Diabetes						
Cancer						
Psychiatric						
Obesity						
Other						

Symptoms I am **experiencing at this time**: (check all that apply)

☐	Unexpected Weight Loss/Gain	☐	Ulcers/Wounds on feet	☐	Sadness/Depression
☐	Swollen Glands	☐	Calf or leg pain while walking	☐	Anxiety/Nervousness
☐	Feeling Sick	☐	Change in bowel habits	☐	New/unusual headaches
☐	Longstanding pain	☐	Heartburn	☐	Falling down
☐	Fever/Chills/Sweats	☐	Abdominal Pain	☐	Skin rashes
☐	Disturbance in Vision	☐	Painful or trouble swallowing	☐	Unexplained hair loss
☐	Eye Pain	☐	Nausea or vomiting	☐	Changing moles
☐	Hearing Loss	☐	Yellow skin/eyes	☐	Drinking too much
☐	Voice Change	☐	Black tar/blood in stools	☐	Low sex drive
☐	Fainting Spells	☐	Constipation	☐	Women Only
☐	Rapid/pounding heart	☐	Diarrhea	☐	Vaginal discharge
☐	Shortness of breath	☐	Trouble Emptying Bladder	☐	Pelvic Pain
☐	Chest Pain	☐	Blood in urine	☐	Breast Lumps
☐	Cough	☐	Painful urination	☐	Nipple discharge
☐	Blood in Sputum	☐	Urinating too frequently	☐	Men Only
☐	Wheezing	☐	Urinary incontinence	☐	Erectile dysfunction
☐	Loud Snoring	☐	Abnormal urge to urinate		
☐	Stop Breathing in Sleep	☐	Joint Swelling		
☐	Not well rested after full night sleep	☐	Abnormal Bleeding/Bruising		
☐	Swelling in legs/ankles	☐	Unexplained lumps or masses		