CHOOSE 2 LOSE

MEDICAL WEIGHT LOSS PROGRAM

YOUR FIRST APPOINTMENT

We value your time and want to help make your first appointment more efficient. Enclosed are a New Patient Information Form, a Medical History Form, and a Weight History Form. Please complete these forms and bring them with you to your first appointment.

Please read and follow these instructions:

1. Bring the completed forms to your first visit.

2. Please be on time. This allows us to make the best use of your time and is considerate of other patients. Being more than 15 minutes late will result in rescheduling your appointment. Please give at least 24 hours notice for change or cancellation of your appointment.
3. While we accept insurance, you will be responsible for any charges not covered by your particular insurance. Payment is due at the time of service. We accept cash, check and all major credit cards. The charge for your first visit will be $155.00
4. We require that you have an EKG which will be done on your first visit. We ask that you do not wear lotion, body oil, Vaseline, or any other products that could make your skin feel oily. We need your skin clean and free of products the day of your first visit.
5. We will be doing a body composition analysis on your initial visit. This will give us your weight and BMI (Body Mass Index). Please wear shoes that are easy to take off.
6. We require blood work on all new patients. On your first visit, you will receive a prescription for these tests. Please get this blood work completed by your second visit. You will be responsible for any charges not covered by your particular insurance. To ensure the most accurate results, please fast for 12 hours prior to your blood draw. You should have nothing to eat during that time. Drink plenty of water and take your medications during your fasting hours. It takes 2 to 3 days for the results of your tests to be faxed to us, so please have your blood work done as soon as possible so that our providers can review the results with you at your second visit with us.
7. On your first and second visits to Choose 2 Lose, we request that you make arrangements for child care. This is an important time for you and our provider to review your history, develop your own personalized plan for weight loss, and to discuss your test results.

We look forward to meeting you. If you have questions, please call 252-514-6594.

"A new you is waiting"

PATIENT INFORMATION FORM

Name: (Last)_____(First)_____(MI) _____

Name you prefer to be Called: _____

Address: _____

City:_____State:_____Zip _____

Home phone:_____Cell phone: _____

Birth date:_____Age:_____Sex: M F Marital Status: _____

Social Security #:_____Drivers License #: _____

Country of Birth:_____Country of Parents' Birth:_____

Education: (Circle the highest level achieved)

Elementary / High School / Technical School / 2-yr College / 4-yr College / Graduate School

Employment Information:

Employer:_____Occupation: _____

Employer address: _____

City:_____State:_____Zip _____

Work phone No:_____Ext. _____

In Case of Emergency:

Name:_____Relationship:_____Phone: _____

Patient's Spouse:_____Phone: _____

Family Physician:_____Phone: _____

How did you hear about us?

Referred by: _____

Newspaper:_____Physician: _____

Other: _____

Financial Policy:

I will be paying today by ☐ Cash ☐ Check ☐ Credit Card

I agree that I have come to Choose 2 Lose to assist me in losing weight. I understand that by joining the weight management program I am agreeing to regular weekly visits, following the instructions I am given and that I will be responsible for full payment each week. For your convenience, we accept Cash, Checks, Visa, MasterCard, Discover, and American Express. 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 am looking forward to being thinner and healthier and commit to my share of the work ahead.

I have read and understand and agree to the Financial Policy of Chose 2 Loose.

_____ _____

Patient's Signature Date

MEDICAL HISTORY

NAME: _____

Do you have any of the following condition or have you had them in the past?

	NOW	PAST
Loss of Hearing		
Ringing In Ears		
Ear Infections		
Bad Vision		
Glaucoma		
Nose Bleeds		
Sinus Trouble		
Sore Throat		
Allergies		
Hoarseness		
Pneumonia		
Bronchitis		
Asthma		
Shortness of Breath		
Tuberculosis		
Heart Murmer		
Palpitations		
Irregular Pulse		
Swollen Ankles		
Chest Pain		
Loss of Appetite		
Indigestion		
Stomach Ulcers		
Diarrhea		
Constipation		
Bloody/Tarry Stools		
Hemorrhoids		
Hernia		
Gall Bladder		

	NOW	PAST
Sudden Weight Loss		
Liver Disease		
Back Pain		
Joint Pain		
Broken Bones		
Dizzy Spells		
Fainting Spells		
Memory Loss		
Insomnia		
Nervousness		
Depression		
Phobias		
Manic Depression		
Anxiety		
Schizophrenia		
Bulimia		
Anorexia		
Other Eating Disorders		
Frequent Urination		
Kidney Disease		
Kidney Stones		
Prostate Disease		
Headaches		
Migraines		
Fatigue		
Anemia		
Immune Disorders		
Alcohol Abuse		
Drug Abuse		

	NOW	PAST
Heart Disease		
Thyroid Disease		
Cancer		
Diabetes		
Stroke		
Osteoporosis		
Gerd		
Rashes		
Chicken Pox		
Mumps/Measles		
Polio		
Nausea		
Vomiting		
Stomach Ulcers		
Heartburn/Reflux		
High Blood Pressure		
High Cholesterol		
Hepatitis		
HIV/AIDS		
MRSA		
Seizure/Epilepsy		
Leg Cramps		
Gout		
Malaria		
Typhoid Fever		
Cholera		
Hypoglycemia		
Arthritis		

FAMILY HISTORY: IF A BLOOD RELATIVE HAS SUFFERED THE FOLLOWING, PLEASE INDICATE THE RELATIONSHIP

Heart Attack	
Cancer	
Hypertension	
Stroke	
Epilepsy/Seizures	
Arthritis	
Diabetes	
Obesity	
Glaucoma	
Other:	

Have you ever been hospitalized or had surgery? If YES, when and why?

YEAR	ILLNESS or SURGERY

Please list all known chronic conditions or medical illnesses:

ALLERGIES: Please list any medications you are allergic to

MEDICATIONS: Please list any medications you are currently taking regularly and as needed;
Include over-the-counter medications.

MEDICATION	DOSAGE	HOW OFTEN	REASON

	YES	NO
Are you pregnant?		
Could you be pregnant?		
Are you breast feeding?		

In the past year, have there been any changes in your family? Check all that apply.

- ☐ Marriage
- ☐ Separation
- ☐ Divorce
- ☐ Loss of job
- ☐ Birth
- ☐ Serious Illness
- ☐ Death
- ☐ Other

Do you take: Check all that apply.

- ☐ Vitamins
- ☐ Laxatives
- ☐ Hormones
- ☐ Pain Medication
- ☐ Stomach Medication
- ☐ Birth Control Pills
- ☐ Nerve Condition
- ☐ Cold Medication
- ☐ Herbal Supplements

Please rate the intensity of any of these symptoms you have had in the past.

0 = NO PROBLEM 1 = MINOR PROBLEM 2 = BIG PROBLEM

- ☐ Hunger
- ☐ Cravings
- ☐ Mood Swings
- ☐ Irritability
- ☐ Headache
- ☐ Feeling “wired”
- ☐ Skin Rash
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hot Flashes
- ☐ Dizziness
- ☐ Dry Mouth
- ☐ Blurred Vision
- ☐ Excess Urination
- ☐ Rapid Heart Rate
- ☐ Palpitations
- ☐ Insomnia
- ☐ Anxiety
- ☐ Shortness of breath
- ☐ Difficulty urinating
- ☐ Excess thirst

WEIGHT HISTORY

Height:_____ Current Weight:_____ Goal Weight:_____

How long have you been trying to lose weight? _____

What has been your heaviest weight? _____

When were you that weight? (at what age?) _____

As best you can recall, what was your body weight at each of the following ages?

Grade School_____High School_____College_____Ages 20-29_____30-39_____40-49_____50-59 _____

At what age did you start trying to lose weight? _____

What do you think is the cause of your weight problem? _____

_____

_____

Have you ever stayed the same weight for 10 years or more?	YES	NO
Are any members of your household overweight?	YES	NO

If yes, please list relationship and details _____

_____

_____

What is your motivation for wanting to lose weight? Check all that apply.

- ☐ Don't like the way I look
- ☐ More energy
- ☐ Better work opportunities
- ☐ More mobility
- ☐ Attend a wedding/graduation
- ☐ Attend a reunion
- ☐ Perform better
- ☐ Feel more confident socially
- ☐ Reduce medications
- ☐ Upcoming event
- ☐ Clothes don't fit anymore
- ☐ Improve health
- ☐ Feel better
- ☐ Want to wear smaller size
- ☐ Upcoming vacation
- ☐ Look better
- ☐ Live longer
- ☐ Look more attractive for my partner
- ☐ Want to wear more stylish clothing
- ☐ Other (please describe)

What dietary problem areas apply to you? Check all that apply.

- ☐ Skipping meals
- ☐ Craving carbohydrates
- ☐ Large portion size
- ☐ Too much alcohol
- ☐ Frequent snacking
- ☐ Binging on food
- ☐ Eating foods too high in fat
- ☐ Eating too many meals in restaurants
- ☐ Eating for reasons other than hunger
- ☐ Eating before going to bed
- ☐ Making yourself vomit after meals

What weight loss programs have you previously participated in?

		RESULTS?	LENGTH OF PARTICIPATION?
	WEIGHT WATCHERS		
	JENNY CRAIG		
	SLIM FAST		
	ATKINS		
	SOUTH BEACH		
	LA WEIGHT LOSS		
	NUTRISYSTEMS		
	LINDORA		
	OVEREATERS ANONYMOUS		
	LIQUID DIETS (EG. OPTIFAST)		
	DIET PILLS: MERIDIA, XENICAL		
	DIET PILLS: PHEN-FEN, REDUX		
	OTC DIET PILLS		
	OBESITY SURGERY		
	OTHER		

Have you maintained any weight loss for up to one year on any of these programs? YES NO

What did you learn from these programs regarding your weight? _____

_____

_____

Why did these programs not meet your expectations? What did not work? _____

_____

_____

Please answer the following questions on a scale of 1 - 5.

SCALE: LEAST 1 2 3 4 5 MOST

- ☐ Your level of interest in losing weight is?
- ☐ Are you ready for lifestyle changes to be part of your weight control program?
- ☐ How much support can your family provide?
- ☐ How much support can your friends provide?
- ☐ How confident are you that you can lose weight this time?
- ☐ How confident are you that you can keep weight off this time?

FOOD ALLERGIES: _____

FOOD DISLIKES: _____

FOOD YOU CRAVE: _____

How much do you smoke daily? _____

How much caffeine do you ingest daily? _____

How much alcohol do you drink? _____

DO YOU

		TYPICAL FOODS	
	EAT BREAKFAST		
	EAT LUNCH		
	EAT DINNER		
	EAT BETWEEN MEALS		
	EAT AT NIGHT		
	EAT WHEN STRESSED		

ACTIVITY LEVEL (CHECK ONLY ONE)

- ☐ Inactive - No regular physical activity with a sit-down job
- ☐ Light activity - No organized physical activity during leisure time
- ☐ Moderate activity - Occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
- ☐ Heavy activity - Consistent lifting, stair climbing, heavy construction, or regular participation in jogging, swimming, cycling or active sports at least 3 times per week
- ☐ Vigorous activity - Participation in extensive physical exercise for at least 60 minutes per session 4 times per week

BEHAVIOR STYLE (CHECK ONLY ONE)

- ☐ You are always calm and easygoing
- ☐ You are usually calm and easygoing
- ☐ You are sometimes calm with frequent impatience
- ☐ You are seldom calm and persistently driving for advancement
- ☐ You are never calm and have overwhelming ambition
- ☐ You are hard driving and can never relax

THIS INFORMATION WILL ASSIST US IN IDENTIFYING YOUR PARTICULAR PROBLEM AREAS. THANK YOU FOR YOUR TIME AND PATIENCE IN PROVIDING THIS INFORMATION.

DIET READINESS TEST

For each question, circle the answer that best describes how you feel:

Section 1: Goals and Attitudes

1. Compared to previous attempts, how motivated to lose weight are you this time?

1	2	3	4	5
Not at all Motivated	Slightly Motivated	Somewhat Motivated	Quite Motivated	Extremely Motivated

2. How certain are you that you will stay committed to a weight loss program for the time it will take to reach your goal?

1	2	3	4	5
Not at all Certain	Slightly Certain	Somewhat Certain	Quite Certain	Extremely Certain

3. How certain are you that you will stay committed to a weight loss program for the time it will take to reach your goal?

1	2	3	4	5
Not at all Certain	Slightly Certain	Somewhat Certain	Quite Certain	Extremely Certain

4. Think honestly about how much weight you hope to lose and how quickly you hope to lose it. Figuring a weight loss of 1 to 2 pounds per week, how realistic is your expectation?

1	2	3	4	5
Not at all Certain	Slightly Certain	Somewhat Certain	Quite Certain	Extremely Certain

5. While dieting, do you fantasize about eating a lot of your favorite foods?

1	2	3	4	5
Always	Frequently	Occasionally	Rarely	Never

6. While dieting, do you feel deprived, angry and/or upset?

1	2	3	4	5
Always	Frequently	Occasionally	Rarely	Never

Section 1 TOTAL SCORE ☐

Section 2: Hunger and Eating Cues

7. When food comes up in conversation or in something you read, do you want to eat even if you are not hungry?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

8. How often do you eat because of physical hunger?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

9. Do you have trouble controlling your eating when your favorite foods are around the house?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

Section 2 TOTAL SCORE ☐

Section 3: Control Over Eating

If the following situations occurred while you were on a diet, would you be likely to eat **more** or **less** immediately afterward and for the rest of the day?

10. Although you planned on skipping lunch, a friend talks you into going out for a midday meal?

1	2	3	4	5
Would Eat Much Less	Would Eat Somewhat Less	Would Make NO Difference	Would Eat Somewhat More	Would Eat Much More

11. You "break" your diet by eating a fattening, "forbidden" food.

1	2	3	4	5
Would Eat Much Less	Would Eat Somewhat Less	Would Make NO Difference	Would Eat Somewhat More	Would Eat Much More

12. You have been following your diet faithfully and decide to test yourself by eating something you consider a treat.

1	2	3	4	5
Would Eat Much Less	Would Eat Somewhat Less	Would Make NO Difference	Would Eat Somewhat More	Would Eat Much More

Section 3 TOTAL SCORE ☐

Section 4: Binge Eating and Purging

13. Aside from holiday feasts, have you ever eaten a large amount of food rapidly and felt afterward that this eating incident was excessive and out of control?

YES = 2 NO = 0

14. If you answered YES to #13, how often have you engaged in this behavior during the last year?

1	2	3	4	5	6
Less Than Once a month	About Once A Month	A Few Times A Month	About Once A Week	About 3 Times A Week	Daily

15. Have you ever purged (used laxatives, diuretics or induced vomiting) to control your weight?

YES = 5 NO = 0

16. If you answered YES to #15, how often have you engaged in this behavior during the last year?

1	2	3	4	5	6
Less Than Once a month	About Once A Month	A Few Times A Month	About Once A Week	About 3 Times A Week	Daily

Section 4 TOTAL SCORE ☐

Section 5: Emotional Eating

17. Do you eat more than you would like to when you have negative feelings such as anxiety, depression, anger or loneliness?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

18. Do you have trouble controlling your eating when you have positive feelings – do you celebrate feeling good by eating?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

19. When you have unpleasant interactions with others in your life, or after a difficult day at work, do you eat more than you'd like?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

Section 5 TOTAL SCORE ☐

Section 6: Exercise Patterns and Attitudes

20. How often do you exercise?

1	2	3	4	5
Never	Rarely	Occasionally	Frequently	Always

21. How confident are you that you can exercise regularly?

1	2	3	4	5
Not at all Confident	Slightly Confident	Somewhat Confident	Highly Confident	Completely Confident

22. When you think about exercise, do you develop a positive or negative picture in you mind?

1	2	3	4	5
Completely Negative	Somewhat Negative	Neutral	Somewhat Positive	Completely Positive

22. How certain are you that you can work regular exercise into your daily schedule?

1	2	3	4	5
Not at all Certain	Slightly Certain	Somewhat Certain	Quite Certain	Extremely Certain

Section 6 TOTAL SCORE ☐

SCORING GUIDE

After you complete each of the six sections, add the numbers of answers and compare them with the scoring guide below:

Section 1: Goals and Attitudes

TOTAL Score _____

If you scored:

6 to 16: This may not be a good time for you to start a weight loss program. Inadequate motivation and commitment together with unrealistic goals could block your progress. Think about those things that contribute to this, and consider changing them before undertaking a diet program.

17 to 23: You may be close to being ready to begin a program but should think about ways to boost your preparedness before you begin.

24 to 30: The path is clear with respect to goals and attitudes.

Section 2: Hunger and Eating Cues

TOTAL Score _____

If you scored:

3 to 6: You might occasionally eat more than you would like, but it does not appear to be a result of high responsiveness to environmental cues. Controlling the attitudes that make you eat may be especially helpful.

7 to 9: You may have a moderate tendency to eat just because food is available. Dieting may be easier for you if you try to resist external cues and eat only when you are physically hungry.

10 to 15: Some or most of your eating may be in response to thinking about food or exposing yourself to temptations to eat. Think of ways to minimize your exposure to temptations, so that you eat only in response to physical hunger.

Section 3: Control Over Eating

TOTAL Score _____

If you scored:

3 to 7: You recover rapidly from mistakes. However, if you frequently alternate between eating out of control and dieting strictly, you may have a serious eating problem and should get professional help.

8 to 11: You do not seem to let unplanned eating disrupt your program. This is a flexible, balanced approach.

12 to 15: You may be prone to overeat after an event breaks your control or throws you off track. Your reaction to these problem-causing eating events can be improved.

Section 4: Binge Eating and Purging

TOTAL Score _____

If you scored:

0 to 1: It appears that binge eating and purging is not a problem for you.

2 to 11: Pay attention to these eating patterns. Should they arise more frequently, get professional help.

12 to 19: You show signs of having a potentially serious eating problem. See a counselor experienced in evaluating eating disorders right away.

Section 5: Emotional Eating

TOTAL Score _____

If you scored:

3 to 8: You do not appear to let your emotions affect your eating.

9 to 11: You sometimes eat in response to emotional highs and lows. Monitor this behavior to learn when and why it occurs and be prepared to find alternative activities.

12 to 15: Emotional ups and downs can stimulate your eating. Try to deal with feelings that trigger the eating and find other ways to express them.

Section 6: Exercise Patterns and Attitudes

TOTAL Score _____

If you scored:

4 to 10: You're probably not exercising as regularly as you should. Determine whether your attitudes about exercise are blocking your way, then change what you must and put on those walking shoes.

11 to 16: You need to feel more positive about exercise so you can do it more often. Think of ways to be more active that are fun and fit your lifestyle.

17 to 20: It looks like the path is clear for you to be active. Now think of ways to get motivated.

Source: Brownell, 1990.

Patient Informed Consent for Appetite Suppressants and Participation in a Weight Management Program

I. Procedure and Alternatives:

1. I, _____(patient) authorize Dr. Richard Lynch 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 12 weeks and, when indicated, in higher doses than the dose indicated in the appetite suppressant labeling.

2. I have read and understand my doctor's statements that follow:

"Medications, including the appetite suppressants, have labeling worked out between the makers 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 12 weeks) using the dosages indicated in the labeling."

"As a bariatric physician, I have found the appetite suppressants helpful for periods far in excess of 12 weeks, 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 based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses. At Choose 2 Lose, an appetite suppressant may be used in combination with other appetite suppressants and other supplements."

"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 outweighed by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses. **However, you must decide if you are willing to accept the risks of side effects , even if they might be serious, for the possible help the appetite suppressants use in this manner may give."**

3. 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.

INITIALS: _____

4. 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 and my compliance with my provider's instructions.

5. I understand there are other ways and other 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.

I. Risks of Proposed Treatment:

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks and in higher doses than the dose indicated in the labeling is considered an "off label" use and involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heartbeat and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

I understand that if I develop side effects from the diet or the medication, I will discontinue the diet and / or the medication(s) and notify the medical staff of Choose 2 Lose as soon as possible. I also understand that if the problem is worrisome or severe, I will go the nearest Emergency room or see my primary care physician as soon as possible. (Take your medications with you.)

II. 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 high blood pressure, 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 increase significantly the more overweight I am.

III. No Guarantees:

I understand that much of the success of the program will depend on my own 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 my life if I am to be successful.

IV. Pregnancy:

If a female, my signature confirms that I am not pregnant, do not plan to get pregnant, and I will take all necessary precautions to prevent pregnancy during the time I will be taking appetite suppressants. If I become pregnant, I will stop the medication immediately and notify Choose 2 Loose.

INITIALS: _____

V. Payment, Insurance, Refunds & Prescriptions:

By consenting to treatment, I agree to pay in full for all visits and charges at the time of each visit.

I understand that your services are not reimbursed by insurance and that you do not provide or complete claim forms for insurance purposes. I understand that no refunds are given at any time for any reason. I also understand that the medications dispensed to me during my weekly visits are included for quality assurance and my convenience: however, I may request a written prescription for my weekly dose of my medication.

VI. Property of Choose 2 Lose:

I understand that all written materials describing your program or any of its parts, all applicable trademarks, copyrights and other intellectual property in or to your program and related materials are and remain your absolute property. I acknowledge that I am purchasing a non-exclusive, nontransferable license to use your program and the related written materials for my own use, and that I have no right to duplicate or to sell, lend or otherwise transfer to any other person or to make any commercial use of the Choose 2 Lose program or related written materials . I may not modify , publish , distribute , perform , participate in the transfer or sale , create derivative work of, or in any way exploit any of the content, in whole or in part.

INITIALS: _____

VII. 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 risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants. My signature further confirms that I do not have a history of alcohol abuse, drug abuse, schizophrenia, severe manic-depressive illness, or history of any eating disorder, since these conditions constitute a contraindication to the use of appetite suppressants. I agree not to take any other appetite suppressants, other medications, or injections other than those listed on my medical history form or those prescribed by Dr. Lynch. I agree to inform Dr. Lynch of any changes in my medications.

WARNING

IF YOU HAVE ANY QUESTIONS REGARDING THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK YOUR DOCTOR NOW BEFORE SIGNING THIS CONSENT FORM.

DATE: _____ TIME: _____

PATIENT: _____ WITNESS: _____

VIII. PHYSICIAN DECLARATION:

I have explained the contents 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 of 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.

_____

Physician's Signature

INITIALS: _____