



PATIENT RELEASE FORM

I understand that as part of this program I will be taking Phendimetrazine, a drug that causes stimulation to the central nervous system and that this drug should only be used in the dosage prescribed and should not be shared with anyone. Additionally, I understand that I must not take any herbal supplements, or other drugs (prescription or over the counter) that I have not specified in the list provided to my doctor at The Woman's Group as part of my initial consultation for the Weight Loss Program.

The prolonged use of Phendimetrazine may cause pulmonary hypertension, a rare but fatal disorder - Symptoms include chest pains, shortness of breath, or swelling of the lower extremities. If I experience any of these symptoms, I understand that I must discontinue use of this medication immediately and notify my Weight Loss Program physician.

Hypertensive crisis may result if I have been treated with a monoamine oxidase inhibitor (typically used in the treatment of mental illnesses) within 14 days. I understand that I must disclose any prior treatment of this type to my Weight Loss Program physician to prevent this adverse result.

I understand that if I take an overdose of Phendimetrazine or if I take recreational drugs or excessive amounts of alcohol concurrently with this medication, I will experience unusual restlessness, confusion, belligerence, hallucinations, and panic states followed by fatigue and depression. I will also experience cardiovascular effects including arrhythmia, hypertension, or hypotension and circulatory collapse. I will experience gastrointestinal symptoms including nausea, vomiting, diarrhea, and abdominal cramps. Poisoning may result in convulsions, coma, and even death.

Potential Adverse Reactions:

The following are potential adverse reactions to Phendimetrazine. I agree to report any of these reactions to my Weight Loss Program doctor if they occur:

Cardiovascular:

Palpitation, tachycardia, elevated blood pressure.

Central Nervous System

Over-stimulation, restlessness, insomnia, agitation, flushing, tremor, sweating, dizziness, headache, psychotic state, blurring of vision.

Gastrointestinal

Dryness of the mouth, nausea, diarrhea, constipation, stomach pain.

Genitourinary

High frequency of urination, changes in libido.

Dependence

Phendimetrazine is related chemically and pharmacologically to the amphetamines. Amphetamines and related stimulant drugs have been extensively abused. Abuse of amphetamines and related drugs may be associated with intense psychological dependence and severe social dysfunction. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression and changes to sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia.

Other

There may be potential negative interactions between Phendimetrazine and other prescription drugs, therefore it is important that you disclose ALL prescription or over-the-counter drugs or supplements that you take to your Weight Loss Program physician at the offset of the program and that you consult with her prior to taking any new over-the-counter drug.

I have read this document, understand its contents and understand my responsibilities with respect to the use of Phendimetrazine.

Date: _____



Diet and Exercise History

Name: _____ Date: _____

Address: _____

Telephone Number: _____ Mobile Phone Number: _____

Email: _____

Estimated Current Weight: _____ Goal Weight: _____

What is the main reason for your desire to lose weight?

Weight and Dieting History:

At what age did you first become overweight? _____

Tell us about a couple of diets that have helped you lose weight in the past. Leave blank if you have never have followed a diet before.

Name of the Diet: _____ Weight Loss: _____

What did you like about this diet? _____

What did you not like about this diet? _____

Name of the Diet: _____ Weight Loss: _____

What did you like about this diet? _____

What did you not like about this diet? _____

Eating and exercise habits (mark all that apply):

- I eat when I am under stress.
- I am not hungry when I am under stress.
- I eat when I am happy.
- I eat when I am sad.
- I eat three good meals a day and few snacks in between.
- I skip big meals and rather snack throughout the day.

- I eat breakfast most days I do not like to eat breakfast
- I like to exercise I do not like to exercise
- I exercise often I do not exercise often
- I rarely eat out I eat out very often

Weight Loss Medication History:

Have you taken prescription diet pills before? Yes No

If yes, what type? _____

Did you experience negative side effects? Yes No

If yes, what type? _____

What is your biggest concern about this diet program?

Treatment History:

Please mark each of the conditions for which you are currently being treated or have been treated for in the past:

- Diabetes Eating disorders Mental Illness
- Hypertension Thyroid Disease Drug Abuse
- Alcohol abuse Gastrointestinal problems Glaucoma

List all current medications and supplements that you are taking:

Allergies: Are you allergic to Sulfa? Yes No