Patient Demographics

Please print (all in capital letters)
Must answer all questions

State or Federal Photo ID

Patient's Name (Last) ______________________ (First) ____________________ Mr./Ms.

Age ________ Date of Birth ____________________

Sex at Birth ________________ Gender (cross out not applicable) Male / Female

Home Address ________________________City ______________Sate/Zip________________

Cell Phone ( ) ________-____________________ I will accept text messages

Home Phone ( ) ________-____________________ work phone:________________________

Email Address____

Emergency Contact/ Relationship ____

primary Care Physician / Tel No____

I the undersigned patient understand to keep quality and affordability of my healthcare, periodically, I will be receiving phone calls, text messages and emails from the clinicians or staff from this facility.

Patient Signature ________________________________ Date____________________

Patient Medical History

Please Print Clearly, Answer or circle all applicable

Name (Last) ______________________________ (First) ___________________________ Date of Birth __________________

Date Last Physical Seen ____________________ Reason ____

Known allergies : Food/Drugs/Dye ____

List Medications or Supplements currently taken ____

____

Surgical History (Date) ____________________ Procedure ____

Do you smoke NO /Yes # of cigarette __________ . Do you drink alcohol regularly No / Yes (how often)______________

Female patients: Are you pregnant/trying to get pregnant or breastfeeding No / Yes Explain _____________________

Do you or your family have history of Pancreatitis No / Yes Explain ____

Do you or your family has history of any GI conditions including but not limited to Gall bladder disease, Gerd, gastroparesis, constipation, colitis, diverticulitis, or paralytic ileus? No / Yes Explain _____________________________

Do you or your family has history of Medullary thyroid Cancer or multiple endocrine neoplasia type 2. No / Yes _______

Do you or your family has history of Kidney disease No / Yes explain ______________________________________

Do you take Aprepitant Capsules or any other medications to prevent nausea or vomiting No / Yes __________________

Do you have a family history of any type of cancer No / Yes Explain ____

Do you have a history of cardiac disease, including but not limited to, coronary artery disease, stroke, cardiac arrhythmias, palpitations, heart failure, or hypertension No / Yes last diagnosed on ______________________________

Do you have any endocrine disorder Diabetes, hypothyroidism, Cushing disease, polycystic ovarian syndrome No / Yes__

Do you have a history of any mental health disorder depression, anxiety, insomnia No / Yes Explain _______________.

Do you have a history of eating disorders (Anorexia, Bulimia, Binge eating, etc.)? No / Yes explain ___________________

Do you have a history of any neurological disorders including but not limited to seizures, frequent headaches, retinopathy, vertigo No / Yes Explain ____

How long have you been over weight ______________ How much have you gained Wt. in past 12 months_____________

List all the causes you think have contributed to your weight gain ____

Please list all medications used in the past to help lose weight ____

Do you or your family has history of eating disorders ____

Do you have stiffness or pain in any joints in your body? No / Yes Explain ____________________________________

List all medicines and supplements you take everyday ____

I the undersigned certify that the medical history I have provided above is true and correct.

Patient Signature ____ Date__________________

ARDEN WELNESS

PHYSICIAN-SUPERVISED
WEIGHT LOSS INITIAL VISIT

PATIENT NAME:______________________________ DOB:___/___/___ DATE:___/___/___

AGE:________ REASON FOR VISIT:______________________________

Sex: M / F Drug Allergies:______________

B/P____/_____ Pulse_______ Height_______ Weight_______ BMI_______

STARTING WEIGHT:_________ GOAL WEIGHT:__________

LMP:________________ PMP:________________

SUBJECTIVE:

When did you first become overweight?______________________________

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

Types of weight programs you have been on?______________________________

History of obesity treatment medications?______________________________

Phentermine use in the past?______________________________

Date of last physical/labwork:______________________________

Current Dietary/Water Intake:______________________________

____

Exercise Habits: O No Activity O 1-2x/wk O ≥ 3x/wk
O ≤ 30 mins O 30-60 mins O ≥ 60 mins

Sleep Habits: O Good O Poor O Insomnia Stressors:______________________

Current Medication:______________________________

Patient Denies: O SOB O palpitations O chest paint OHTN O thyroid disorder Oinsomnia

Past Medical Hx:

Family Hx:

Social Hx: Alcohol? Y / N Smoking? Y / N Illicit Drug Use? Y / N

ROS:

General :______________________
HEENT:______________________
Cardiac:______________________
Pulmonary:______________________
Endocrine:______________________
Musculoskeletal:______________________
Integument:______________________

Hematologic:______________________
Gastrointestinal:______________________
Neurologists:______________________
Psychiatric:______________________

O ROS reviewed today and found negative except per CC/HPI.

	EXAM
GENERAL	O A&O x3, in no acute distress.
NECK	O no evidence of goiter or lymph node abnormalities.
LUNG	□ BBC clear/ equal.
HEART	□ S1/S2 normal, no murmur.
ABDOMEN	□ Full, soft, non-tender. No organomegaly or masses noted.
SKIN	□ Intact, no lesions.
EXTREMITICS	□ no edema or varicosities.

▯ OBESITY	▯ *DIABETES.*
▯ MORBID OBESITY	▯ VITAMIN D DEFICIENCY.
▯ ABNORMAL WEIGHT GAIN	▯ THYROID DISEASE (PREVIOUS HISTORY)
▯ OVERWEIGHT	▯ SUSPECTED ENDOCRINE ABNORMALITIES
▯ MAINTENANCE WEIGHT LOSS	▯ LOW POSSIBILITY OF ABUSE
▯ HYPERTENSION previously	
▯ NEW ONSET HYPERTENSION	

PLAN:

Nutrition: O Low calories diet O Modified low calories diet O Ketogenic diet
O 1,000 calories diet O Maintenance O Refer to RD/Nutritionist
O Cardio O Resistance exercises

Behavior:

O Motivational interviewing performed O referral for counseling portion size reduction
O Reduce consumption of dietary fat O Read food labels O increase water intake
O Reduce consumption of alcohol and caffeine and/or juice O Minimize or eliminate eating fast food.
O Maintain food journal O track intake of carbs per gram daily O eliminate snacking between meals
O Chew food slowly O Use of healthy cooking techniques O Reduce Red meat O Discussed strategies to overcome habits/challenges for focus. O others________________________

Medications:

O Phentermine 37.5 or 30 mg OD BID TID #__________RX/DISPENSED
O Phentermine Caps 37.5 or 30mg Blue & Clear or Blue & White #__________RX/DISPENSED
O Phentermine Caps 30mg or 15mg Yellow or Green #__________RX/DISPENSED
O Phendimetrazine 35 mg OD BID TID #__________RX/DISPENSED
O Metformin 500 mg PO after dinner
O Topiramate 25 mg or 50 mg PO OD
O HCTZ 25mg or 50mg PO O A.M
O HCG (10,000 IU/0.35 ML SO/IM INI ONCE DAILY) O (.033 ML SL DIB)
O AOD (1 OR 2 BOTTLES)
O B12 1ml IM STAT
O Semaglutide B12 or B6 5 units or 10 units or 20 units or 34 units or 48 units
O Monjauro .25ML or 0.5ML or 0.1ML

REVIEWED:

O Nutrition and the importance of regular protein intake
O Labs ordered/reviewed: OA1C OFBS O LIPIDS O TSH/TFT OCMP O LFT
O Hidden CHO/carbohydrate sources
O Alcohol as possible source of hidden/amnesia calories and its effects
O Importance of physical activity and reduce sedentary time

Comment:________________________________

Follow up visit:_____weeks/month

Provider's signature ________________________ Date:___/___/_____

PT CONFIRM PICKING UP MEDICATION BY SIGNING BELOW

Patients Signature ________________________ Date___/___/_____

Medical Weight Management Controlled Prescription Drug Management Consent

This document is intended to serve as a confirmation of informed consent for Phentermine/Phendimetrazine and all other schedule II, III, IV, V prescription (stimulant) weight management medications

A. Patient Informed consent for Cost/Pricing

- My charge will include my time with the provider (NP/MD) supplies, and medication. Prices may vary and change. I understand that medication will only be dispensed to me if I am eligible (i.e. medically fit) which is determined by a licensed medical professional. If for any reason (ie. elevated BP, abuse or other contraindications) it is determined that I am not eligible to receive Phentermine, I understand that the cost of consultation is non-refundable.

B. Patient Informed Consent

I voluntarily request that licensed medical professionals at Arden Med Spa treat me for weight loss management

1. I have informed my provider of any known allergies, my medical conditions, medications, social/family history.
2. I have the right to be informed of any alternative options, side effects, and the risks and benefits.
3. Phentermine is a diet pill that works by affecting parts of the central nervous system which effectively suppress hunger and therefore cravings. Phentermine is a pill that is known to increase energy levels within patients which is ideally expended through exercise and being active. The mechanism of action (the way the medication works) of the medication has been explained to me and I fully understand
4. I understand that Phentermine is not intended for long-term use and that it is a controlled substance regulated by the DEA. I understand that it may be necessary to take a "pill holiday". A period of time where I am not taking the medication
5. I understand that based on several factors (availability, shipping time, cost) the pharmacy may change and I will be informed if this happens
6. It has been explained to me that this medication could be harmful if taken inappropriately or without advice from the provider.
7. I understand this medication may cause adverse side effects (see below). I understand this list is not complete and it describes the most common side effects.
8. I understand that Phentermine can cause "false positive" urine test for amphetamines

Common side effects include, but are not limited to:

- **Gastrointestinal:** Hypoglycemia (low blood sugar), Dehydration, Dry mouth, Nausea/vomiting, abdominal pain, Diarrhea/constipation, dyspepsia, abdominal distension, flatulence, gastroenteritis, GERD, gastritis,
- **Neurological:** Insomnia, Headache, dizziness, tremors, behavioral changes, sexual dysfunction, vision changes
- **Cardiac:** Heart rate increase, palpitations, Hypertension (elevated BP)

Serious Reactions include, but are not limited to:

- Anaphylaxis/ Angioedema/hypersensitivity reaction, seizures
- Cardiac dysfunction, Heart failure, stroke, chest pain
- drug abuse, death

B. I understand that I have the following responsibilities:

1. I agree to obtain prescriptions for Phentermine only from licensed medical providers at Arden Med Spa
2. Medical history: I will honestly disclose my complete medical history, including allergies, medications, medical/surgical/social/family history to my licensed medical providers at Arden Med Spa and update them with any changes at each visit/encounter
3. **I understand that if I become pregnant or start trying for pregnancy, I must stop this medication.**
4. My provider can discuss my treatment plan with any co-treating pharmacist and/or healthcare provider
5. I understand that I must make my primary medical care provider and all other medical providers aware of any and all medications I am taking.
6. I understand that the medications prescribed by the licensed medical providers at Arden Med Spa are meant to assist me in weight loss and that the medical advice that they provide is NOT a substitute for seeing a primary care doctor
7. **I will take my medications only as prescribed according to the directions given by my licensed medical providers at Arden Med Spa**
   a. If I feel my medications are not effective, or are causing undesirable side effects, I will contact my provider for instructions. Medih
   b. I will not adjust my medications without prior instruction to do so.
   c. **I understand that prior to any surgery I may need to stop the medication and will contact my licensed medical providers at Arden Med Spa for directions**
   d. I understand it is important to keep my medication away from children (<18 years old)
   e. I am the only one who will use my medication. I will not give or sell or give my medication to anyone else.
   f. i understand once medication is dispensed to me is cannot be returned

Discontinuation of medication: I understand that licensed medical providers at Arden Med Spa may stop prescribing my medications if:

a. I am having unfavorable side effects or it's not working to treat my medical condition
b. I have been untruthful in my medical or family history
c. I do not follow through with the recommended plan of care
d. I do not follow any parts of "Part B: responsibilities" in this agreement.

I have read this form in its entirety. I have had the opportunity to ask questions and have all my questions answered. I fully understand the above information and have no further questions. By signing this form, I voluntarily give my consent for treatment and agree to the risks.

Patient name printed ______________________________ Date__________

Signature of patient ______________________________ Date__________

Weight Management (Semaglutide and Tirzepitide) Prescription Drug Management Consent

This document is intended to serve as a confirmation of informed consent for compounded Semaglutide and Tirzepitide, which is a prescription weight management medication.

A. Patient Informed Consent

1. I voluntarily request that licensed medical professionals at Arden Med Spa treat my medical condition.
2. I have informed my provider of any known allergies, my medical conditions, medications, social/family history.
3. I have the right to be informed of any alternative options, side effects, and the risks and benefits.
4. The mechanism of action (the way the medication works) of the medication has been explained to me and I fully understand
5. I understand the prescription will come from a compounding pharmacy. I have been told that the manufacturing facility itself is FDA monitored along with third party testing on the medication itself.
6. My charge will include my time with the provider (NP/MD) supplies, and medication. Prices may vary and change
7. I understand that based on several factors (availability, shipping time, cost) the pharmacy may change and I will be informed if this happens
8. It has been explained to me that this medication could be harmful if taken inappropriately or without advice from the provider.
9. I understand this medication may cause adverse side effects (see below). I understand this list is not complete and it describes the most common side effects. I understand symptoms may be worse after there has been a change in my medication dose or when first starting the medication.

Common side effects include, but are not limited to:

- **Gastrointestinal**: Nausea/vomiting, abdominal pain, Diarrhea/constipation, dyspepsia, abdominal distension, flatulence, gastroenteritis, GERD, gastritis, lipase increase, amylase increase
- **Neurological:** Headache, dizziness
- **Cardiac:** Heart rate increase, Hypotension
- **Endocrine:** Fatigue, hypoglycemia (diabetic patients), alopecia
- **Ophthalmic:** Retinal disorder (diabetic patients)

Serious Reactions include, but are not limited to:

- **Thyroid C-cell tumor (animal studies)**
- **Medullary thyroid cancer**
- Anaphylaxis/ Angioedema/hypersensitivity reaction
- Acute kidney injury/ Chronic renal failure exacerbation
- Pancreatitis
- Cholelithiasis/ Cholecystitis

B. I understand that I have the following responsibilities:

1. I agree to obtain prescriptions for compounded Semaglutide or Tirzepitide only from licensed medical providers at Arden Med Spa

2. Medical history: I will honestly disclose my complete medical history, including allergies, medications, medical/surgical/social/family history to my licensed medical providers at Arden Med Spa and update them with any changes at each visit/encounter

3. **I understand that if I become pregnant or start trying for pregnancy, I must stop this medication IMMEDIATELY.**

4. My provider can discuss my treatment plan with any co-treating pharmacist and/or healthcare provider. I acknowledge that this is a telehealth visit and is not considered an "in-office" visit. I agree to take sole responsibility to learn about the education, side effects and instructions regarding dispensing the medication and its intended use.

5. I understand that I must make my primary medical care provider and all other medical providers aware of any and all medications I am taking.

6. I understand that the medications prescribed by the licensed medical providers at Arden Med Spa are meant to assist me in weight loss and that the medical advice that they provide is NOT a substitute for seeing a primary care doctor

7. **I will take my medications only as prescribed according to the directions given by my licensed medical providers at Arden Med Spa**
    a. If I feel my medications are not effective, or are causing undesirable side effects, I will contact my provider for instructions.
    b. I will not adjust my medications without prior instruction to do so.
    c. I understand that the medication must be either kept frozen or refrigerated.
    d. I understand this medication must be self-injected in the subcutaneous tissue once weekly. I will not inject any less than 7 days unless directed to do so by my licensed medical providers at Arden Med Spa (example: travel).
    e. **I understand that prior to any surgery I may need to stop the medication and will contact my licensed medical providers at Arden Med Spa for directions**
    f. I understand it is important to keep my medication away from children (<18 years old)
    g. I am the only one who will use my medication. I will not give or sell my medication to anyone else.
    h. I will not share needles and dispose of needles safely.

Discontinuation of medication: I understand that licensed medical providers at Arden Med Spa may stop prescribing my medications if:

a. I am having unfavorable side effects or it's not working to treat my medical condition
b. I have been untruthful in my medical or family history
c. I do not follow through with the recommended plan of care
d. I do not follow any parts of "Part B: responsibilities" in this agreement.

I have read this form in its entirety. I have had the opportunity to ask questions and have all my questions answered. I fully understand the above information and have no further questions. By signing this form, I voluntarily give my consent for treatment and agree to the risks.

Patient name printed ____ Date__________