



Telehealth - Return Patient Medical History and Demographic Update Form

Video and recording are strictly prohibited

Name _____ Date of Birth _____

Email _____ Phone _____

Address _____ City _____ State _____ Zip _____

S.S.# _____ (Required)

Current Weight: _____ (lbs.) Goal Weight: _____ (lbs.)

Are you currently pregnant or nursing? Yes No

Any new changes to your medical history since your previous visit? Yes No

If Yes what? _____

Any new side effects from Phentermine HCL since your previous visit? Yes No

If Yes what? _____

Current Medications (include over the counter):

Name	Dose	Frequency

Do you have any allergies to medication? Yes No

If Yes what? _____

Recent Surgeries? Yes No

If Yes what? _____



Do you have any of the following health conditions:					
Heart Disease	<input type="radio"/> Yes	<input type="radio"/> No	Cancer	<input type="radio"/> Yes	<input type="radio"/> No
High Blood Pressure	<input type="radio"/> Yes	<input type="radio"/> No	Ovarian Problems	<input type="radio"/> Yes	<input type="radio"/> No
Irregular Heart Beats	<input type="radio"/> Yes	<input type="radio"/> No	Stroke	<input type="radio"/> Yes	<input type="radio"/> No
Chest Pain	<input type="radio"/> Yes	<input type="radio"/> No	History of Substance Abuse	<input type="radio"/> Yes	<input type="radio"/> No
Seizures	<input type="radio"/> Yes	<input type="radio"/> No	Eating Disorders	<input type="radio"/> Yes	<input type="radio"/> No
Glaucoma	<input type="radio"/> Yes	<input type="radio"/> No	Diabetes	<input type="radio"/> Yes	<input type="radio"/> No

I certify that every answer provided was accurate to the best of my knowledge below with my Electronic Signature.

Signature: _____ Date: _____

Print Name: _____

DO NOT WRITE BELOW THIS LINE

Last Recorded Vitals

Date: _____ P _____ R _____ BP _____ HT _____ WT _____ BMI _____

Alert: Yes No Oriented: Yes No Heart _____ Lungs _____

Advised Low Fat, Low cholesterol, low calorie & high fiber diet and increased exercise.

Rx- Phentermine HCL 37.5 mg 1 PO Daily or 1/2 PO BID #30 #60
 Rx- HCG 45 Day Diet 1000 IU/mL 0.125 (12.5 units) SQ QAM #4000 IU Refill x _____
 Rx- Sermorelin 1mg/MI 0.3 (30 units) SQ QHS #9 mg Refill x _____
 Rx- B12 Injections 1 mL / IM weekly Refill x _____

Medical Leaflet given _____ Diet instructions given _____ RTC 1 & 4 wks & prn

Diagnosis: EXOGENOUS OBESITY

 Physician Signature
 (Electronic Signature)