Victoria Green FNP-C
1810 Lindberg Dr. Suite 2400
Slidell, La 70458
Ph. 985-214-4330 Fax: 985-214-4853

MEDICAL WEIGHT LOSS PROGRAM

☐ Semaglutide ☐ Tirzepatide

Client's Information

Full Name: _____

Date of Birth: _____ Age: _____ ☐ Female ☐ Male

Address: _____ City: _____ ZIP: _____

E-mail: _____ Phone: _____

Patient Informed Consent

- I voluntarily consent that the provider listed above treat my medical condition.
- I have informed my provider of any known allergies, medical conditions, medications, and social/family history.
- I have the right to be informed of any alternative options, side effects, and the risks and benefits.
- I understand the mechanism of action of the medication.
- I understand how the medication is administered.
- I understand the prescription will come from a compounding pharmacy, which is not FDA approved.
- I understand prices may vary and are subject to change.
- I understand that this medication could be harmful if taken inappropriately or without advice from the provider.
- I understand this medication may cause adverse side effects (see below). I understand this list is not comprehensive and it describes the most common side effects, and that death is also a possibility of taking this medication.
- 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 Not Limited To:

Nausea
Vomiting
Abdominal Pain
Abdominal Distention
Diarrhea
Constipation
Belching
Flatulence
GERD
Headache
Dizziness
Increased Heart Rate
Hypotension
Fatigue
Low Blood Sugar
Hair Loss
Redness or Pain at Injection Site

Serious Reactions Include, But Not Limited To:

Thyroid C-Cell Tumor
Medullary Thyroid Cancer
Hypersensitivity Reaction
Anaphylaxis
Angioedema
Acute Kidney Injury
Chronic Renal Failure Exacerbation
Pancreatitis
Cholelithiasis
Cholecystitis
Syncope

B. **I understand that I have the following responsibilities**

- I agree to obtain prescriptions for compounded Semaglutide or Tirzepatide from Iconic Healthcare.
- **Medical history**: I will disclose my complete medical history, including: allergies, medications, medical / surgical / social/ family history. Iconic Healthcare may ask to review, with your permission, your medical history (medications, recent lab results, pertinent imaging results, etc.).
  - I understand that if I become pregnant or start trying for pregnancy, I must stop this medication.
  - I will disclose to my provider any updated health information (medication, allergies, personal medical issues/surgeries/social history, or family history changes).
  - I agree my provider can discuss my treatment plan with any co-treating pharmacist and/or healthcare provider.
- **Directions for use:** I will take my medications only as prescribed according to the directions given.
  - If I feel my medications are not effective, or are causing undesirable side effects, I will contact my provider for instructions.
  - I will not adjust my medications without prior instruction to do so.
  - I understand that the medication must be refrigerated.
  - I understand this medication must be self-injected in the subcutaneous tissue once weekly. I will not inject any less than 7 days unless otherwise directed.
  - I will not share needles and I will dispose of needles safely.
  - If I'm having troubles with the administration of the medication, I will seek help from my provider.
  - The medication expires after 12 weeks. I will refer to the Beyond Usage Date (BUD).
- **Refills:** All refills will require an appointment.
  - I understand, I need to schedule refill appointments ahead of time to avoid delays in refills.
  - I understand that I may be asked to bring the medication with me to my appointments to check the quantity left or assess how I am injecting.
- **Safety:** I understand it is important to keep my medication away from children (<18 years old).
  - I understand I am the only one who will use this medication. I will not give or sell my medication to anyone else.
- **Discontinuation of medication:** I understand that my provider may stop prescribing my medications if:
  - I am having unfavorable side effects or it's not working to treat my medical condition.
  - I have been untruthful in my medical or family history.
  - I do not follow through with the recommended plan of care set by my provider.
  - I do not follow any parts of "Part B: responsibilities" in this agreement.

I have read this form in its entirety. It has been explained to me. 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.

Client's Signature:	Office Personnel's Signature:
Date:	Date:

PATIENT MEDICAL HISTORY

ALLERGIES – Please list medication and reaction below.

❑ NONE/Known Allergies

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER
Bleeding Disorder		
Arthritis		
Cancer		
Diabetes		
Heart Problems		
Hypertension		
Stroke		
Thyroid Disorder		

SOCIAL HISTORY

□ **Yes** □ **No -** Do you drink alcohol? □ Daily □ Weekly □ Infrequently □ Recovering Alcoholic
□ **Yes** □ **No -** Do you smoke? □ Smoke (___packs per day) □ Chew
□ **Yes** □ **No -** Do you drink caffeine? □ Daily □ Weekly □ Infrequently
□ **Yes** □ **No –** Are you sexually active?
□ **Yes** □ **No –** Do you wish to be checked for STDs?

SURGICAL HISTORY: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR OR DATE	DOCTOR	LOCATION

MEDICAL HISTORY: Have you ever had any of the following?

❑ NONE of the problems listed
❑ Allergies
❑ Anemia
❑ Arthritis
❑ Asthma
❑ Arterial fibrillation
❑ Bleeding problems
❑ BPH
❑ CAD coronary artery disease
❑ Cancer
❑ Cardiac arrest
❑ Celiac disease
❑ Chest pain
❑ Congestive heart failure
❑ Chronic fatigue syndrome
❑ Depression
❑ Diabetes
❑ Drug/alcohol abuse
❑ Erectile dysfunction
❑ Fibromyalgia
❑ Gerd
❑ Heart Disease
❑ Hyperinsulinemia
❑ Hyperlipidemia
❑ Hypertension
❑ Hypogonadism male
❑ Hypothyroidism
❑ Infection problems
❑ Insomnia
❑ Irritable bowel syndrome
❑ Kidney problems
❑ Menopause
❑ Migraines/headaches
❑ Neuropathy
❑ Onychomycosis
❑ Organ injury
❑ Osteoporosis
❑ Pulmonary embolism
❑ Seizure disorders
❑ Shortness of breath
❑ Sinus conditions
❑ Stroke
❑ Tremors

MEDICATIONS: List any medications you are currently taking (please include over the counter medications): **PLEASE PRINT LEGIBLY**

MEDICATION	DOSAGE

Patient Name: _____ Date: _____

What is your purpose for having Semaglutide/Tizepatide treatment?

_____

_____

_____

What is the reason you want to lose weight?

_____

_____

_____

How long has your weight been a problem?

_____

_____

_____

Are you currently at your heaviest weight (if not, how much did you weigh at your heaviest)?

_____

_____

My worst food habit is: _____

Are you a stress eater? _____ Do you eat in the middle of the night? _____

Does your significant other struggle with weight issues? _____

What methods have you previously tried to lose weight?

_____

_____

Are you scared of needles/faint easily when you have blood taken? _____

Woman ONLY:

Are you trying for pregnancy or planning pregnancy in the near future? _____

Are you or could you possibly be pregnant? _____

Are you breastfeeding? _____

Are you on any type of hormone replacement therapy? _____

Are you on any contraceptive methods? _____