



Success by Design of Tampa Bay Weight Management
6026 Park Blvd • Pinellas Park FL 33781 • 727 548 0001
Debra Figueroa, MD • Sherri Morrison RN

PATIENT INFORMATION

Name _____ Date _____

Address _____

City _____ State _____ Zipcode _____

DOB _____ SS# _____ - _____ - _____

Home Phone _____ Mobile Phone _____

Work Phone _____ Email Address _____

Emergency Contact _____ Phone Number _____

Married _____ Single _____ Divorced _____ # of Children _____

Occupation _____

Hobbies _____

How did you hear about us? _____

GUARANTOR INFORMATION *If self and same as above please check here* _____

Name _____ Date _____

Address _____

City _____ State _____ Zipcode _____

DOB _____ SS# _____ - _____ - _____

Home Phone _____ Mobile Phone _____ Work Phone _____



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MEDICAL INFORMATION & HISTORY

Primary Care Physician _____ **Phone Number** _____

Medications (prescribed and over-the-counter) _____

Please list any allergies _____

Tobacco use No ___ Yes ___ # of packs ___ for ___ years

Alcohol use No ___ Yes ___ Details _____

Have you had any of the following? Please circle.

- | | | | | |
|---------------------|---------------|---------------------|--------------|------------|
| Arrythmia | Blackouts | Blurry Vision | Cancer | Chest Pain |
| Constipation | Diabetes | Diarrhea | Dizziness | Glaucoma |
| Headaches | Heart Disease | High Blood Pressure | Palpitations | Seizures |
| Shortness of Breath | Stroke | Thyroid Disease | Tremors | |

If yes please explain _____

Surgery _____ **Date** _____ **Where** _____

Surgery _____ **Date** _____ **Where** _____

Surgery _____ **Date** _____ **Where** _____

Surgery _____ **Date** _____ **Where** _____

Family Medical History _____



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PATIENT CONSENT FORM

Name _____ Date _____

- ___ I understand that treatment with weight loss medications is on a short-term basis only.
- ___ I understand that the medicine given may lose its effectiveness over time.
- ___ I understand that any successful weight loss program must involve diet and exercise and lifestyle changes.
- ___ I understand to maintain weight loss, diet and exercise must be a continued part of my lifestyle.
- ___ I have been given options that do not involve appetite suppressants.
- ___ I have read the side effects of Phendimetrazine/Phentermine and all my questions have been satisfactorily answered.
- ___ I understand that medication dispensed by Dr. Figueroa is also available at retail pharmacies.
- ___ I understand that there may be less expensive generic options available.
- ___ I understand that there is a lack of scientific data relating to the dangers of long term use of medicine.
- ___ I understand that I have the right to request an itemized statement of my costs.
- ___ I understand that the weight loss medication is not to be shared with anyone.
- ___ I understand that lost medication will not be refilled any earlier than anticipated.
- ___ I understand that there is possibility of bruising and redness at the site of injection or at the site of the blood draw.

Patient Signature _____ Date _____