Dream Weight + Botox Clinic
MS Location:1060 E County Line Rd, Suite 1A, Ridgeland Mississippi, 39157 769444-5673
ATL Location: 2521 Piedmont Rd NE, Suite 2101, Atlanta Georgia, 30324 706-509-2345
www.dreamweight.me office@dreamweight.me

Please fill out this form and bring it with you on your first appointment with your photo ID

First Name_____ MI_____ Last Name_____
Date of Birth _____/_____/_____ Age: _____
Social Security#_____—_____—_____
Address: _____
City/State: _____Zip:_____
Phone: _____ Email: _____

☐ Emergency Contact and phone_____
Occupation: _____
Primary Physician: _____ Physician phone:_____
ŸYour lifetime max weight: _____ Pounds (lbs)ŸYour dream weight: _____ Ÿ
What was your weight 1 year ago _____?
ŸDo you smoke? Y/ N ŸDrink Alcohol Y/ N ŸHow much? _____/day or week Ÿ
LADIES: Are your periods regular? Y/ N If not, do you skip periods? Y/ N Ÿ Last period? _____ Ÿ ? Infertility _____ Ÿ? Unwanted hair? Y/ N Ÿ Are you Pregnant? Y/ N ŸBreastfeeding? Y N ŸDo you plan on becoming pregnant in the next few months? ŸBirth control method (includes male or female sterilization): _____ Ÿ
MEN: Muscles Weak? Y/ N ŸLow Sex Drive ? Y / N Ÿ Erectile Dysfunction Y/ N ŸLow Energy? Y/ N

What have you done in the past to try to lose weight? Circle all that apply:

Weight Watchers Purging/Vomiting Medifast Jenny Craig Atkin's Diet
Diet pills Starvation Nutrition Consult
Low Carb Surgery NutriSystem Optifast Overeaters Anonymous
Other

Current Medications
1.) _____ **2.)** _____
3.) _____ **4.)** _____
5.) _____ **6.)** _____
7.) _____ **8.)** _____
9.) _____

Over the counter meds/supplements _____
_____ _____

Please list Any Major Surgery (including weight loss surgery) Specify: (List all) Date
_____
_____
_____
_____
_____

Ÿ**Any known drug allergies?**
_____
_____

Please circle the medical conditions that YOU have been diagnosed with in the past or currently. Please circle:

High Blood Pressure High Cholesterol Heart Disease
Thyroid Disease Liver Disease Kidney Disease Asthma
Diabetes Pre-Diabetes or metabolic syndrome Low Testosterone (Men)
PCOS Depression/Anxiety Drug Abuse
History of current or past Alcohol Abuse Bipolar Disorder Seizures
Cancer Stroke Drug addiction

Has any blood relative ever had any of the following? Please circle

Unexplained death <40 years age Heart Attack Cancer
High Blood Pressure Heart Disease/Stroke Overweight
Diabetes or "borderline diabetes" Kidney Disease High Cholesterol

Exercise History (What you are doing right now)

Type**:** _____
_____

☐None
☐ 1-2 times weekly ☐ 3-5 times/week ☐ Daily

Behavior/Lifestyle: Which of the following best describes you? Please circle:

Lack of time for self or exercise Stress eating Large Portions
Eating late or waking up to eat Eating too fast Drinking soda Always hungry
Boredom eating Food cravings (carbs)
Other:

ŸHow would you rate your readiness for lifestyle changes to reduce your weight? Please circle:
✪Low w1 w2 w3 w4 w5 ✪High

ŸWhat is your main reason for wanting to lose weight?
_____

I _____ authorize **Dr. Rommel Asagwara, MD** and his team members to help me in my weight loss efforts. I understand that they use a holistic approach to weight loss which may comprise of different individualized diet recommendations, physical activities, FDA approved appetite suppressant medications and healthy supplements. Other treatment options may include a very low calorie diet, or a protein supplemented diet. FDA approved medications used are safe and used for weight loss when clinically necessary and the duration of use of these medications may vary from person to person and may be for extended periods for some patients.

I understand that this is a participative and voluntary program from which I may withdraw at any time. I understand that the success of weight loss is better achieved from the efforts I put into the program under physician supervision and that there are no guarantees as to the amount of weight loss that each person will achieve as it varies from person to person. I understand that lifestyle changes will be necessary to help lose weight and help maintain any weight loss during the course of the program and this may be a life long change that may need to be continued in order to be successful.
I certify that I will disclose all my medical history and medications to Dream Weight Clinic staff and to Dr. Rommel Asagwara while I participate as a patient in their program. I certify that I will not receive other weight loss medications and appetite suppressants like Phentermine from other clinics or physicians while I am a patient of Dream Weight Clinic without informing Dr. Rommel Asagwara and the staff of Dream Weight Clinic.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Date: _____ Patient: _____
(Or person with authority to consent for patient)

Notice of Privacy

Our Notice of Privacy Practices provides information about how we may use disclose protected health information about you. You have the right to review our Notice of Privacy Practices before signing this acknowledgment. As provided in our Notice, The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by requesting a copy from the Privacy Officer, Dream Weight Clinic, 1060 E County Line Rd, Suite 1A, Ridgeland, MS, 39157 or 2521 Piedmont Rd NE, Suite 2101, Atlanta GA, 30324 or contact us at office@dream-weightclinic.me

By signing this form, you acknowledge that you have been provided a copy of our Notice of Privacy Practices.

Patient Signature _____ Date _____