

Weight Management (Weight Loss Peptide) Medical History Form

Consultation Date & Time: _____

Date of birth: _____

First name: _____

Last name: _____

Gender: Male Female

Occupation: _____

Phone: _____

Mobile: _____

Address: _____

Driver's License #: _____ State Issued: _____ Exp: _____

Emergency Contact

Name: _____ Phone: _____

Address: _____

I am

Married _____ Not Married _____ Divorced _____ Widowed _____ Other _____

PCP Information

Name: _____

Phone: _____

Address: _____



Patient signature: _____ Date: _____

What is your purpose for having Semaglutide 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 no, how much did you weight at your heaviest weight)?

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/needle phobic/faint easily when you have blood taken? _____

Women only answer the following:

Check those questions to which you answer yes (leave the others blank).

- Are you trying for pregnancy or planning pregnancy in the near future?
- Are you or could you be pregnant?
- Are you breastfeeding?
- Are you on any type of hormone replacement therapy?
- Are you on any contraceptive methods?

Number of live births? _____

Comments: _____



Patient Signature: _____

Men and women answer the following:

List any prescription medications you are now taking: _____

List any self-prescribed medications, dietary supplements, or vitamins you are now taking:

Date of last complete physical examination: _____

- Normal Abnormal Never Can't remember

List any other medical or diagnostic test you have had in the past two years: _____

List hospitalizations, including dates of and reasons for hospitalization (including any surgeries):

List any drug, food or environmental allergies you may have: _____

Are you on any blood thinners? _____

Weekly alcohol intake? _____

Do you or have you ever smoked? _____

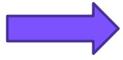
At this time, my current exercise routine includes....

Past or current medical history

Check those questions to which you answer yes (leave the others blank).

- Heart disease (such as heart attack, rheumatic fever, irregular heartbeat, angina, heart murmur, chest pain)
- Diseases of the arteries
- High blood cholesterol
- Anemia or other blood disorders i.e. Sickle Cell disease, Thalassemia
- History of dizziness, seizures or stroke
- Medullary thyroid cancer
- Any thyroid disease/problems
- Parathyroid problems or Adrenal gland problems
- Diabetes or abnormal blood-sugar tests
- Phlebitis (inflammation of a vein)
- Deep vein thrombosis/blood clot in the leg (DVT) or PE (pulmonary embolism)
- Gallstones or any gallbladder disease (including jaundice)
- High blood pressure
- (Hypertension) Severe reflux
- Any breathing problems (such as asthma, COPD, bronchitis)
- Infective endocarditis
- Kidney problems including Chronic Kidney disease (CKD)
- Pancreas/digestion problems (including acute or chronic pancreatitis)
- Stomach/duodenum/gastric ulcer
- Liver problems (including hepatitis, liver failure, fatty liver, alcoholic liver disease)
- Any neurological problems (including Parkinson Disease)
- Severe stomach/gut problems (incl. inflammatory bowel disease: Crohn's disease or Ulcerative colitis)
- Irritable bowel syndrome (IBS)
- Jaundice or gall bladder problems
- Skin conditions
- Eating disorder (such as anorexia or bulimia)
- Mental health problems (including personality disorder, psychosis, diagnosis of depression)
- Self-diagnosis of depression, low mood, nervous or emotional problems
- Substance abuse (including alcohol or drugs)
- Any allergies (including food or drugs)
- Do any of the discussed contraindications apply to you (refer to last page)

Comments: _____



Patient Signature: _____

Family History

Have you or your blood relatives had any of the following (include grandparents, aunts and uncles, but exclude cousins, relatives by marriage and half-relatives)? Check those questions to which you answer yes (leave the others blank).

- Heart attacks under age 50
- Strokes under age 50
- High blood pressure
- Elevated cholesterol
- Diabetes
- Asthma or hay fever
- Skin allergies
- Congenital heart disease (existing at birth but not hereditary)
- Heart operations
- Red blood cell disorders i.e. Sickle Cell, Thalassemia, and Anemia
- Glaucoma
- Kidney Disease
- Obesity (20 or more pounds overweight)
- Leukemia or cancer under age 60

Comments: _____



Patient Signature: _____

Practitioner Name:

Signature: _____ Date: _____

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