Weightloss
CLIENT INTAKE FORM

Name _____ **Date** _____

Address _____ **Phone** _____

_____

Occupation_____ **Gender at Birth:** ☐ **Male** ☐ **Female**

PCP Information

Name _____

Address _____

Phone _____

Patient Signature: _____ **Date** _____

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 cholesterol
- ☐ Anemia or other blood disorders i.e. Sickle Cell disease, Thalassemia
- ☐ History of dizziness, seizures, or stroke
- ☐ Medullary thyroid cancer
- ☐ Any thyroid/parathyroid or Adrenal gland disease or problems
- ☐ Multiple Endocrine Neoplasia
- ☐ Diabetes or abnormal blood-sugar tests
- ☐ Phlebitis (inflammation of a vein)
- ☐ Deep vein thrombosis/blood clot in the leg (DVT) or pulmonary embolism (PE)
- ☐ Gallstones or any gallbladder disease (including jaundice)
- ☐ High blood pressure
- ☐ Lung disease or breathing problems (such as asthma, COPD, bronchitis)
- ☐ Ineffective endocarditis
- ☐ Kidney problems including Chronic Kidney Disease (CKD)
- ☐ Pancreas problems (including acute or chronic pancreatitis)
- ☐ Stomach/duodenal/gastric ulcers
- ☐ Liver problems (including hepatitis, fatty liver, liver failure, alcoholic liver disease)
- ☐ Neurological problems
- ☐ Severe stomach/gut problems (including Crohn's Disease or Ulcerative Colitis; gastroporesis)
- ☐ Irritable Bowel Syndrome
- ☐ Skin conditions
- ☐ Eating disorders
- ☐ Mental health problems (including anxiety, depression, mood disorders, substance abuse)
- ☐ Allergies

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Weightloss
CLIENT INTAKE FORM

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? _____

Family Medical History

Have you or any 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 and leave the others blank.

- [ ] Heart attacks under age 50
- [ ] Strokes under age 50
- [ ] High blood pressure
- [ ] High cholesterol
- [ ] Diabetes
- [ ] Medullary thyroid cancer
- [ ] Asthma or hay fever
- [ ] Multiple Endocrine Neoplasia
- [ ] Diabetes or abnormal blood-sugar tests
- [ ] Congenital heart disease (existing at birth but not hereditary)
- [ ] Bleeding or blood disorders
- [ ] Glaucoma
- [ ] Kidney Disease
- [ ] Obesity (20 or more pounds overweight)
- [ ] Leukemia or cancer under age 60

Comments:

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WEIGHT MANAGEMENT (SEMAGLUTIDE) MEDICAL HISTORY FORM

List any prescription medications (including dosage) you are taking:

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

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

List any drug, food, or environmental allergies that you have:

Are you on any blood thinners?

Yes **No**

Do you or have you ever smoked? (cigarettes, marajuana, vaping)

Yes **No**

Weekly alcohol intake? _____

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WEIGHT MANAGEMENT (SEMAGLUTIDE) MEDICAL HISTORY FORM

List an

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 not, how much did you weigh at your heaviest weight?

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WEIGHT MANAGEMENT (SEMAGLUTIDE) MEDICAL HISTORY FORM

My worst food habit is:

What methods have you previously tried to lose weight? Did any of these methods work and for how long?

Are you a stress eater?

Yes No

Do you eat in the middle of the night?

Yes No

Does your significant other struggle with weight issues?

Yes No

Are you scared of needles/needle-phobic/faint easily when you have blood taken?

Yes No

Do you exercise? Yes No

If yes, how many times per week ? ____

How many hours? ____

Patient Signature: _____ **Date** _____

Practitioner Name: _____

Practitioner Signature: _____ **Date** _____

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