WEIGHT MANAGEMENT (Semaglutide) MEDICAL HISTORY FORM

Name: ______________________________

Address: ______________________________

City: ____________________ State: ____________ Zip: __________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Email: ______________________________

Date of Birth: _____ / _____ / _____ Age: ________ Gender: ❑ Male ❑ Female

Driver's License #: ____________________ State Issued: ____________Exp: ________

Occupation: ____________________ Marital Status: ____________________

Emergency Contact

Name ______________________________

Phone: ______________________________

Address: ______________________________

City: ____________________ State: ____________ Zip: __________

Primary Care and Specialty Doctors:

Doctor's Name: ____________________ Phone: ____________________

Location: ______________________________

Doctor's Name: ____________________ Phone: ____________________

Location: ______________________________

Doctor's Name: ____________________ Phone: ____________________

Location: ______________________________

____

Signature *Date*

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QUESTIONS

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? ❑ Yes ❑ No (If no, how much did you weigh at your heaviest weight?)

My worst food habit is...

What methods have you previously tried to lose weight?

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

WOMEN ONLY:

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

❑ Are you trying to achieve 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 using any type of contraceptives (birth control)?

Number of live births? _________

Signature *Date*

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Medications: Please list all prescription medications you currently take, including samples.

Medication Name	Dose	Number of times per day	Doctor

Herbal/Supplements: Please list all vitamins, herbs, enzymes, protein supplements, pro-hormones or any other supplements.

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Date of last complete physical exam:______________ ❑ Normal ❑ Abnormal ❑ Never ❑ Can't Remember

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

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

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Allergies: Pleae list medications, food, or environmental allergies and what reactions have occurred (if any):

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Past Medical History and Current Medical Conditions: Please check all that apply to you.

- ❑ Heart Disease (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
- ❑ Thyroid disease/problems
- ❑ Parathyroid problems/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/duodenumigastric 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)

Are you on any blood thinners? ❑ Yes ❑ No Weekly alcohol intake? ______________________

Do you or have you ever smoked? ❑ Yes ❑ No

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

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Do any of the discussed contraindications apply to you? *Please check all that apply to you.*
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:

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Signature *Date*

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