Weight Management (Semaglutide) Medical History Form

Please fill out your medical history in the form below so we can craft your customized treatment program.

* Required

1. Consultation Date & Time: *

2. First Name: *

3. Last Name: *

4. Date of birth: *

   Example: January 7, 2019

5. Sex at Birth *

   Mark only one oval.

   - ◯ Male
   - ◯ Female

6. Occupation: *

7. Phone Number: *

8. Address: *

9. Driver's License Number: *

10. State Issued: *

11. Expiration Date: *

    Example: January 7, 2019

12. I am... *

    Mark only one oval.

    - ◯ Married
    - ◯ Not Married
    - ◯ Divorced
    - ◯ Widowed
    - ◯ Other:

Emergency Contact Information

13. Full Name: *

14. Phone Number: *

15. Address: *

PCP Information

16. Name: *

17. Phone: *

18. Address: *

19. Patient Signature: *

20. Date: *

    Example: January 7, 2019

21. What is your purpose for having Semaglutide treatment? *

22. What is the reason you want to lose weight? *

23. How long has your weight been a problem? *

24. Are you currently at your heaviest weight (if no, how much did you weight at your heaviest weight)? *

25. Are you a stress eater? *

    Mark only one oval.

    - ◯ Yes
    - ◯ No
    - ◯ Occasionally

26. Do you eat in the middle of the night? *

27. Does your significant other struggle with weight issues? *

28. What methods have you previously tried to lose weight? *

29. Are you scared of needles/needle phobic/faint easily when you have blood taken? *

Women only answer the following:

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

    Check all that apply.

    - ☐ 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?
    - ☐ Does not apply to me

31. Number of live births?

32. Comments:

33. Patient Signature: *

Men and women answer the following

34. List any prescription medications you are now taking: *

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

36. Date of last complete physical examination: *

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

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

39. List any drug, food or environmental allergies you may have: *

40. Are you on any blood thinners? *

41. Weekly alcohol intake? *

42. Do you or have you ever smoked? *

43. At this time, my current exercise routine includes: *

Past or Current Medical History

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

    Check all that apply.

    - ☐ 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)
    - ☐ Other:

45. Comments:

46. Patient Signature:

Family History

47. 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).

    Check all that apply.

    - ☐ 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
    - ☐ Other:

48. Comments:

49. Patient Signature:

Practitioner Name:

50. Signature:

51. Date:

    Example: January 7, 2019