MEDICAL INTAKE QUESTIONNAIRE

Before we can proceed with prescribing weight loss injections, we kindly ask you to complete a medical intake questionnaire. This form is essential for us to provide you with the safest and most effective treatment possible. By filling out this questionnaire to the best of your knowledge, you help us understand your current health status, any existing medical conditions, and medications you are taking. This information is crucial as it allows us to assess whether weight loss injections are suitable for you and will allow us to tailor the treatment plan to meet your specific needs.

Today's Date: __/__/_____

PATIENT INFORMATION

Patient Name: _____
DOB: _____ Gender: _____
Address: _____
Phone: _____ Email: _____

Emergency Contact Name: _____
Phone Number: _____ Relationship: _____
Primary Care Provider: _____ Phone: _____

WEIGHT HISTORY

What is your:

Current Height: _____
Current Weight: _____
Goal Weight: _____
Weight 1 year ago: _____
Lowest Weight in the past 5 years: _____

When did you first become overweight? Age: _____ Year: _____

How long have you been overweight? _____

How did your weight gain start? _____

Does your weight fluctuate or does it stay the same? _____

What do you think is the cause of your weight gain? _____

Do you feel as if any factors specifically affect your inability to lose weight on your own?

_____

What is your current diet like (describe how often you eat and what kind of foods you eat)?

_____

_____

Do you have any eating related problems or concerns? Any history of eating disorders? (anorexia, bulimia, binge eating)

_____

_____

_____

How many glasses of water do you drink per day? _____

What is your current exercise routine like? _____

_____

Do you have any physical restrictions that prevent you from exercising? _____

_____

Are you currently taking any medications (prescription or OTC) or supplements to aid in weight loss? _____

_____

Have you had bariatric surgery? Yes / No

If yes, which procedure and when? _____

Is there a history of obesity in your family? Yes/ No

If yes, please describe: _____

Are there any other concerns or history relevant to your weight that have not been addressed above? _____

_____

_____

_____

MEDICAL HISTORY

Are you currently under the care of a medical physician? Yes / No

If yes, for what: _____
_____
_____

Are you currently under the care of a mental health professional? Yes / No

If yes, for what: _____
_____
_____

Do you currently have or previously have a history of any of the following (*circle yes or no*):

Diabetes	Yes / No
Hepatitis	Yes / No
HIV	Yes / No
Anemia	Yes / No
Thyroid problems	Yes / No
Liver problems	Yes / No
Bleeding Disorders	Yes / No
Blood Clots	Yes / No
Seizures	Yes / No
Heart Disease or Condition	Yes / No
Autoimmune Disorder	Yes / No
Cancer	Yes / No
Chemotherapy/Radiation	Yes / No
Gallbladder Disease	Yes / No
Pancreatitis	Yes / No
Gastrointestinal Disease	Yes / No
Depression/Anxiety	Yes / No
Suicidal Thoughts/Attempts	Yes / No

If you answered yes to any of the above, please describe:

_____
_____
_____

Do you have a personal or family history of any of the following:

Medullary thyroid cancer	Yes / No
Multiple endocrine neoplasia type 2 syndrome	Yes / No

If you answered yes to any of the above, please describe:

_____
_____
_____

Please list all medications (prescription, over the counter, vitamins, herbs, and supplements) you are currently using:

_____
_____
_____

Please list any allergies you have to medication, food, or metals:

_____
_____
_____

Please list any prior surgeries or hospitalizations you have had and the dates:

_____
_____
_____

Females: when was your last menstrual period? _____

Are you currently pregnant or breastfeeding? Yes/No

Do you plan to become pregnant in the next few months? Yes/No

Do you smoke? Yes/No
If yes, how often? _____

Do you drink alcohol? Yes/ No
If yes, how many drink per week? _____

Do you use recreational drugs? Yes/No

If yes, what kind and how often? _____

Please describe any other health history or concerns that you have that have not been addressed above: _____

_____

I, _____certify that the information provided by me in this form is accurate and correct to the best of my knowledge.

Patient Signature: _____

Print Name: _____

Date: _____