**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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What weight loss methods have you tried in the past? (circle)

Weight Watcher’s Intermittent Fasting Medi fast

Jenny Craig Nutrisystem Atkins

Fen-phen Keto Other\_\_\_\_\_\_\_\_\_\_\_

Did they work? Why or why not? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you tried weight loss injections in the past? Yes / No

 If yes, please describe when and what kind: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had blood work done in the past 3 months? Yes / No

 If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were there any abnormalities? Yes / No

 If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any of the following medications?

 Insulin Yes / No

Sulfonylureas (circle)

 (Such as glyburide, glipizide, Yes / No

 glimepiride, and tolbutamide)

Other weight loss injections: (circle) Yes / No

Ozempic, Wegovy, Zepbound, Adlyxin, Byetta, Bydureon, Rybelsus, Trulicity, and Victoza

Blood thinners Yes / No

If yes, which one? (circle) Plavix, Warfarin, Coumadin, Aspirin, Xarelto, Heparin, Eliquis, other\_\_\_\_\_\_\_\_\_\_\_\_

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)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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How many glasses of water do you drink per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your current exercise routine like? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have any physical restrictions that prevent you from exercising? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

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

 If yes, for what: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

professional?

 If yes, for what: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Females: when was your last menstrual period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently pregnant or breastfeeding? Yes/No

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

few months?

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_