Weight Management (Semaglutide) Medical History Form

Consultation Date & Time:_____ Date of birth:_____

First name:_____ Last name: _____

Gender: ☐ Male ☐ Female Occupation: _____

Phone: _____ Mobile: _____

Address: _____

_____

_____

Driver's License #:_____ State Issued: _____ Exp: _____

Emergency Contact

Name:_____ Phone:_____

Address: _____

_____

_____

I am

Married ____ Not Married _____ Divorced _____ Widowed _____ Other _____

PCP Information

Name:_____ Phone: _____

Address: _____

_____

Patient signature:_____Date: _____

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 no, how much did you weight at your heaviest weight)?

_____

_____

My worst food habit is. _____

Are you a stress eater? _____ Do you eat in the middle of the night? _____

Does your significant other struggle with weight issues? _____

What methods have you previously tried to lose weight? _____

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

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? _____

Comments: _____

_____

Patient Signature: _____

Men and women answer the following:

List any prescription medications you are now taking: _____

_____

_____

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

_____

_____

_____

_____

Date of last complete physical examination: _____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

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

_____

_____

_____

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

_____

_____

_____

_____

_____

List any drug, food or environmental allergies you may have: _____

_____

_____

_____

Are you on any blood thinners? _____

Weekly alcohol intake? _____

Do you or have you ever smoked? _____

At this time, my current exercise routine includes….

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 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)

Comments: _____

_____

Patient Signature:_____

Family History

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: _____

_____

_____

_____

Patient Signature: _____

Practitioner Name:

Signature:_____Date: _____

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