SEMAGLUTIDE AND WEIGHT LOSS PRE APPOINTMENT QUESTIONAIRE

Client Name ______________________________ Today's Date________________

Date of Birth__________Age_______Occupation____________________________

Home Address__________________________________City__________________ State___

Zip Code_______ Home Phone (   )____________ Cell Phone (___)__________

Email____

Emergency Contact Name/Phone: ____

How were you referred to us? ____________________

How did you hear about us? (Please circle all that apply) Google Yelp 4Memphis Magazine

Social media (ex. facebook, Instagram) Health and fitness OTHER:_____________________

Medical History

- ☐ Pancreatitis
- ☐ Pregnant or breastfeeding
- ☐ Do you have any numbness/tingling, frequent urination, frequent thirst, or hunger?
- ☐ Unstable mental health, depression, or eating disorders
- ☐ Medullary thyroid, carcinoma, or Endocrine Neoplasia Syndrome type 2
- ☐ Kidney concerns
- ☐ Do you visit your doctor annually
- ☐ Cancer
- ☐ High blood pressure
- ☐ Post stroke
- ☐ HIV/AIDS
- ☐ Blood transfusion
- ☐ High Cholesterol
- ☐ Hepatitis
- ☐ Hormone imbalance
- ☐ Thyroid imbalance
- ☐ Gallbladder Disorder
- ☐ Do you suffer from depression
- ☐ Do you suffer from anxiety
- ☐ Have you suffered a nervous breakdown
- ☐ Do you have an autoimmune disorder
- ☐ Sleep apnea
- ☐ Pleurisy
- ☐ Ulcers
- ☐ Rheumatic Fever
- ☐ Anemia
- ☐ Prone to Pneumia
- ☐ Frequent headaches or migraines

- ☐ Suffer or have suffered from eating disorder
- ☐ Chickenpox
- ☐ Osteoporosis
- ☐ Liver Disease
- ☐ Lung disease
- ☐ Heart disease, heart valve disorder, or heart attack
- ☐ Swelling feet
- ☐ Measles
- ☐ Date of last blood/ lab work/ EKG__________
- ☐ Please list any abnormalities____

Present Health Status

Are you in good health at the present time? Yes/ No: If No please explain: ______________
____

Are you under a doctor's care at the present time? Yes/ No: If Yes please explain: __________
____

What current medications/ vitamin supplements are you taking? Please list with dosage: ______
____

Any allergies? Yes/ No: If Yes please explain: ________________________________

History of Diabetes? Yes/ No: If Yes what age was diagnosis: _______________________
____

Have you had any Recent Surgeries? Yes/ No: If Yes please explain: _________________
____

Female:
Date of last menstrual cycle: ________
Regular Cycle: Yes/ No

Family History

Tell us of your family's medical history to the best of your knowledge including the items listed as they apply: Age/ General health/ Diseases/ Overweight/ Cause of death

Father: ____

Mother: ____

Brother: ____

Sister: ____

Nutritional Evaluation

What is the main reason for your decision to lose weight? ______________________
What is your desired weight? ______________________
In how many months would you like to be at your goal weight? ______________________
What was your weight one year ago? ________________
When did you begin gaining excess weight? ______________________
What is the most you have weighed (non- pregnant) and when? ______________________
How often per week do you eat out? ______________________
How often per week do you eat "fast food"? ______________________
What foods do you crave? And how often do you crave it? ______________________
What foods do you strongly dislike? ______________________
Do you drink coffee or tea? Yes/ No: If Yes how much and how often? ____________
Do you wake up hungry during the night? Yes/ No: If Yes how often? ____________
Please list the previous diets you have followed:

____
____
____

Lifestyle Considerations

Do you drink alcohol?
Male: _____1 drink a day _____2 days a week ____7 days a week
Female: _____1 drink a day _____2 days a week ____7 days a week

Drug abuse? If yes, please explain: ______________________________

Smoking habits:
☐ You have never smoked cigarettes, cigars or a pipe
☐ You have quit smoking ___ years ago ____months ago
☐ Smoke 1 pack (20 cigarettes) per day
☐ Smoke 1.5 packs (30 cigarettes) per day
☐ Smoke 2 packs (40 cigarettes) or more per day

Activity level:
☐ Inactive: No regular physical activity with a sit down job
☐ Light activity: No organized physical activity during leisure time
☐ Moderate activity: Occasionally involved in activities such as jogging, swimming, or Cycling
☐ Heavy activity: Consistent workouts or heavy activities more than 3 times per week
☐ Vigorous activity: Extensive physical exercise for at least 60 minutes a day for 4 or more times per week

Signature: ______________________________ Date: ________________

Medical personnel: _________________________ Date: ________________