Allure
HEALTH & WELLNESS

NEW PATIENT MEDICAL HISTORY FORM
WEIGHT LOSS

Name: (First)_____ (Last) _____ (MI)____
Date of Birth: ____/____/_____ Date of Visit: ____/____/_____
Phone: (Home/Cell)_____ (Work) _____ Gender: M / F
Referred By: _____

How does your weight is affect your life and health? _____
_____
_____

Weight History
When did you become overweight?
☐ Childhood ☐ Teens ☐ Adulthood ☐ Pregnancy ☐ Menopause
Did you ever gain more than 20 pounds in less than 3 months? Y / N If so, how long ago? _____
As best you can remember, how much did you weigh one year ago? _____
Five years ago? _____ 10 years ago? _____

Triggers for your weight gain (check all that apply):
☐ Stress ☐ Marriage ☐ Divorce ☐ Illness ☐ Medication abuse ☐ Travel ☐ Injury
☐ Nightshift work ☐ Insomnia ☐ Quitting (circle all that apply): Smoking / Alcohol / Drugs

Previous weight-loss programs (check all that apply):
☐ Weight Watchers ☐ Nutrisystem ☐ Jenny Craig ☐ LA Weight Loss ☐ Atkins
☐ South Beach ☐ Zone diet ☐ Medifast ☐ Dash diet ☐ Paleo diet
☐ HCG diet ☐ Mediterranean diet ☐ Ornish diet ☐ Other: _____

What was your maximum weight loss? _____
What are your greatest challenges with dieting? _____
_____

Have you ever taken medication to lose weight? (check all that apply):
☐ Phentermine(Adipex) ☐ Meridia ☐ Xenecal/Alli ☐ Phen/Fen
☐ Phendimetrazine(Bontril) ☐ Topamax ☐ Saxenda ☐ Diethylpropion
☐ Bupropion(Wellbutrin) ☐ Belviq ☐ Qsymia ☐ Contrave
Other: _____
What worked? _____
What didn't work? _____
Why or why not? _____
_____

138 Coursevall Drive, Centreville, MD 21666
Phone: 410-505-7800 Fax: 883-449-2022
Website: Allurehealthandwellness.com

Nutritional History

How often do you eat breakfast? _____ days per week at _____:_____ a.m.
Number of times you eat per day: _____
Do you get up at night to eat? Y / N If so, how often? _____ times

*Name: (First)*_____ *(Last)*_____ *(MI)*____
Food triggers (check all that apply):
☐ Stress ☐ Boredom ☐ Anger ☐ Seeking Reward ☐ Parties ☐ Eating Out
☐ Fast Food ☐ Other: _____
Food cravings:
☐ Sugar ☐ Chocolate ☐ Starches ☐ Salty ☐ High Fat ☐ Large Portions
Favorite foods: _____

Medical History

Exercise type: _____
Duration: _____ hours _____ minutes Number of times per week: _____
What prevents you from exercising? _____

How many hours do you sleep per night? _____ Do you feel rested in the morning? _____

Past medical history (check all that apply):

☐ Heart attack	☐ Angina	☐ Gall bladder stones	☐ Sleep apnea
☐ High blood pressure	☐ Stroke	☐ Indigestion/reflux arthritis	☐ Thyroid
☐ High cholesterol	☐ Diabetes	☐ Celiac disease	☐ Anxiety
☐ High triglycerides	☐ Gout	☐ Pancreatitis	☐ Depression
☐ Infertility	☐ Polycystic Ovarian Syndrome		

☐ Cancer (type/s): _____
Have you ever be diagnosed with an eating disorder? Y / N If yes, which one? _____

Past surgical history (check all that apply):
☐ Gastric bypass ☐ Gastric banding ☐ Gastric sleeve ☐ Gall bladder ☐ Heart bypass
☐ Hysterectomy ☐ Other: _____

Medications (list all current medications and dosages):
_____ _____ _____ _____
_____ _____ _____ _____

Allergies:
(Medications)_____
(Food)_____

_____

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Social History

Smoking: ☐ Never ☐ Current smoker (_____ packs/day) ☐ Past smoker (quit _____ years ago)
Alcohol: ☐ Never ☐ Occasional ☐ Regularly (_____ drinks per day)
Prior treatment for alcoholism? Y / N
Drugs: ☐ Never ☐ Current ☐ Past ☐ Type of drugs: _____
Marijuana: ☐ Never ☐ Current user (_____ times/day)

Family History

Obesity (check all that apply): ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son
Diabetes (check all that apply): ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son
Other (check all that apply): ☐ High blood pressure ☐ Heart disease ☐ High cholesterol
Name: (First)_____ (Last) _____ (MI)____
Date of Birth: ____/____/_____

☐ High triglycerides ☐ Stroke ☐ Thyroid problems ☐ Anxiety ☐ Depression
☐ Bipolar disorder ☐ Alcoholism ☐ Cancer (type/s): _____
Other: _____

Gynecologic History

Age periods started? _____ Age periods ended _____
Periods are: Regular / Irregular Heavy / Normal / Light
Number of pregnancies: _____ Number of children: _____
Age of first pregnancy: _____ Age of last pregnancy: _____

System Review

(Check all that apply)

☐ Recent weight loss more than 10 pounds
☐ Recent weight gain more than 10 pounds

☐ Acne	☐ Skin rash	☐ Cough
☐ Snoring	☐ Shortness of breath	☐ Chest pain
☐ Difficulty breathing when flat	☐ Fainting/Blacking out	☐ Palpitations
☐ Swelling ankles/extremities	☐ Abdominal pain	☐ Bloating
☐ Constipation	☐ Diarrhea	☐ Food intolerance
☐ Dysphagia/difficulty swallowing	☐ Indigestion	☐ Nausea/vomiting
☐ Increased appetite	☐ Decreased appetite	☐ Heartburn
☐ Gas and bloating	☐ Urinary frequency/urgency	☐ Slow urine flow
☐ Nighttime urination	☐ Blood in stools	☐ Back pain (upper)
☐ Back pain (lower)	☐ Joint pain	☐ Muscle aches/pain
☐ Dizziness	☐ Headaches	☐ Seizures
☐ Weakness/low energy	☐ Anxiety	☐ Depression
☐ Insomnia	☐ Memory loss	☐ Inability to concentrate
☐ Mood changes	☐ Nervousness	☐ Loss of interest

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☐ Cold intolerance
☐ Heat intolerance
☐ Excessive sweating
☐ Blood clots
☐ Hair changes
☐ Fatigue/tiredness

(Women only)
☐ Absence of periods
☐ Abnormal/excessive menstruation
☐ Hot flashes
☐ Facial hair
☐ Change in bladder habits

Comments:

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HIPAA NOTICE OF PRIVACY PRACTICES

PATIENT AUTHORIZATION FOR SPECIFIC DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

I, the undersigned, hereby authorize _____ ("Provider") to disclose certain information (described below) about me to **Allure Health and Wellness** for purposes of assisting Provider (or one of Provider's employees and agents) in the Weight Loss process and/or for general training and educational purposes.

I acknowledge and agree that my information may be used in **Allure Health and Wellness** training or website instruction or in connection with certification and renewal of certification examinations.

Provider is hereby authorized to disclose the following protected health information: my name, birth date, dates of services, treatment records that include treatment technique in your medical history, any unaltered x-rays used for diagnosis.

I understand that signing this Authorization is voluntary and that my treatment, payment, or eligibility for benefits will not be conditioned upon execution of this Authorization.

This Authorization shall expire one (1) year from the date of my signature, unless I revoke this Authorization sooner.

I understand that I may revoke this Authorization at any time by delivering a revocation in writing to the Provider. I understand that, if I revoke this Authorization, it will have no effect on actions already taken by Provider or **Allure Health and Wellness** in reliance on this Authorization.

I have read and understand the terms of this Authorization, and I agree to those terms.

_____ _____

Signature of Patient or Guardian, if applicable Date

_____ _____

Name of Guardian, if applicable Relationship of Guardian to Patient, if applicable

A signed copy of this Authorization must be provided to the patient and attached to the patient's medical record. A copy of this Authorization is as effective as the original.

Semaglutide Consent Form

Semaglutide is a human-based glucagon-like peptide-1 receptor agonist prescribed as an adjunct to a reduced calorie diet and increased physical activity for chronic weight management in adults with an initial body mass index (BMI) that is considered outside a healthy range. Obesity is classified as a systemic inflammatory condition (metainflammation) and long-term weight loss is difficult due to underlying systemic inflammation. Semaglutide can address the underlying inflammation with the hope for more sustained weight loss and better systemic health.

While using Semaglutide it is highly recommended that you:

- Eat a fibrous diet. Focus on fruits and vegetables that are high in fiber.
- Eat small high protein meals as digestion is slowed down while on this medication.
- Avoid foods high in fat as they take longer to digest.
- Limit alcohol intake as this medication can lower blood sugar.
- Drink at least 32 oz of water per day to avoid constipation.

Do not take this medication if:

- You have a personal or family history of medullary thyroid carcinoma (Thyroid Cancer)
- Multiple Endocrine Neoplasia Syndrome type 2
- You are pregnant or plan to become pregnant while taking this medication.
- You are diabetic and/or taking any medications related to lowering your blood sugar levels without speaking with your endocrinologist.
- Specifically, if you are prescribed insulin - because the combination may increase your risk of hypoglycemia (low blood sugar).
- You have a history of Pancreatitis.
- You are allergic to Semaglutide, BPC-157, or any other GLP-1 Agonist such as Ozempic, Wegovy, Adlyxin, Byetta, Bydurteon, Rybelsus, Trulicity, Victoza.
- If you have other allergies. This product may contain inactive ingredients, which can cause allergic reactions, which can cause allergic reactions or other problems. Talk to your pharmacist for more details. Before using this medication, tell your doctor your medical history.

Possible drug interactions: Anti-diabetic agents, specifically: Insulin and Sulfonylureas (i.e., glyburide, glipizide, glimepiride, tolbutamide) due to the increased risk of hypoglycemia (low blood sugar). Do not take with other agonist medicines such as: Ozempic, Wegovy, Adlyxin, Byetta, Bydurteon, Rybelsus, Trulicity, Victoza (THIS MAY NOT BE AN ALL-INCLUSIVE LIST). Other medications used in diabetes, please tell your provider about any medications that may lower your blood sugar.

Possible side effects: Nausea, diarrhea, vomiting, constipation, abdominal pain, headache, fatigue, dyspepsia, dizziness, abdominal distention, belching, hypoglycemia, flatulence, gastroenteritis, and gastroesophageal reflux disease (GERD). Subcutaneous injections: common injection site reactions characterized by itching, burning at site of administration with or without thickening of thin skin (welting). If you notice other side effects not listed above, contact your doctor or pharmacist.

A very serious allergic reaction to this medication is very rare, however, get medical help right away if you notice any symptoms of a serious allergic reaction, including rash, itching/swelling (especially of the face/tongue/throat), severe dizziness, trouble breathing. Report adverse side effects to your doctor or pharmacist. In the event of any emergency, call 911 immediately.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THIS TREATMENT, OR ANY QUESTIONS CONCERNING THIS PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK THE STAFF NOW BEFORE SIGNING THIS CONSENT FORM.

By signing, I certify that I have read and understand the contents of this form. I am aware of the possible side effects and drug interactions and give my consent for treatment. I have informed the medical staff of any known allergies to drugs or other substances, and any past adverse reactions I've experienced. I have informed the medical staff of all medication and supplements I am currently taking; I understand there are other ways and programs that can assist me in my desire to decrease my body weight, and acknowledge that no guarantees have been made to me concerning my results.

1. I understand the information provided on this form and agree with all statements made above.
2. Pharmaceutical assisted weight loss therapy has been adequately explained to me by my nurse and/or physician.
3. I have received all the information and explanation I desire concerning the procedure.
4. I authorize and consent to the performance of Pharmaceutical assisted weight loss therapy.
5. I release Nurse Practitioner, Heather Yannitto, Allure Health Clinic and all the medical staff from all liabilities for any complications or damages associated with my Pharmaceutical assisted weight loss therapy

Patient Signature _____ Date of Birth _____

Patient Signature _____ Date of Birth _____