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Clinic Name

Address

Clinic Logo

PATIENT CHECK-IN & MEDICAL HISTORY

Medical Record Number (MRN): _____

Patient Information

Full Name: _____

Date of Birth: mm/dd/yyyy **Medical Record #:** _____

Date of Visit: 12/07/2025

Phone Number: _____

Email Address: _____

Residential Address:

_____

Emergency Contact

Name: _____ **Phone:** _____

Relationship: _____

Primary Care Provider / Referring Clinician

_____

Insurance Details

Plan Name: _____

Subscriber / Member ID: _____

Pharmacy Information

Name / City / Phone:

_____

Allergy Information

(Include medications, foods, latex, or environmental allergies)

Current Medications

(Include prescription, OTC, supplements, with dose/route/frequency if known)

Relevant Medical History

(Please check all that apply)

- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ History of Pancreatitis
- ☐ Gallbladder Disease or Gallstones
- ☐ Thyroid Cancer ☐ Self ☐ Family
- ☐ Multiple Endocrine Neoplasia Type 2 ☐ Self ☐ Family
- ☐ Kidney Disease or Renal Impairment
- ☐ Liver Disease or Hepatic Impairment
- ☐ Active or Recent Cancer Diagnosis
- ☐ Currently Pregnant
- ☐ Breastfeeding
- ☐ History of Eating Disorder
- ☐ History of Bariatric Surgery
- ☐ Competitive Athlete Subject to Anti-Doping Rules (WADA/USADA)

Vitals (to be completed by staff)

Height: in/cm _____ **Weight:** lbs/kg _____ **BMI:** _____

Blood Pressure: _____ / _____ **Heart Rate:** bpm _____ **SpO_2:** % _____

Primary Goals / Reason for Visit

Please describe your goals for therapy, symptoms, or health outcomes you'd like to address:

Baseline Screening / Labs Ordered

(Check all that apply – initial or as indicated)

- [ ] CBC
- [ ] CMP
- [ ] HbA1c
- [ ] TSH
- [ ] IGF-1
- [ ] Lipid Panel
- [ ] Pregnancy Test (if applicable)

Other: _____

Clinician Notes / Contraindications Review

(To be completed by provider)

Acknowledgment & Signatures

> I affirm that the information provided above is accurate to the best of my knowledge and understand that it is used to guide clinical care decisions. I agree to update the clinic should my medical history or medication list change.

Patient/Guardian Signature: _____ **Date:** mm/dd/yyyy

Clinician Signature: _____ **Date:** mm/dd/yyyy