

Patient Registration DOB: __/__/ Name: Social Security Number: Current Address: Phone: Alt. Phone: Email: Current Medications: Allergies: Please list the family members or persons we may speak to regarding your general medical condition and your diagnosis (including treatment, payment and health care options). Please list the family members or persons we may inform about your medical condition ONLY IN AN EMERGENCY. _____ Phone # ____ Please list the address where you would like any correspondence from our office to be sent if other than your home. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL". □ Yes □No Please list the telephone number where you want to receive calls about your appointments, labs, results or health care information if other than your home phone number. May we leave a message on your answering machine regarding your results, appointments or other health care information? □ Yes □No Plea be aware a cell phone is not a secure and/or private line. PLEASE READ BE AWARE OF THE FOLLOWING STATEMENT BEFORE SIGNING. I understand that under Florida State Law ALL prescription products are non-refundable. This includes, but is not limited to: Weightloss Injections, Obagi Products, Products containing Hydroquinone, Retin A or Metronidazole & Latisse.

Date:

Patient Signature:

New patient history This form is to be completed by the patient.

Last name:		First name:			MI:
Age:	Date of birth:/_		Last menstrual pe	eriod:	
Pharmacy:	Address:			P	none:
	an:				
					'hone:
Address:		and the second of the second			
Medications (List all 1	medications you are taking	including herb	os and vitamins.):		
			200		
	y family members have an	, of the following	ing please chec	k the box and indice	ate the following:
Palative: Mother/Eather	y family members have an Brother/Sister, Aunt/Uncle, Grand <i>N</i>	Mother/Father, So	in/Daughter) Side of f	amily: (Maternal vs. Pate	ernal) Age of diagnosis
Retailer. Monter Famon	Relative Side of fam			Relative	Side of family Age
Breast cancer			Diabetes		
Pancreatic cancer			į		
Uterine/endometrial co	ancer				
Ovarian cancer					
Colon cancer					
Stomach cancer					
Melanoma			Other cancers		
THE MEDICAL PROPERTY OF THE PROPERTY OF THE	PROPERTY OF STREET STREET, STREET STREET, STRE		in the second		
Past medical history	y: Check the items that appl				C 11D/
☐ Anxiety	Uterine/endometrial car		idache/migraine	☐ diabetes	☐ HPV vaccine
□ Depression	☐ Polycystic ovarian syndr		vical cancer	☐ Thyroid disease	☐ HPV ☐ HIV
☐ Melanoma	Stomach cancer	☐ Fibr		☐ Liver disease☐ Kidney infection	☐ Chlamydia
☐ Breast cancer	Pancreatic cancer	•	n blood pressure	☐ Kidney stones	☐ Herpes
Ovarian cancer	☐ Convulsions/epilepsy	☐ Stro	ke Irt murmur	☐ Blood clot	☐ Gonorrhea
☐ Colorectal cancer	☐ Asthma		normal pap date(s)		☐ Syphilis
☐ Bleeding disorder	☐ 10 or more colon polyps		atment for pap		e dyprime
Other cancers or dic	ranosis?			f Ashkenazi Jewish d	escent? 🗌 Yes 🔲 N
Officer curricers of dic	191100101	THE REPORT OF THE PARTY	NOTE THE PARTY OF THE PARTY.	Acres Marketing on the Arthresis Con-	
Past surgical history	y: List all surgeries that you h	nave had and	the year they we	re done.	
No. 1 Listanova					
Menstrual history:	Interval between	pariada:	days Aver	age days of menstr	rual flow:
Age at onset:			'	-	
Pain with menstrual	l periods 🗌 Mild 🗍 Seve	ere Emo	ononai changes y	vith menstrual perio	us. [] 141110 [] 0640
Sexual history:			Optional (*Requi	red for Medicare)	
Are you sexually activ	ve? ☐ Yes	□No	* Did the onset of yo	our sexual activity occur	- · ·
Are you having any		□ No	under 16 yrs. of ag		☐ Yes ☐ No ☐ Yes ☐ No
If Yes, do you want to		□No		or more sexual partners?	
, 55, 65 , 56 , 76		Laboratoria (" Have you had a P	ap smear within the past	/ yeurs:



WEIGHT LOSS PROGRAM CONSENT FORM

I,, authorize Elevate Health, More reduction efforts. I understand that my program may consist of a behavior modification techniques, and the medications for weight loss.	palanced-deficit diet, a regular exercise
I understand that much of the success of the program will depend guarantees that the program will be successful. I also understand that we require changes in eating habits and permanent changes in behavior to	veight loss is a lifelong journey and will
As part of the weight loss program medical monitoring is mandatory program, I willingly agree to have monthly or weekly weigh-ins, bloneeded.	. Consequently, upon acceptance to the ood-pressure checks and bloodwork, as
I recognize that if I should become pregnant my participation in the pro-	ogram must be terminated.
I understand that any medical treatment may involve risks as well as that there are certain health risks associated with having excess weight usually temporary, reversible, and may include but are not limited to be air or gas in the stomach or intestines, gaseous stomach pain, heartburdiscomfort, fullness, stomach pain, diarrhea, constipation or yellow eyellow eyellow.	t or obesity. Risks of this program are belching, bloated or full feeling, excess n, passing gas, recurrent fever, stomach
Risks associated with remaining overweight are high blood pressure, of arthritis of the joints, including hips, knees, feet and back, sleep appetities risks may be modest if I am not significantly overweight but with over time.	ea, and sudden death. I understand that
I have read and fully understand this consent form and it has been ful been answered to my complete satisfaction.	ly explained to me. My questions have
Patient Signature:	Date:
Witness Signature:	



Semaglutide Track Sheet

DOB: _____

Name:

Date	Week	Weight	Dose	Lot # / Exp.	Inj. Site	Injector
	1		0.1ml (0.27mg)			
	2		0.1ml (0.27mg)			
	3		0.1ml (0.27mg)			
	4		0.1ml (0.27mg)			
	5		0.2ml (0.54mg)			
	6		0.2ml (0.54mg)			
	7		0.2ml (0.54mg)			*
	8		0.2ml (0.54mg)			
	9		0.4ml (1.08mg)			
	10		0.4ml (1.08mg)			
	11		0.4ml (1.08mg)			
	12		0.4ml (1.08mg)			
	13		0.8ml (2.16mg)			
	14		0.8ml (2.16mg)			
	15		0.8ml (2.16mg)			
	16		0.8ml (2.16mg)			
	17		1ml (2.65mg)			

Notes:		

1ml (2.65mg)

1ml (2.65mg)

1ml (2.65mg)

1ml (2.65mg)

1ml (2.65mg)

1ml (2.65mg)

18

19

20

21

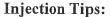
22

23

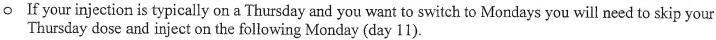


How-to Self inject our compounded Semaglutide w/ L-Carnatine

- 1. Pull your dose out of the freezer to thaw for 3-5 minutes. Frozen shots will look slightly cloudy, when it has thawed it should be clear.
- 2. Wash your hands while the injection thaws.
- 3. Carefully remove any air out of the syringe.
- 4. Choose your injection site (alternating every week.)
- 5. Cleansed with 70% alcohol.
- 6. Pinch the skin and inject the medication at once, then hold for the count to three and remove needle.
- 7. Massage in the medication to make it disperse into your skin.
- 8. Apply a Band-Aid if needed, typically there is no bleeding with this type of injection.



- Our Semaglutide injections <u>MUST</u> be stored in the freezer, <u>NOT</u> the fridge. If traveling with your injection please plan accordingly.
- Semaglutide injections should be given every 7+ days, never sooner than 7 days.



o If you miss a dose you can either inject when you remember and make that your new injection day or wait until you are due for your next dose.

o Injection Sites: The best location for Semaglutide is in the abdomen around the belly button.

