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HEALTH | GYN | MED SPA

305 S. Childs Street; Leesburg, Fl 34748

Patient Registration

Name: ______________________________ DOB: ___/___/_____

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.

Name: ______________________________ 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.

X Patient Signature: ______________________________ Date: ________________

New patient history

This form is to be completed by the patient.

Last name: ______________________ First name: ______________________ MI: ________

Age: __________ Date of birth: ______/______/______ Last menstrual period: ______________________

Pharmacy: ______________ Address: ______________________________ Phone: ______________

Primary care physician: ____

Address: ____ Phone: ______________

Allergies: ____

Medications (List all medications you are taking including herbs and vitamins.): ______________________

____

Family history: If any family members have any of the following – please check the box and indicate the following:
Relative: Mother/Father, Brother/Sister, Aunt/Uncle, Grand Mother/Father, Son/Daughter) **Side of family:** (Maternal vs. Paternal) **Age of diagnosis**

	Relative	Side of family	Age
Breast cancer			
Pancreatic cancer			
Uterine/endometrial cancer			
Ovarian cancer			
Colon cancer			
Stomach cancer			
Melanoma			

	Relative	Side of family	Age
Diabetes			
Heart disease			
High cholesterol			
High blood pressure			
Osteoporosis			
Bleeding disorder			
Other cancers			

Past medical history: Check the items that apply to you now or in the past.

- ☐ Anxiety
- ☐ Depression
- ☐ Melanoma
- ☐ Breast cancer
- ☐ Ovarian cancer
- ☐ Colorectal cancer
- ☐ Bleeding disorder
- ☐ Uterine/endometrial cancer
- ☐ Polycystic ovarian syndrome
- ☐ Stomach cancer
- ☐ Pancreatic cancer
- ☐ Convulsions/epilepsy
- ☐ Asthma
- ☐ 10 or more colon polyps
- ☐ Headache/migraine
- ☐ Cervical cancer
- ☐ Fibroids
- ☐ High blood pressure
- ☐ Stroke
- ☐ Heart murmur
- ☐ Abnormal pap date(s)

  Treatment for pap ______________
- ☐ diabetes
- ☐ Thyroid disease
- ☐ Liver disease
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Blood clot
- ☐ HPV vaccine
- ☐ HPV
- ☐ HIV
- ☐ Chlamydia
- ☐ Herpes
- ☐ Gonorrhea
- ☐ Syphilis

Other cancers or diagnosis? ______________________ Are you of Ashkenazi Jewish descent? ☐ Yes ☐ N

Past surgical history: List all surgeries that you have had and the year they were done.

____

____

Menstrual history::

Age at onset: __________ Interval between periods: ________ days Average days of menstrual flow: __________

Pain with menstrual periods ☐ Mild ☐ Severe Emotional changes with menstrual periods: ☐ Mild ☐ Sever

Sexual history:

Are you sexually active?	☐ Yes	☐ No
Are you having any sexual problems?	☐ Yes	☐ No
If Yes, do you want to discuss today?	☐ Yes	☐ No

Optional (*Required for Medicare)

* Did the onset of your sexual activity occur under 16 yrs. of age?	☐ Yes	☐ No
* Have you had five or more sexual partners?	☐ Yes	☐ No
* Have you had a Pap smear within the past 7 years?	☐ Yes	☐ No

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WEIGHT LOSS PROGRAM CONSENT FORM

I, ______________________________, authorize Elevate Health, Medspa & Gyn to help me in my weight-reduction efforts. I understand that my program may consist of a balanced-deficit diet, a regular exercise program, instruction on behavior modification techniques, and the use of FDA approved injectable medications for weight loss.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees that the program will be successful. I also understand that weight loss is a lifelong journey and will require changes in eating habits and permanent changes in behavior to be treated successfully.

As part of the weight loss program medical monitoring is mandatory. Consequently, upon acceptance to the program, I willingly agree to have monthly or weekly weigh-ins, blood-pressure checks and bloodwork, as needed.

I recognize that if I should become pregnant my participation in the program must be terminated.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with having excess weight or obesity. Risks of this program are usually temporary, reversible, and may include but are not limited to belching, bloated or full feeling, excess air or gas in the stomach or intestines, gaseous stomach pain, heartburn, passing gas, recurrent fever, stomach discomfort, fullness, stomach pain, diarrhea, constipation or yellow eyes or skin.

Risks associated with remaining overweight are high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints, including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight but will increase with additional weight gain over time.

I have read and fully understand this consent form and it has been fully explained to me. My questions have been answered to my complete satisfaction.

Patient Signature: ____________________________________ Date: ____________________

Witness Signature: ____________________________________

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Semaglutide Track Sheet

Name: ______________________ DOB: ______________

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)			
	18		1ml (2.65mg)			
	19		1ml (2.65mg)			
	20		1ml (2.65mg)			
	21		1ml (2.65mg)			
	22		1ml (2.65mg)			
	23		1ml (2.65mg)			

Notes: ____

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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.

Injection Tips:

- Our Semaglutide injections **MUST** be stored in the freezer, **NOT** the fridge. If traveling with your injection please plan accordingly.
- Semaglutide injections should be given every 7+ days, never sooner than 7 days.
- If your injection is typically on a Thursday and you want to switch to Mondays you will need to skip your Thursday dose and inject on the following Monday (day 11).
- 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.
- Injection Sites: The best location for Semaglutide is in the abdomen around the belly button.