NEW PATIENT WEIGHT LOSS INTAKE FORM

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BASIC PATIENT INFORMATION

Name: Date:

Street Address:

Phone: Home Phone:

Email: Birth Date:

Sex: ☐ M ☐ F Birth Gender: ☐ M ☐ F Height: Weight:

Race (ie. White, Asian, African American): Hispanic or Latino: ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Occupation: How did you hear about us?

Primary Care Physician: Phone:

Emergency Contact: Phone: Relationship:

HEALTH AND WELLNESS HISTORY

Has your doctor advised you to lose weight?

Do you have any dietary restrictions? ☐ Yes ☐ No Please explain:

How often do you exercise? What type of exercise?

Do you feel stressed? ☐ Yes ☐ No Please explain:

Check ALL that apply to you: ☐ Pregnant ☐ Might Be Pregnant ☐ Breast Feeding
☐ Currently Undergoing Chemotherapy

Please answer the following questions honestly so we can do our best to help you reach your goals.

What changed that caused the weight gain (if anything)? _____

What's the main reason you are seeking treatment at this time? _____

What are your goals about weight control and management? _____

What do you consider to be your ideal weight? _____

When was the last time you were at your ideal weight? _____

How much weight do you want to lose? _____

How many times a year do you diet? _____

What is the hardest part about managing your weight? _____

What have you tried in the past that has failed? _____

Please check all previous programs that you have tried in order to lose weight. Indicate dates and length of and
any current medications:

Program	Date	Medication	Dose/Freq.
Weight Watchers			
Liquid Diets			
Keto Diet			
Diet Pills (Phen-Fen)			
Nutrisystem/Jenny Craig			
Surgery			

Have you maintained weight loss for up to a year with any of these programs?_____
What did NOT work for you about these programs?_____
What has been your lowest _____ and highest _____ weight as an adult?
What's more important inches lost or pounds? _____
What's more important, fast or permanent? _____
How fast do you want to be slim, trim and fit? _____
What would stop you from a weight loss program? _____

Do you binge eat?	☐ Yes ☐ No
Do you suffer from uncontrollable cravings?	☐ Yes ☐ No
Do you feel that food controls you?	☐ Yes ☐ No
Do you eat because of your emotions?	☐ Yes ☐ No
Do you eat between meals?	☐ Yes ☐ No
What do you choose to eat between meals?	
Do you feel that your eating behaviors are normal?	☐ Yes ☐ No
Briefly describe your daily eating behaviors:	
Does your family support your weight loss efforts?	☐ Yes ☐ No
Can you remember being at your ideal weight? What do you remember most about it? _____	☐ Yes ☐ No
Commitment to weight loss: (please rate): (low) 1 2 3 4 5 6 7 8 9 10 (high)	

List **ALL** medications & supplements you take (prescription & over the counter)

Drug Name:	Dosage:	How long have you taken & for what conditions?

Please list all known **DRUG and FOOD** allergies:

Drug Name Food:	Reaction:

Check **ALL medical conditions** that you may have had or currently have now:

- ☐ ADD/ADHD
- ☐ Alcoholism
- ☐ Allergy
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Appendicitis
- ☐ Asthma
- ☐ Arthritis
- ☐ Cancer
- ☐ Celiac Disease
- ☐ Chronic Fatigue
- ☐ Migraine
- ☐ Depression
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy/seizures
- ☐ Fibromyalgia
- ☐ Gall Bladder
- ☐ Goiter
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Vertigo/Dizziness
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ High Blood Sugar
- ☐ HIVIAIDS
- ☐ Irritable Bowel
- ☐ Kidney Infect./stones
- ☐ Low Blood Pressure
- ☐ Low Blood Sugar
- ☐ Lyme Disease
- ☐ Lupus
- ☐ Miscarriage
- ☐ Multiple Sclerosis
- ☐ Parkinson's
- ☐ Pneumonia
- ☐ Raynaud's
- ☐ Rheumatoid Arthritis
- ☐ Ringing in ears
- ☐ Sinus Infection
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Ulcers

Other: _____

Please list all previous surgeries & dates:

_____

_____

Alcohol use? ___Yes / ___ No Amount _____ Daily / Weekly / Socially

Tobacco use? ___ Yes / ___ Never / Former Smoker PPD _____ How many years? _____

SEMAGLUTIDE/TIRZEPATIDE CONSENT FORM

This document is intended to serve as a confirmation of informed consent for compounded Ssemaglutide & Tirzepatide which is a prescription weight management medications.

A. Patient Informed Consent

1. I voluntarily request that Medical Stop, L.L.C provider treats my medical condition.
2. I have informed my provider of any known allergies, my medical conditions, medications, social/family history.
3. I have the right to be informed of any alternative options, side effects, and the risks and benefits.
4. I understand the mechanism of action of the medication.
5. I understand how it is to be administered.
6. I understand the prescription will come from a compounding pharmacy, which is not FDA approved. I have been told that the manufacturing facility itself is FDA monitored along with third party testing on the medication itself.
7. Prices may vary and change. My charge will include my time with Medical Stop, L.LC (in person and via communication outside of the office), supplies, and medication.
8. Medical Stop, L.L.C may change the pharmacy based on several factors (availability, shipping time, cost).
9. It has been explained to me that this medication could be harmful if taken inappropriately or without advice from the provider.
10. I understand this medication may cause adverse side effects (see below). I understand this list is not complete and it describes the most common side effects, and that death is also a possibility of taking this medication. I understand symptoms may be worse after there has been a change in my medication dose or when first starting the medication.

Common side effects include, but are not limited to:

- Gastrointestinal: Nausea/vomiting, abdominal pain, Diarrhea/constipation, dyspepsia, abdominal distension, eructation, flatulence, gastroenteritis, GERD, gastritis, lipase increase, amylase increase.
- Neurological: Headache, dizziness
- Cardiac: Heart rate increase, Hypotension
- Endocrine: Fatigue, hypoglycemia (diabetic patients), alopecia
- Ophthalmic: Retinal disorder (diabetic patients)
- Skin: redness or pain at injection site

Serious Reactions include, but are not limited to:

- Thyroid C-cell tumor (animal studies)
- Medullary thyroid cancer
- Hypersensitivity reaction
- Anaphylaxis
- Angioedema
- Acute kidney injury
- Chronic renal failure exacerbation
- Pancreatitis
- Cholelithiasis
- Cholecystitis
- Syncope

B. **I understand that I have the following responsibilities.**

I agree to obtain medications for compounded Semaglutide or Tirzepatide only from Medical Stop, L.L.C. Medical Stop, L.L.C. Medical Stop does NOT accept nor file for any medical insurance or medical insurance claims reimbursement for coverage.

2. Medical history: I will tell Medical Stop, L.L.C my complete medical history, including: allergies, medications, medical surgical / social/family history.

a. Medical Stop, L.L.C may ask to review, with your permission, your medical history (medications, recent lab results, pertinent imaging results).
b. I understand that if I become pregnant or start trying for pregnancy, I must stop this medication.
c. I will be honest to the best of my ability the history she needs to know.
d. I will tell my provider any updated health information (medication, allergies personal, medical issues/surgeries/social history, or family history changes).
e. My provider can discuss my treatment plan with any co-treating pharmacist and/or healthcare provider.
f. I will always tell other providers about all medications I am taking.
g. Medical Stop, L.L.C may ask for me to seek additional labs while on treatment to ensure its safety. LAB FEES ARE PATIENT RESPONSIBILITY.LAB FEES ARE NOT COVERED BY MEDICAL STOP, L.L.C NOR INCLUDED IN MEDICAL STOP FEES.

3. Directions for use: I will take my medications only as prescribed according to the directions, led by Medical Stop, L.L.C.

a. If I feel my medications are not effective (after 30 days), or are causing undesirable side effects (immediately), I will contact Medical Stop, L.L.C for instructions.
b. I will not adjust my medications without prior instruction to do so.
c. I understand that the medication must be kept refrigerated.
d. I understand this medication must be self-injected in the subcutaneous tissue once weekly. I will NOT inject any less than 7 days unless directed by Medical Stop, L.L.C (example: travel).
e. I will not share needles and will dispose of needles safely.
f. If I'm having troubles with the administration of the medication, I will seek help from Medical Stop, L.L.C.
g. The medication expires after 12 weeks. I will refer to the Beyond Usage Date (BUD).

4. Refills:

a. All refills will require an appointment.
b. I understand, I may need to schedule refill appointments ahead of time to avoid delays in refills.
c. Refills will get ordered Monday.
d. I will not ask for early refills.
e. I understand that I may be asked to bring the medication with me to my appointments to check the quantity left or assess how I am injecting.
f. **MEDICAL STOP RECOMENDS 6 MONTH PROGRAM FOR EFFECTIVE WEIGHT LOSS RESULTS**

5. Safety:

a. I understand it is important to keep my medication away from children (<18 years old)
b. I am the only one who will use my medication. I will not give or sell my medication to anyone else.

6. If Medical Stop, L.L.C deems it appropriate to start weaning my medication or transition to maintenance dosing, I will comply.

C. Discontinuation of medication: I understand that Medical Stop, L.L.C may stop prescribing my medications if:

a. I am having unfavorable side effects or it's not working to treat my medical condition.
b. I have been untruthful in my medical or family history.
c. I do not follow through with the recommended plan of care set by Medical Stop, L.L.C.
d. I do not follow any parts of "Part B: responsibilities" in this agreement.

I have read this form in its entirety. It has been explained to me. I have had the opportunity to ask questions and have all my questions answered. I fully understand the above information and have no further questions. By signing this form, I voluntarily give my consent for treatment and agree to the risks.

Signature

Date

AUTHORIZATION /VIRTUAL PHONE APPOINTMENTS & NOTICE OF PRIVACY PRACTICES

I understand that my private healthcare information is protected under HIPPAA Privacy Regulations.

*May we leave a message for you on your answering device? Yes_____ No_____

- I authorize to receive calls from Medical Stop, L.L.C for Virtual / Phone medical appointments. During this appointment. with Medical Stop, LLC, personal medical information will be discussed.

I fully understand that my signature is consent and authorization to be examined by Medical Stop, L.L.C.

I understand that my entire patient history will remain completely confidential and will not be released without express written consent from me.

Patient Signature _____ Date _____