HEALY
Plastic Surgery
YOUR PARTNER IN THE PURSUIT OF PERFECTION

Semaglutide Injection

CONSULTATION FORM

PATIENT INFORMATION:

Name: _____ Date: _____

Date of birth: _____ Age: _____ ☐ Female ☐ Male ☐ Non-Binary

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Emergency Contact: _____ Phone Number: _____

How did you hear about us? _____

Employer: _____ Occupation: _____

MEDICAL HISTORY

Please mark any of the following conditions you may currently have.

- ☐ Adrenal disorder
- ☐ Diabetes/retinopathy
- ☐ Kidney disorder/disease
- ☐ Angioedema
- ☐ Eating disorder history
- ☐ Liver disorder
- ☐ Anemia/blood disorder
- ☐ Epilepsy/seizures
- ☐ Mental health problems
- ☐ Depression/suicidal ideation
- ☐ Asthma
- ☐ Gastric/duodenum ulcer
- ☐ Neurological disorder
- ☐ Autoimmune condition
- ☐ Heart disease
- ☐ Pancreatitis
- ☐ Blood clotting disorder
- ☐ High blood pressure
- ☐ Parathyroid disorder
- ☐ Infective endocarditis
- ☐ Cancer/history of cancer
- ☐ High blood cholesterol
- ☐ Phlebitis
- ☐ Cholelithiasis
- ☐ HIV/AIDS or Hepatitis
- ☐ Renal failure
- ☐ Deep vein thrombosis
- ☐ IBD/IBS
- ☐ Substance abuse
- ☐ Thyroid disease

Currently, do you have any medical condition? ☐ No ☐ Yes _____

List any medications/ supplements you take regularly: _____

_____

_____

Have you or a family member been diagnosed with either of the following?

☐ Multiple Endocrine Neoplasia Syndrome Type 2 (MEN2) ☐ Medullary Thyroid Carcinoma

SEMAGLUTIDE INJECTION CONSULTATION FORM

Are you allergic to any of the following?

☐ GLP-1 Receptor Agonists ☐ Vitamin B ☐ Adhesives/latex ☐ Benzyl Alcohol ☐ L-Carnitine

Any other known allergies? _____

Are you currently taking any blood thinning drugs? (i.e., Aspirin and Warfarin) ☐ No ☐ Yes

If yes, please explain: _____

Have you had surgery in the past year? ☐ No ☐ Yes _____

Have you had any prior surgeries? ☐ No ☐ Yes _____

HEALTH HABITS

Do you smoke? ☐ No ☐ Yes; please specify how many per day or week _____

_____

Do you drink alcohol on a regular basis? ☐ No ☐ Yes; please specify _____

How is your activity level? ☐ Sedentary ☐ Lightly active ☐ Moderately active ☐ Very active

What methods or interventions have you used to lose weight previously?

☐ Diet ☐ Exercise ☐ Prescription medication ☐ Fasting ☐ Herbal supplements

What are your main motivations and concerns for wanting to lose weight with Semaglutide?

_____

_____

What are your areas of concern?

☐ Alcohol ☐ Low energy ☐ Sedentary lifestyle ☐ Perimenopause

☐ Excess calories ☐ Medical condition ☐ Sleep disruptions ☐ Hormonal changes

☐ Family history ☐ Pregnancy ☐ Stress/busy lifestyle ☐ Other _____

FEMALE MEDICAL HISTORY - ONLY FEMALES

Are you pregnant or trying to become pregnant? ☐ No ☐ Yes

Are you taking any contraceptives?: _____

I certify that all the information I have provided on this form is accurate and complete to the best of my knowledge. I am aware that withholding information or providing false details may lead to adverse reactions or complications.

_____ _____ _____

Patient Name (Printed) Patient (signature) Date