HEADSUP Medical Clinic

PATIENT INTAKE FORM

NAME_____ DATE_____

(Last) (First) (Middle Initial)

ADDRESS_____

(Street) (City) (State) (Zip)

CELL NUMBER_____ HOME NUMBER_____

AGE_____ DATE OF BIRTH_____ EMAIL_____

EMPLOYER_____ OCCUPATION_____

EMERGENCY CONTACT_____ NUMBER_____

HOW DID YOU HEAR ABOUT US? TV RADIO PRINT BILLBOARDS FACEBOOK INSTAGRAM GOOGLE OTHER

STATION/PROGRAM _____

Medical History

PRIMARY PHYSICIAN:_____ LAST PHYSICAL_____

Do you smoke? ( ) Yes ( ) No ( ) Quit How much?_____ How often?_____

Do you drink alcohol? ( ) Yes ( ) No ( ) Quit How much?_____ How often?_____

Any known drug allergies: ( ) Yes ( ) No If yes please explain:_____

_____

Current Medications/Supplements/Vitamins:

_____

_____

_____

_____

Current Hormone Replacement Therapy:_____ Past HRT: _____

Surgeries, list all and Year:_____

_____

_____

WEIGHT LOSS H & P

Name_____ DOB_____

Current Medications_____

Medication Allergies_____

Previous Weight Loss Meds Used_____

Weight Gain Last 2 Years_____

Activity Level Active Moderate Sedentary

PATIENT MEDICAL HISTORY

YES	NO	PCOS	YES	NO	THYROID CANCER
YES	NO	DIABETES	YES	NO	MULTIPLE ENDOCRINE NEOPLASIA
YES	NO	HTN	YES	NO	PANCREATITIS
YES	NO	HYPERCHOL	YES	NO	ALCOHOLISM
YES	NO	GASTRIC BAND	YES	NO	CURRENT/PLANNED PREGNANCY
YES	NO	GASTRIC BYPASS			
YES	NO	OTHER SURGERY			

Height_____

Weight_____

B/P_____

Pulse_____

BMI_____

PATIENT FAMILY HISTORY

YES	NO	OBESITY	YES	NO	HEART DISEASE
YES	NO	DIABETES	YES	NO	PCOS

The patient appears to be in good health and is a good candidate for semaglutide therapy for weight loss. We discussed the following with the patient:The results of clinical studies, the risks and benefits of the treatment, the possible side effects of treatment, the durability of results and patient expectations. The patient was given the opportunity to ask questions and all questions were answered. The patient wishes to proceed with semaglutide treatment.

Treatment Approved YES NO
2.5mg/ml Concentration Morning Weekly Injections

20 units per week for first 2 weeks
30 units per week for next 2 weeks
40 units per week for next four weeks
50 units if needed per week thereafter

Zofran or Dramamine or Emetrol for nausea
Tums for indegestion
Start dailymultivitamins

Physician Signature_____ Date:____/_____/____

NAME_____

(Last) (First) (Middle Initial)

MEDICAL HISTORY - MALE

ENLARGED PROSTATE	YES	NO	MAJOR DEPRESSION	YES	NO
PROSTATE CANCER	YES	NO	LIVER DISEASE	YES	NO
PROSTATE SURGERY	YES	NO	GI SURGERY	YES	NO
URO-GENITAL PROBLEMS	YES	NO	HEPATITIS	YES	NO
UROGENITAL SURGERY	YES	NO	HEART DISEASE	YES	NO
TESTICULAR CANCER	YES	NO	ARRYTHMIA	YES	NO
VASECTOMY	YES	NO	VASCULAR DISEASE	YES	NO
PEYRONIE'S (CURVED PENIS}	YES	NO	BLEEDING DISORDER	YES	NO
BLOOD CLOT	YES	NO	HIGH BLOOD PRESSURE	YES	NO
STD	YES	NO	LUPUS	YES	NO
HIV INFECTION/ AIDS	YES	NO	HIGH CHOLESTEROL	YES	NO
PULMONARY EMBOLISM	YES	NO	SICKLE CELL DISEASE	YES	NO
KIDNEY DISEASE	YES	NO	ARTHRITITS	YES	NO
MULTIPLE SCLEROSIS	YES	NO	PARKINSON'S DISEASE	YES	NO
FIBROMYALGIA	YES	NO	DIABETES	YES	NO
STROKE	YES	NO	BOWEL PROBLEMS	YES	NO
THYROID DISEASE	YES	NO	ORTHOPEDIC SURGERY	YES	NO
CARDIAC SURGERY	YES	NO	GASTRO SURGERY	YES	NO

MEDICAL EXAM IN THE LAST 12 MONTHS	YES	NO
BONE DENSITY IN THE LAST 12 MONTHS	YES	NO
PELVIC ULTRASOUND IN THE LAST 12 MONTHS	YES	NO
TROUBLE PASSING URINE OR TAKE FLOMAX OR AVODART	YES	NO

OTHER:

_____

_____

_____

_____

_____

NAME_____

(Last) (First) (Middle Initial)

MALE HRT CHECKLIST

Place an "X" for EACH symptom you are currently experiencing. *Please mark only ONE box.*
For symptoms that do not apply, please mark NONE.

	None	Mild	Moderate	Severe	Extremely Severe
1. Decline in your feeling of general well-being (general state of health, subjective feeling)	☐	☐	☐	☐	☐
2. Joint pain and muscular ache (lower back pain, joint pain, pain in a limb, general back ache)	☐	☐	☐	☐	☐
3. Excessive sweating (unexpected/sudden episodes of sweating, hot flushes independent of strain)	☐	☐	☐	☐	☐
4. Sleep problems (difficulty in falling asleep difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness)	☐	☐	☐	☐	☐
5. Increased need for sleep, often feeling tired	☐	☐	☐	☐	☐
6. Irritability (feeling aggressive, easily upset about little things, moody)	☐	☐	☐	☐	☐
7. Nervousness (inner tension, restlessness, feeling fidgety)	☐	☐	☐	☐	☐
8. Anxiety (feeling panicky)	☐	☐	☐	☐	☐
9. Physical exhaustion / lacking vitality (general decrease in performance, reduced activity, lacking interest in leisure activities, feeling of getting less done, of achieving less, of having to force oneself to undertake activities)	☐	☐	☐	☐	☐
10. Decrease in muscular strength (feeling of weakness)	☐	☐	☐	☐	☐
11. Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use)	☐	☐	☐	☐	☐
12. Feeling that you have passed your peak	☐	☐	☐	☐	☐
13. Feeling burnt out, having hit rock-bottom	☐	☐	☐	☐	☐
14. Decrease in beard growth	☐	☐	☐	☐	☐
15. Decrease in ability/frequency to perform sexually	☐	☐	☐	☐	☐
16. Decrease in the number of morning erections	☐	☐	☐	☐	☐
17. Decrease in sexual desire/libido (lacking pleasure in sex, lacking desire for sexual intercourse)	☐	☐	☐	☐	☐

Please share any additional comments about your symptoms you would like to address._____

Do you have cold hands and feet? ☐ Yes ☐ No **Do you have daily bowel movements?** ☐ Yes ☐ No

Do you have gas, bloating or abdominal pain after eating? ☐ Yes ☐ No

Please select your WEEKLY Activity Level based on this criteria ➔ *Physical activity that accelerates heart rate / Breathlessness*

☐ 0-1 day per week (Low) ☐ 2-3 days per week (Average) ☐ More than 3 days per week (High)

Please list any prior hormone therapy?_____

Recent PSA:_____**Recent Digital Rectal Exam (Date):**_____**Normal / Abnormal**

History of Prostate problems or Biopsy. If so, please provide details._____

NAME_____

(Last) (First) (Middle Initial)

MEDICAL HISTORY FEMALE

MAJOR DEPRESSION	YES	NO	LIVER DISEASE	YES	NO
GI SURGERY	YES	NO	URO-GENITAL PROBLEMS	YES	NO
HEPATITIS	YES	NO	UROGENITAL SURGERY	YES	NO
HEART DISEASE	YES	NO	ARRYTHMIA	YES	NO
VASCULAR DISEASE	YES	NO	BLEEDING DISORDER	YES	NO
BREAST CANCER	YES	NO	BLOOD CLOT	YES	NO
OVARIAN CANCER	YES	NO	HIGH BLOOD PRESSURE	YES	NO
STD	YES	NO	LUPUS	YES	NO
HIV INFECTION/ AIDS	YES	NO	HIGH CHOLESTEROL	YES	NO
UTERINE CANCER	YES	NO	PULMONARY EMBOLISM	YES	NO
MENOPAUSE	YES	NO	SICKLE CELL DISEASE	YES	NO
HYSTERECTOMY	YES	NO	KIDNEY DISEASE	YES	NO
PARTIAL HYSTERECTOMY	YES	NO	ARTHRITITS	YES	NO
OOPHERECTOMY	YES	NO	MULTIPLE SCLEROSIS	YES	NO
TUBAL LIGATION	YES	NO	PARKINSON'S DISEASE	YES	NO
BIRTH CONTROL	YES	NO	FIBROMYALGIA	YES	NO
STROKE	YES	NO	BOWEL PROBLEMS	YES	NO
DIABETES	YES	NO	THYROID DISEASE	YES	NO
CARDIAC SURGERY	YES	NO	GASTRO SURGERY	YES	NO
ORTHOPEDIC SURGERY	YES	NO			

MEDICAL/GYN EXAM IN THE LAST 12 MONTHS	YES	NO
MAMMOGRAM IN THE LAST 12 MONTHS	YES	NO
BONE DENSITY IN THE LAST 12 MONTHS	YES	NO
PELVIC ULTRASOUND IN THE LAST 12 MONTHS	YES	NO

OTHER:

_____

_____

_____

_____

_____

NAME_____

(Last) (First) (Middle Initial)

FEMALE HRT CHECKLIST

Place an "X" for EACH symptom you are currently experiencing. *Please mark only ONE box.*

For symptoms that do not apply, please mark NONE.

	None	Mild	Moderate	Severe	Extremely Severe
1. **Hot flashes, sweating** (episodes of sweating)	☐	☐	☐	☐	☐
2. **Heart discomfort** (unusual awareness of heart beat, heart skipping, heart racing, tightness)	☐	☐	☐	☐	☐
3. **Sleep problems** (difficulty in falling asleep, difficulty in sleeping through the night, waking up early)	☐	☐	☐	☐	☐
4. **Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings)	☐	☐	☐	☐	☐
5. **Irritability** (feeling nervous, inner tension, feeling aggressive)	☐	☐	☐	☐	☐
6. **Anxiety** (inner restlessness, feeling panicky)	☐	☐	☐	☐	☐
7. **Physical and mental exhaustion** (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	☐	☐	☐	☐	☐
8. **Sexual problems** (change in sexual desire, in sexual activity and satisfaction)	☐	☐	☐	☐	☐
9. **Bladder problems** (difficulty in urinating, increased need to urinate, bladder incontinence)	☐	☐	☐	☐	☐
10. **Dryness of vagina** (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
11. **Joint and muscular discomfort** (pain in the joints, rheumatoid complaints)	☐	☐	☐	☐	☐

Please share any additional comments about your symptoms you would like to address.

_____

_____

Do you have cold hands and feet? ☐ Yes ☐ No **Do you have daily bowel movements?** ☐ Yes ☐ No

Do you have gas, bloating or abdominal pain after eating? ☐ Yes ☐ No

Please select your WEEKLY Activity Level based on this criteria ➔ *Physical activity that accelerates heart rate / Breathlessness*

☐ 0-1 day per week (Low) ☐ 2-3 days per week (Average) ☐ More than 3 days per week (High)

Please list any prior hormone therapy?

_____