NEW PATIENT INTAKE

Weight Loss Medical History Form

Please complete this form before your appointment. Accurate, complete answers help us provide you with the safest and most personalized care.

FULL NAME | DATE OF BIRTH | PRIMARY CARE PHYSICIAN

REASON FOR VISIT

1. What brings you in today? (check all that apply)

❑ Weight Management ❑ Type 2 Diabetes ❑ Cardiovascular Risk ❑ Other (describe below)

WEIGHT LOSS HISTORY & GOALS

2. What is your current weight loss goal? (e.g., a specific number, an outfit size, or simply 'feel better')

HIGHEST ADULT WEIGHT | LOWEST ADULT WEIGHT | WEIGHT 1 YEAR AGO

3. Have you previously tried weight loss medications, programs, or surgery?

❑ No ❑ Yes (please describe)

CURRENT MEDICAL CONDITIONS

4. Do you currently have any of the following? (check all that apply — if yes, briefly explain)

❑ Type 2 Diabetes — *If yes, briefly explain:*

❑ Hypertension (high blood pressure) — *If yes, briefly explain:*

❑ Heart disease or prior heart attack — *If yes, briefly explain:*

❑ Kidney disease — *If yes, briefly explain:*

❑ Liver disease — *If yes, briefly explain:*

❑ Hypothyroidism — *If yes, briefly explain:*

❑ GI disorders (IBS, GERD, etc.) — *If yes, briefly explain:*

❑ Hypoglycemia (low blood sugar) — *If yes, briefly explain:*

5. Other current conditions or diagnoses (please list):

PERSONAL & FAMILY HISTORY

6. Personal history of any of the following? (check all that apply)

- ❑ Pancreatitis
- ❑ Gastroparesis (delayed stomach emptying)
- ❑ Gallstones or gallbladder disease
- ❑ Heart attack
- ❑ Eating disorder (bulimia, anorexia, binge eating)
- ❑ Stroke
- ❑ Cancer (any type)
- ❑ Multiple Endocrine Neoplasia (MEN) syndrome

If yes to any — please specify type and approximate date(s):

IMPORTANT — FAMILY HISTORY OF THYROID CANCER

GLP-1 medications carry a boxed warning regarding medullary thyroid cancer. Please answer carefully so our providers can make a safe recommendation.

7. Has anyone in your family (parents, siblings, children) had any of the following?

- ❑ Medullary thyroid cancer (MTC)
- ❑ Multiple Endocrine Neoplasia (MEN 2)
- ❑ Other thyroid cancer
- ❑ Pancreatic cancer
- ❑ Other cancer (any type)
- ❑ None of the above

If yes — please specify the relative and the type of cancer:

MEDICATIONS, ALLERGIES & LABS

8. List all current prescription medications, over-the-counter medications, and supplements:

9. Are you currently taking insulin or any other injectable medication?

- ❑ No
- ❑ Yes (please list)

10. Have you ever used a GLP-1 medication (Ozempic, Wegovy, Mounjaro, Zepbound, etc.)?

- ❑ No
- ❑ Yes (which one and your experience?)

11. Do you have any medication allergies?

- ❑ No known allergies
- ❑ Yes (please list)

12. Have you had recent labs in the last 6 months? (CMP, CBC, A1C, lipid panel, etc.)

- ❑ No
- ❑ Yes — I will bring a copy
- ❑ Yes — please request from PCP

If yes — date and lab/facility:

MENTAL HEALTH

13. Do you currently have, or have you been diagnosed with, any of the following?

❑ Depression
❑ History of an eating disorder
❑ History of suicidal thoughts or attempts
❑ Bipolar disorder or mood disorder
❑ Anxiety
❑ Other (please describe below)

14. If you marked depression or anxiety: are you currently in treatment, and do you feel it is well-controlled?

REPRODUCTIVE HEALTH (IF APPLICABLE)

GLP-1 medications are not recommended during pregnancy or breastfeeding. We advise stopping at least 2 months before trying to conceive.

15. Are you currently pregnant?

❑ No ❑ Yes ❑ Not applicable

16. Are you planning to become pregnant in the next 12 months?

❑ No ❑ Yes ❑ Not sure ❑ Not applicable

17. Are you currently breastfeeding?

❑ No ❑ Yes ❑ Not applicable

LIFESTYLE

18. Do you smoke or use tobacco/nicotine products?

❑ No
❑ Yes (how much per day?)

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19. Do you consume alcohol?

❑ Never ❑ Occasionally (1–2/week) ❑ Regularly (3–7/week) ❑ Daily

20. What is your current physical activity level?

❑ Sedentary (little or none) ❑ Light (1–3 days/week) ❑ Moderate (3–5 days/week) ❑ Very active (6–7 days/week)

21. How would you describe your typical diet? (check all that apply)

❑ High in carbohydrates
❑ Frequent fast food
❑ High in protein
❑ Mostly whole / home-cooked foods
❑ Low in vegetables/fruit
❑ Other (describe below)

22. Do you have any dietary restrictions or allergies?

❑ No
❑ Yes (please list)

SLEEP & STRESS

23. Average hours of sleep per night:

❑ Less than 5 ❑ 5–6 ❑ 7–8 ❑ More than 8

24. How is your sleep quality?

❑ Excellent ❑ Good ❑ Fair ❑ Poor

25. Do you have trouble falling or staying asleep?

❑ No ❑ Trouble falling asleep ❑ Wake up frequently ❑ Both

26. How would you rate your current stress level? (1 = very low · 10 = extremely high)

❑ 1–2 ❑ 3–4 ❑ 5–6 ❑ 7–8 ❑ 9–10

How do you currently manage stress?

ADDITIONAL INFORMATION

27. Do you have any upcoming surgeries or procedures planned in the next 6 months?

❑ No ❑ Yes (please describe)

28. Anything else you would like your provider to know?

SIGNATURE

I certify that the information provided is accurate and complete to the best of my knowledge. I understand that withholding or falsifying medical information may affect the safety and appropriateness of my care.

PATIENT SIGNATURE DATE