Semaglutide/Tirzepatide Weight Loss Intake

Please complete all sections.

Date: ______________________________

Patient Name: ☐ Ms. ☐ Mrs. ☐ Miss ☐ Mr. ____________________ ____________________
First Last

Date of Birth: ______________________ Age: __________

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

Occupation: ______________________________

Address: ______________________________

City: ______________ State: ______________ ZIP: ______________

Home Phone: ______________ Cell: ______________ Work Phone: ______________

Email: ______________________ Pharmacy: ______________________

Emergency contact: ______________________ ______________________
First Name Last Name

Relationship to Patient: ______________________ Phone: ______________________

Primary Care Physician: ______________________________

Pharmacy: ______________________________

Please Note: We do not accept insurance for the weight loss program. The patient is responsible for all charges generated.

Weight Management Patient History Questionnaire

*The information requested below is very important. To give you the best care, we must have complete and **honest** answers. Please be thorough and print clearly with black ink. Thank you.*

Patient Name: ______________________ Date of Birth: ______________________

Please record current home values below.

Height: ____________ Weight: ____________ Blood Pressure (If Available): ______________________
Feet/Inches Pounds

WEIGHT HISTORY - *Please estimate as closely as possible for all that applies.*

Life Events	Age	Weight
Lowest weight in past five years		
Highest weight in past five years		
Weight one year ago		
Other:		

What is your Goal Weight? ______________________

Do you use a home scale? ☐ No ☐ Yes How often do you weigh yourself? ______________________

Have you had bariatric surgery? ☐ No ☐ Yes

If Yes, which procedure and when? ☐ LapBand ☐ Gastric Bypass ☐ Gastric Sleeve Date: ____________

What is the #1 thing that is motivating you to seek weight loss treatment at this time? How would losing weight change your life?

____

____

SOCIAL HISTORY

Do you use any tobacco? ☐ No ☐ Yes Do you vape? ☐ No ☐ Yes

If Yes, what? ______________________

How often/much? ______________________

Do you drink alcohol? ☐ No ☐ Yes

If Yes, what kind/how much/often? ______________________

Any drug use? ☐ No ☐ Yes

If Yes, what type/how much/often? ______________________

Weight Management Patient History Questionnaire

FOOD INTAKE

What specific food plan/diet are you currently following, if any? ______

How many meals do you consume per day? ______

Do you skip meals? ☐ No ☐ Yes Number of snacks per day: ______

Do you eat breakfast? ☐ No ☐ Yes

How late is your dinner? ______ When is your typical bedtime? ______ Do you snack after dinner? ______

Do you snack between meals? ☐ No ☐ Yes

If so, what and how often? ______

Do you have any eating related problems or concerns? ☐ No ☐ Yes

If Yes, please explain: ______

Are you willing to cook, or do you prefer purchasing meals? ______

Do you have any diet restrictions?

Vegetarian? ☐ No ☐ Yes

Gluten Free? ☐ No ☐ Yes

Other? ______

What is your daily protein intake from drinks and/or food? ______

How much **WATER** do you drink in a 24-hour period?

☐ 24oz (3 cups or less) ☐ 32oz (4+ cups) ☐ 64oz (8+ cups) Other: ______

What do you drink other than water? ______ How much? ______

LIST YOUR FOOD INTAKE FROM YESTERDAY

	Time	Place	Food/Beverage	Amount
Breakfast				
Lunch				
Dinner				
Snack				
Snack				

Weight Management Patient History Questionnaire

PHYSICAL ACTIVITY

Do you exercise regularly? ☐ No ☐ Yes If yes, do you have an exercise regimen? Please list in table below.

Do you have any physical restrictions that keep you from exercising? ☐ No ☐ Yes

If yes, explain: ____________________

Type of Physical Activity (Walking, Yoga, Cardio, Weights, Swim, etc.)	**Intensity** (Light, Medium, or High)	**Daily?**	**How Often?**	**Comments**
		☐ No ☐ Yes		
		☐ No ☐ Yes		

PERSONAL MEDICAL HISTORY

Do you have or have you had any of the following? Check all that apply.

Psychological

Do you have any of the following? (Please check all that apply)

☐ Depression ☐ Panic Attacks ☐ Anxiety ☐ Bipolar Disease ☐ Eating Disorder

☐ Obsessive Compulsive Disorder ☐ Other: ____________________

Seeking treatment? ☐ No ☐ Yes

Medications? ☐ No ☐ Yes (Please list under medications - page 6)

Are you currently seeing a psychologist/psychiatrist/therapist? ☐ No ☐ Yes

Are you currently experiencing high circumstantial stress? ☐ No ☐ Yes

How well do you feel you are coping with your current level of stress? ☐ Not Well ☐ Pretty Well ☐ Very Well

Sleep Health

How many hours do you typically sleep per night?__________ hours ☐ No ☐ Yes

If you have insomnia, do you have trouble falling asleep or staying asleep? ☐ No ☐ Yes

Has anyone told you that you snore loudly or stop breathing for a few seconds during sleep? ☐ No ☐ Yes

Do you have excessive daytime sleepiness? ☐ No ☐ Yes

Have you been diagnosed with Sleep Apnea? ☐ No ☐ Yes

If yes, are you currently on CPAP or other oral device? ☐ No ☐ Yes

Cardiovascular

High blood pressure ☐ No ☐ Yes

If yes, medication? ☐ No ☐ Yes (Please list under medications - page 6)

Heart attack? ☐ No ☐ Yes When? ____________________

Heart bypass surgery? ☐ No ☐ Yes When? ____________________

Stents? ☐ No ☐ Yes When? ____________________

Pacemaker? ☐ No ☐ Yes When? ____________________

Weight Management Patient History Questionnaire

Endocrine

Diabetes? ☐ No ☐ Yes If yes, do you have low sugar episodes? ______________________

If yes, please write your current A1C blood test value, if known: ______________________

If yes, medication? ☐ No ☐ Yes (Please list under medications - page 6)

Thyroid problems? ☐ No ☐ Yes When? ______________________

Medications? ☐ No ☐ Yes (Please list under medications - page 6)

Gastrointestinal

Heartburn? ☐ No ☐ Yes If yes, how often a week? ______________________

Medications? ☐ No ☐ Yes (Please list under medications - page 6)

Do you get pain in your upper abdomen after eating or in the middle of the night, other than heartburn? ☐ No ☐ Yes

Have you ever been told you have gallstones? ☐ No ☐ Yes

Have you ever been told you have a fatty liver? ☐ No ☐ Yes

Respiratory

Do you have asthma? ☐ No ☐ Yes

Do you have COPD/Emphysema? ☐ No ☐ Yes

If yes, medications? ☐ No ☐ Yes (Please list under medications - page 6)

How far can you walk before you get short of breath? ______________________

Musculoskeletal

Do you have joint pain? ☐ No ☐ Yes If yes, where? ______________________

Do you take medications for this? ☐ No ☐ Yes (Please list under medications - page 6)

Have you seen an Orthopedic MD for this? ☐ No ☐ Yes

Have you had surgery for this? ☐ No ☐ Yes

If yes, when and what? ______________________

Are you waiting for a joint replacement until you lose weight? ☐ No ☐ Yes

Gynecologic and Obstetric

Age at onset of periods: ____________ Frequency: ____________ Length of Period: ____________

Pregnancies: ____________ Births: ____________ Miscarriages: ____________

Prolonged or abnormal bleeding? ☐ No ☐ Yes If yes, describe: ______________________

Any other medical history/conditions besides listed above? (Include Medication/Food Allergies)

Weight Management Patient History Questionnaire

MEDICATIONS (Including vitamins and supplements - please attach medication list if applicable)

☐ I do not currently take any medications

Medication	Dosage	Frequency	Comments

☐ I certify that all the information that I provided on this questionnaire is true, accurate, and complete. Initials: ________

FAMILY HISTORY

Is there obesity in the family? ☐ No ☐ Yes

If Yes, please list: ____________________

Are there any medical illnesses in your immediate family? (Mother, Father, Sibling?) ☐ No ☐ Yes

Diabetes? ☐ No ☐ Yes Who: ____________ Type: ____________

Hypertension? ☐ No ☐ Yes Who: ____________ Type: ____________

Coronary Artery Disease? ☐ No ☐ Yes Who: ____________ Type: ____________

Cancer? ☐ No ☐ Yes Who: ____________ Type: ____________

Medullary Thyroid Cancer? ☐ No ☐ Yes Who: ____________ Type: ____________

Heart Attack? ☐ No ☐ Yes Who: ____________ Type: ____________

Stroke? ☐ No ☐ Yes Who: ____________ Type: ____________

Other: ____________________

Weight Management Patient History Questionnaire

Weight Loss History

Please list past loss attempts, etc. starting with the most recent.
Types : (Keto, Intermittent Fasting, Lindora, Weight Watchers, Weight Loss Meds, HcG, etc.).
If certain diet has been followed more than once, Please lsit each attempt separately.
Answer to the best of your recollection. Approximate times, weight amounts, etc. are fine.

Approximate Month/Year	Diet Type	Starting Weight	Weight Lost	Length of time weight kept off (or N/A)

List any other physician-supervised and documented weight-loss treatment: _______ None

Maintaining weight loss is a challenge. Both physiologic and behavioral factors are involved. With learning, motivation, and commitment, it can be done! A maintenance plan is also a part of this program.

What factors are you aware of that have contributed to regaining lost weight? ________ N/A

Is there anything else you would like to share with us about your weight?

Weight Loss Intake

OC Health and Physical Medicine Disclaimer

1. The staff at OC Health & Physical Medicine will provide the tools you need to achieve the weight loss goal that YOU set to yourself. We will offer the best advice that we can give and add some little "tricks'' that we have either learned from personal experience or from the many clients who have shared their helpful hints with us. **Initial:** ________

2. We offer no magic potions, but we will educate you on some supplements which we have found to be helpful to some clients. We will not upsell you on any products that are not relative to you reaching your goal. **Initial:** ________

3. The program is made up of the following: The client's desire to lose weight, improve their health and the willingness to make the necessary lifestyle changes to achieve their goal and maintain that goal. **Initial:** ________

4. The tools that we provide include nutrition education, exercise suggestions, a B12 injection once per month, lots of personal support and ideas on a weekly basis as we track your progress. **Initial:** ________

5. The staff will share some little tricks to help you learn from day one how to keep the weight off. We do not believe that clients "cheat", we call it "living". It is not necessary to feel like you have lost all progress if you have a big party to go to or some bad days which ended up with some comfort foods. Those days will happen and as long as it is not day after day, it is easy to "offset" those days. We will teach you what to do while you are in the "dieting phase" so that once you reach your goal you will have already practiced and become comfortable with the remedies to help you maintain your desired weight. **Initial:** ________

6. To justify the use of semaglutide/tirzepatide, your Body Mass Index (BMI) must be at least 27. Your Body Mass Index (BMI) will be calculated at your initial visit. **Initial:** ________ ________
   Counselor:

Please CHECK if you have any of the following:

- ☐ Cardiovascular disease
- ☐ Myocardial Infarction (MI)
- ☐ Hypertension (HBP)
- ☐ Chronic Lung Disease
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Emphysema

Client Signature: ______________________________ Date: ______________________

Counselor Signature: ______________________________ Date: ______________________

Weight Loss Intake

Informed Consent: Semaglutide / Tirzepatide for Weight Loss

Put simply, both Semaglutide and Tirzepatide mimic hormones the body makes after eating that create a feeling of fullness (satiety) and help lower blood sugar. The hornones do not work as well in overweight and obese individuals compared to people at a healthy weight.

Semaglutide is a GLP 1 Receptor. It mimics the action of a hormone called Glucagon-Like Peptide (GLP). Glucagon is the storage form of carbohydrates, which is a factor in weight gain. Glucagon causes stored carbohydrates to break down and move into the bloodstream for metabolism. Glucagon decreases carbohydrate absorption from the gut while decreasing appetite by slowing gastric mobility. When blood sugar rises after eating, these drugs stimulate the body to produce more insulin. The extra insulin helps lower blood sugar. The lower blood sugar levels help control type 2 Diabetes. Tirzepatide affects two receptors (dual action), acting on both GIP (glucose insulinotropic polypeptide) and GLP-1 receptors (glucagon-like peptide). This dual response further increases safety and decreases hunger. Combined with a sensible diet and healthy lifestyle changes, Semaglutide and Tirzepatide effectively reduce body weight. Semaglutide and Tirzepatide curb appetite and slow food movement from the stomach to the small intestines. As a result, clients feel full longer and subsequently eat less, leading to weight loss.

Further studies have demonstrated that GLP-1 and SGLT-2 (sodium-glucose transport protein 2) inhibitors may reduce the risk of heart disease, heart failure, stroke, and kidney disease. Many clients prescribed these medications have seen blood pressure and cholesterol levels improve.

Side Effects

Like most prescription drugs, both Semaglutide and Tirzepatide can have moderate to severe side effects in some users.

- Abdominal Pain (most common)
- Redness
- Constipitation
- Dizziness
- Nausea
- Belching
- Diarrhea
- Vomitting
- Injection site reactions
- Blurred Vision
- Headache
- GERD
- Depression; confusion; mood changes
- Gall Bladder pain with pre-existing cholelithiasis or gallstones
- Irritability
- Hair Loss
- Complications with anesthesia

Initials: ________

Hypoglycemia (low blood sugar) has been linked to GLP-1 medications when combined with insulin or sulfonylureas.

Any severe abdominal pain, vomitting, or constipation should be reported to the OC Health & Physical Medicine staff for guidance.

Weight Loss Intake

Informed Consent: Semaglutide / Tirzepatide for Weight Loss

Medications

Initial Health Assessment will review all medications before clearance for participation in a GLP-1 Weight Loss Program. Do you take any of the following medications? Please check if currently prescribed:

☐ **Amaryl**	☐ **Glipizide ER**
☐ **Glimepiride**	☐ **Glynase**
☐ **Glucotrol**	☐ **Tolbutamide**
☐ **Glipizide**	☐ **Tolazamide**

Warnings

Effects on Birth Control and Pregnancy

GLP-1 medications may affect the efficacy of oral contraceptives and birth control shots. Clients using oral birth control medications and birth control shots are strongly encouraged to use an alternative birth control plan while enrolled in GLP-1 Weight Loss Programs.

Pregnancy

Clients who are pregnant or think they are pregnant are NOT a candidate for our weight loss program. Animal studies have shown that these agonists may reduce embryo size and may cause developmental abnormalities.

Anesthesia

Clients scheduling any surgical procedure involving anesthesia must stop using GLP-1 medications at least two weeks before the procedure. Clients should notify anesthesiologists that they have been prescribed GLP-1 medications.

Initials: ______________

Exclusions from GLP-1 Weight Loss Programs

Clients diagnosed with one or more of the following conditions may not participate in GLP-1 Weight Loss Programs. Please review this list carefully and check any pre-existing conditions.

☐ **Medullary Thyroid Cancer**	☐ **Multiple Endocrine Neoplasia (all types, tumor or mass lesion)**
☐ **Pancreatis**	☐ **Hepatobiliary disease (Gallbladder disease)**
☐ **Gastroparesis**	☐ **Abnormal liver function tests**

Please initial here if, to the best of your knowledge, you are **free** of all the above medical conditions.

Initials: ______________

Following a thorough review of your health assessment, our Medical Team will make the final determination for full participation in the GLP-1 Weight Program.

Initials: ______________

Weight Loss Intake

Consent to Participate in OC Health & Physical Medicine Weight Loss Program

I understand that I will be meeting with a member of the medical staff to review all the information associated with the program and I will be given the opportunity to have all of my questions regarding the weight loss program answered. All of the information that I have provided to the medical staff is correct and complete to the best of my knowledge.

I understand that medications used in this program may cause or aggravate high blood pressure or alter insulin requirements in diabetes and that both hypertension and diabetes may improve with weight loss. I understand that although unusual, there may be adverse reactions to the medications used including rapid heart rate, restlessness, agitations, poor sleeping, dizziness, headaches, blurred vision, psychotic states, dryness of the mouth, constipation, diarrhea, nausea, stomach pains, urinary frequency/discomfort, and changes in sex drive.

I understand that dietary management and physical exercise are a necessary component of this, and all weight loss programs and MUST be utilized for optimum results. I have not been given any guarantees or promises regarding the expectations or results in this weight loss program. I freely and voluntarily consent to participate and agree to follow the instructions given. **I will not change dosages or frequency of any medications prescribed.**

Please be advised using any recreational drugs; ie: cocaine, marijuana, or heroin will cause FATAL adverse reactions with any medication prescription.

I give my permission for the medical staff/counselors to review this program with me and guide me in my weight loss journey.

Client Name: ____

Client Signature: ______________________________ Date: ____________________

OC Health Witness: ______________________________ Date: ____________________

OC HEALTH

HIPAA Consent Form
Release of Medical Information

____I authorize the release of my medical information to any health care providers involved in my care.
____I do not authorize release my medical information to any other health care providers involved in my care.
____I authorize the release of my medical information to the following providers:
____
____
____

Use and Disclosure of Protected Information
including treatment,
payment, or other healthcare operations.

____I give my consent to be contacted via my ____.__mobile phone _____work phone
____A message can be left on my ____mobile phone ____work phone
____I give my consent to be contacted via email
____I do not give my consent to be contacted via email
____I do not give my consent for messages to be left with anyone other than me.
____I give my consent for messages to be left with the following people:

____________________________	____________________________
Name	Relationship to patient
____________________________	____________________________
Name	Relationship to patient

Please specify the following:
Best phone number to reach you:____
Best time (s) to call: ____
Best email address: ____

Preferred method of contact: (please choose one)
___Text
____Phone
____Email

Name: (print) ____

Signature: _________________________________Date: ________________________