Establish Care for Weight Loss Management Intake Form

Patient Name: _____ Date of Birth: _____

Allergies: _____

List all home medications and over the counter supplements with dosages:

_____

_____

Reason for today's visit: _____

Height: _____ Weight: _____ Goal weight: _____Last menstrual period: _____

Past Medical History:

Pancreatitis	YES	NO	Lung Disease	YES	NO
Gastroparesis or constipation	YES	NO	Skin conditions	YES	NO
Personal or family history of Medullary thyroid carcinoma	YES	NO	Are you currently pregnant or trying to get pregnant:	YES	NO
Thyroid Disease or other endocrine disorders	YES	NO	Anxiety/Depression/Other mental health disorders	YES	NO
Multiple endocrine neoplasia syndrome type 2	YES	NO	Blood clots/Blood disorders/Stroke	YES	NO
Liver disease	YES	NO	Kidney Disease	YES	NO
Heart Disease	YES	NO	Reproductive Disorders	YES	NO

Past surgeries: _____

Do you smoke: _____ Do you drink alcohol, if so, how much per day: _____