

### Health History for Medical Weight Loss

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>Patient Name:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                               | <b>Date of Birth:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |
| <b>Gender:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Male <input type="checkbox"/> Female | <b>Occupation:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |
| <b>Address:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                               | <b>City, State, ZIP</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |
| <b>Phone:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                               | <b>E-Mail:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |
| <b>Emergency Contact/ Relationship:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                               | <b>Phone:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| <b>Current Weight:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                               | <b>Height:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |
| <b>Weight in 2024:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                               | <b>Weight in 2023:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |
| <b>Weight in 2022:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                               | <b>Weight in 2021:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |
| <b>Previous Weight loss Treatments Tried</b><br><i>(i.e., Paleo, Keto, Atkins, South Beach, Weight Watchers, Intermittent Fasting)</i><br><b>Please provide a brief description/outcome:</b>                                                                                                                                                                                                                                                                                                                                            |                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| <b>Previous Exercise Programs Tried</b><br><i>(i.e., walking, running, biking, swimming, tennis, weights, group exercise classes)</i><br><b>Please provide a brief description/outcome:</b>                                                                                                                                                                                                                                                                                                                                             |                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| <b>Do you have a history of Diabetes?</b><br><b>Family history of Diabetes:</b><br><b>Personal or family history of Medullary Thyroid Carcinoma (MTC)?</b><br><b>Personal or family history of Multiple Endocrine Neoplasia Syndrome Type 2 (MEN 2)?</b><br><b>Personal history of thyroid cancer or disease?</b><br><b>Personal history of pancreatitis or gall bladder disease?</b><br><b>Prior severe gastrointestinal disease?</b><br><b>Personal history of kidney disease?</b><br><b>Personal history of high blood pressure?</b> |                                                               | <input type="checkbox"/> No <input type="checkbox"/> Type I <input type="checkbox"/> Type II; For how long: _____<br><input type="checkbox"/> No <input type="checkbox"/> Type I <input type="checkbox"/> Type II<br><br><input type="checkbox"/> No <input type="checkbox"/> Yes<br><br><input type="checkbox"/> No <input type="checkbox"/> Yes<br><input type="checkbox"/> No <input type="checkbox"/> Yes<br><br><input type="checkbox"/> No <input type="checkbox"/> Yes<br><input type="checkbox"/> No <input type="checkbox"/> Yes<br><input type="checkbox"/> No <input type="checkbox"/> Yes<br><input type="checkbox"/> No <input type="checkbox"/> Yes |  |

**Personal history of high cholesterol?**

☐ No ☐ Yes

**Personal history of heart disease?**

☐ No ☐ Yes

**Personal history of liver disease?**

☐ No ☐ Yes

**Personal history of depression?**

☐ No ☐ Yes

**Personal history of anxiety?**

☐ No ☐ Yes

**Are you currently pregnant?**

☐ No ☐ Yes ☐ N/A

**Are you currently breast feeding?**

☐ No ☐ Yes ☐ N/A

**Please list any allergies:**

**Please list any additional medical conditions:**

**Please list any surgeries, including cosmetic surgeries and/or cosmetic treatments/injectables:**

Have you had any abdominal surgeries (i.e. c-section)? ☐ No ☐ Yes

**Please list current prescription medications, over the counter drugs, supplements/herbal remedies and their dosages:**

**Lifestyle & Habits:**

**Do you smoke, or have you smoked?**

☐ No ☐ Yes

**Do you drink Alcohol?**

☐ No ☐ Yes Frequency/Amount: \_\_\_\_\_

**What is your current diet?**

**What is your current exercise routine?**

**Have you previously used Semaglutide or Tirzepatide?**

☐ No ☐ Yes

**If yes, please provide details:**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Email/Text Communications:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                      |
| <b>It is ok to email me the following information:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <input type="checkbox"/> Appointment Reminders<br><input type="checkbox"/> Medical/Scheduling Information<br><input type="checkbox"/> Special Offers |
| <b>It is ok to text me the following information:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/> Appointment Reminders<br><input type="checkbox"/> Medical/Scheduling Information<br><input type="checkbox"/> Special Offers |
| <b>Goals &amp; Expectations:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                      |
| Please share any specific goals or expectations you have regarding medical weight loss treatment:                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                      |
| <p><b>General Health Acknowledgement:</b> I acknowledge that the information provided is accurate and complete to the best of my knowledge. I understand this information will be used for my medical assessment and treatment planning at More Medical Aesthetics &amp; Wellness.</p> <p>Thank you for completing this health history form. Your cooperation is vital in ensuring safe and effective care. If you have any questions or concerns, please feel free to discuss them during your consultation.</p> |                                                                                                                                                      |
| <b>Patient Signature:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                      |

MORE

MEDICAL AESTHETICS & WELLNESS