Drive Home Hydration
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drIVe
HOME HYDRATION

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Weight Loss Program Questionnaire

Name:_____ Date of Birth:_____ Age: _____ Sex: ☐ Female ☐ Male

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Email:_____

How did you hear about this clinic? _____

What are your main motivating factors for wanting to lose weight?

_____

What reasons do you feel contribute to having excess weight? Check all that apply:

☐ Alcohol Intake ☐ Comfort Foods ☐ Hormone Changes ☐ Medical Condition ☐ Sedentary Lifestyle
☐ Busy Lifestyle ☐ Excess Snacking ☐ Increased Stress ☐ Perimenopause ☐ Sweetened Beverages
☐ Child Birth ☐ Family History ☐ Low Energy/Fatigue ☐ Sleep Disruptions ☐ Other:_____

What methods and/or interventions have you used for weight loss in the past?

☐ Diet Modification ☐ Exercise Programs ☐ Herbal Supplements ☐ Prescription Medication ☐ Talk Therapy

Please explain any items you marked above:

_____

_____

Do you feel you experience any of the following potential obstacles to weight loss?

☐ Binge Eating ☐ Psychological Factors ☐ Skipping Meals ☐ Stress Eating ☐ Unsupportive Partner

Please explain any items you marked above:

_____

What is your ideal weight?_____ **What is your current weight?** _____

1- Do you have known allergies/sensitivities to:

☐ Adhesives ☐ Benzyl Alcohol ☐ B Vitamin Formulations ☐ GLP-1 Receptor Agonists ☐ Latex ☐ L-Carnitine

2- Have you ever fainted during injections or blood draws? ☐ Yes ☐ No

3- Have you ever had an adverse reaction or significant side effects to any weight loss meds? ☐ Yes ☐ No

If you marked an allergy above in line item 1 or marked yes to items 2-3 above, please explain below:

_____

Do you take antidiabetics? ☐ Yes ☐ No If yes, please check all that apply: ☐ Insulin ☐ Sulfonylureas

Do you take blood pressure medication? ☐ Yes ☐ No

Do you take any medications that may cause increased risk of bleeding or delayed healing? ☐ Yes ☐ No

If yes, please check all that apply: ☐ Anti-Platelets ☐ Blood Thinners ☐ Corticosteroids ☐ NSAIDS

Female Medical History:

Are you currently: ☐ Pregnant ☐ Trying to conceive ☐ Breastfeeding ☐ Post-Menopause

Birth Control: ☐ Abstinence ☐ Depo Provera ☐ IUD ☐ Nexplanon ☐ Tubal Ligation ☐ Birth Control Pill ☐ Hysterectomy ☐ Menopause ☐ NuvaRing ☐ Vasectomy

☐ Other (Please Explain): _____

Date of Last Menses: _____

General Medical History:

Have you or a family member ever been diagnosed with:

☐ Medullary Thyroid Carcinoma (Thyroid Cancer) ☐ Multiple Endocrine Neoplasia syndrome type 2 (MEN2)

Have you ever been diagnosed with or currently have:

☐ Adrenal Fatigue/Issues	☐ Congestive Heart Failure	☐ High Blood Pressure	☐ Neurological Disorder
☐ Anemia/Blood Disorders	☐ Diabetes	☐ High Cholesterol	☐ Pancreas Disease
☐ Asthma	☐ Depression	☐ Immune Deficiency	☐ Poor Wound Healing
☐ Autoimmune Disorder	☐ Digestive Issues	☐ Intestinal Issues	☐ Retinopathy
☐ Blood Clotting Disorder	☐ Gallbladder Disease	☐ Kidney Disease/Stones	☐ Stroke/TIAs
☐ Cancer	☐ Eating Disorder	☐ Liver Disease	☐ Thyroid Disease
☐ Chemical Dependence	☐ Heart Disease/Arrhythmia	☐ Mental Health Disorder	☐ Ulcers (Gastric)

Please explain any items you marked above:

_____

_____

Do you have any other medical issues not listed above? ☐ Yes ☐ No

If yes, please describe issue here: _____

Date of last blood work: _____ **Date of last physical:** _____

Describe any abnormal results: _____

_____

Do you consume alcohol? ☐ Yes ☐ No

If yes, please list number of drinks you consume per week: _____

Do you smoke? ☐ Yes ☐ No

If yes, please describe how often and how much you smoke: _____

Do you exercise regularly? ☐ Yes ☐ No

If yes, please describe activity, frequency, and duration:

_____

If there is anything else you'd like the NP or Physician to know, please let us know here:

_____

_____

_____

Patient Name: _____ **DOB:** _____ **Date:** _____

Medication Record

Please list all medications, over the counter drugs, and herbal supplements you are currently taking. Please include any prescription topical creams and hormone replacement therapy medications/implants.

Medication or Supplement	*Frequency*	*Dose*	*Purpose/Prescribed For*

Allergies & Sensitivities

Do you have any allergies or sensitivities to foods, medications, implants, etc? ☐ Yes ☐ No

If yes, please list all allergens and how you react to them:

_____

_____

Surgical History

Have you been hospitalized or received acute medical care, including surgeries, in the past year? ☐ Yes ☐ No

If yes, please describe here: _____

Primary Care Physician: _____ **Phone:** _____

*I affirm the information I have provided regarding my health history, medication record, and prior surgeries and aesthetic treatments is accurate to the best of my knowledge. I acknolwedge that **YOUR BUSINESS NAME** Staff are not responsible for any errors that may occur as a result of any omissions or incorrect information on this form.*

Patient Name (Print) _____ **Patient Signature** _____ **Date** _____