



## Weight Loss Program Questionnaire

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Female  Male

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### 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?

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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?

*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

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### Female Medical History:

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

Birth Control:  Abstinence     Depo Provera     IUD     Nexplanon     Tubal Ligation

Control:  Birth Control Pill     Hysterectomy     Menopause     NuvaRing     Vasectomy

Date of Last Menses: \_\_\_\_\_

Date of last blood work: \_\_\_\_\_

Date of last physical: \_\_\_\_\_

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: \_\_\_\_\_

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Do you exercise regularly?  Yes  No

**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:**

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

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

If yes, please describe here: \_\_\_\_\_

**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.**

<i>Medication or Supplement</i>	<i>Frequency</i>	<i>Dose</i>

**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: \_\_\_\_\_

*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 acknowledge that Drive Wellness Lounge Staff are not responsible for any errors that may occur as a result of any omissions or incorrect information on this form.*

<b>Patient Name (Print)</b>	<b>Patient Signature</b>	<b>Date</b>
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