ETERNAL BEAUTY LIFESTYLE

Weight loss and Aesthetic care

Eternal Beauty Lifestyle
Weight Loss Medical History Form

Today's date:_____ Date of Birth:_____

First Name: _____ Last Name:_____

Phone Number:_____ Email:_____ Gender: ____

Address:_____

Emergency Contact

Name:_____

Phone Number:_____ Relationship:_____

Primary Care Physician (PCP):

Name:_____ Phone number:_____

Address:_____

Pharmacy Information:

Name:_____ Phone number:_____

Address:_____

Patient Signature:_____

What is the reason for wanting to loose weight now?

How long has your weight been a problem?

Are you currently at your heaviest weight? (If not how much did you weight at your heaviest?)

What is your worst food habit?

Do you stress eat?_____

Do you eat late at night?_____

Have you tried anything else in the past that has helped you loose weight?
_____

_____

Women only:

- Are you currently pregnant?
- Are you trying to get pregnant?
- Are you breastfeeding?
- Are you on any contraceptive method (this medication can make oral contraception ineffective)

Additional information:_____

Patient Signature:_____
Medical History:

Prescription medications that you are currently taking:

List any vitamins and dietary supplement:

Recent hospitalizations or surgeries?_____

Do you have any allergies to medications, foods or environmental allergies?
_____

Are you on blood thinners? If yes, which one?_____

Weekly alcohol intake?_____

Do you exercise?_____

Past or Current Medical History (Check all that apply to you)

- Heart Disease (Heart attack, rheumatic fever, irregular heartbeat, angina, heart murmur, chest pain)
- Arterial disease
- High Cholesterol
- Anemia or other blood disorders
- Dizziness
- Seizures
- Stroke
- Thyroid disease
- Parathyroid disease
- Adrenal gland disease
- Diabetes type 1
- Diabetes type 2
- Deep Vein Thrombosis
- Gallstones, gallbladder disease
- High Blood Pressure
- GERD (gastrointestinal reflux)
- Asthma
- COPD
- Kidney disease

- Pancreatitis (current or history of it)
- Gastric ulcer
- Liver disease (hepatitis, liver failure, fatty liver, alcoholic liver disease)
- Severe stomach problems (Inflammatory bowel disease; Chron's disease; Ulcerative colitis)
- Irritable bowel Syndrome (IBS)
- Mental health problems (Depression, anxiety, Bipolar disorder, psychosis)
- Eating disorder (anorexia, bulimia)
- Self-diagnosis of depression, low mood, nervous or emotional problems
- Substance abuse (drugs or alcohol)

Additional comment:_____

Family Medical History:
Have you or anyone in your family, who is blood related, ever had:

- Diabetes type 2
- High Blood pressure
- Heart attack under 50
- Stroke under 50
- High Cholesterol
- Blood disorders
- Pancreatitis
- Liver disease
- Kidney disease
- Thyroid disease
- Thyroid Cancer
- Obesity (BMI 30 or higher)
- Prior allergic reaction to GLP-1 medications
- Diabetic Retinopathy
- Depression with history of suicidal thoughts
- Stomach problems

It is vital to disclose all of your history, current medications, or any allergies prior to starting your GLP-1 weight loss medication.

Patient Signature:_____

Date:_____