KILGORE
QUICK CARE

Weight Loss New Patient Registration

PLEASE PRINT AND COMPLETE IN FULL **Today's Date:** _____

Patient's Full Name:_____
First Middle Last

Birthday:_____ Gender: Male_____ Female _____
MM/DD/YYYY

Address: _____
City State Zip

Home Phone Number:_____ Cell Phone Number: _____

Email: _____

Emergency Contact: _____

Relation to Patient:_____Phone Number:_____

Preferred Pharmacy & Pharmacy Location: _____

Do you have any drug allergies? Yes_____ No _____

If yes, what are you allergic to?:_____

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I,_____, authorize my Kilgore Quick Care physician(s), or advanced practice clinician(s) and/or whomever may be designated as the medical assistant(s), to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavioral modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low caloric diet, or a protein supplemented diet. I further understand that if appetite suppressants are prescribed, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me to my complete satisfaction that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the medication product literature. I authorize Kilgore Quick care providers to hold and dispense my Tirzepatide or Semaglutide according to clinic protocol.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks associated with remaining overweight are tendencies to have high and increasing higher blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances made to me that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require drastic changes in eating habits and permanent changes in behavior to be treated successfully.

DO YOU HAVE: (Circle Yes or No)

1. Family or personal history of medullary thyroid cancer	Yes	No
2. Personal history of Multiple Endocrine Neoplasia syndrome type 2	Yes	No
3. Personal history of Pancreatitis	Yes	No
4. Personal history of Gallbladder disease / stones	Yes	No
5. Personal history of Hypoglycemia	Yes	No
6. Personal history of Acute kidney injury / abnormal kidney function	Yes	No
7. Personal history of Diabetic retinopathy	Yes	No
8. Personal history of Suicidal thoughts or attempt	Yes	No
9. Personal history of Gastroparesis	Yes	No

ADVERSE REACTIONS:

- Anaphylactic/ allergic reaction and angioedema have been reported.
- Most common adverse reactions: nausea, diarrhea, vomiting, constipation, abdominal pain, headache, fatigue, indigestion, dizziness, abdominal distention, belching, gas pain, acid reflux.

WARNING: May cause fetal harm. Discontinue semaglutide at least 2 months before planned pregnancy and immediately when pregnancy is recognized.

Patient Signature: _____ Date:_____

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MEDICAL WEIGHT LOSS QUESTIONNAIRE

Name: _____ Date of Birth:_____
MM/DD/YYYY

Current weight: _____ Height: _____

Describing My Current Lifestyle

Occupation: _____

My exercise routine: Activity_____ Minutes_____Times/week_____

Current stress level: None Low Medium High

My biggest stressor: Job Relationship Health Other:_____

My tobacco use: Current Former Never Quitting

My current alcohol use: None Occasional Weekly Daily A Problem

My current TV/Computer time per week: Less than 7 hrs. 7 to 15 hrs. Over 15 hrs.

My most important reason(s) for wanting to change my weight is:

_____

My **worst** food habit is:_____

I am a stress eater: Yes No

I eat in the middle of the night: Yes No

My significant other has a weight issue: Yes No N/A

How many sweet drinks per day: _____

How many sweets/carbs per day:_____

Long term, I would like to maintain my weight at_____lbs. (goal weight)

My Medical History (page 1 of 2)

My regular doctor is:_____Town:_____

At this time my overall health is: Excellent Good Fair Poor

Females - Date of Last Menstrual Period: _____

Previous or Current Health **Conditions I have** had include: **(circle** all that apply to you)

HIgh Blood Pressure	Diabetes	Sleep Apnea	Thyroid Problems
Depression	Anxiety	Asthma	Gout
Heart Disease	PTSD	COPD	Arthritis
Kidney Disease	Binge Eating Disorder	Acid Reflux	Fibromyalgia
Chronic Leg Swelling	Anorexia Nervosa	Irritable Bowel/Colitis	Osteoporosis
Bleeding Disorder	Bulimia	FattyLiver	Urinary Incontinence
Blood Clot	ADHD/ADD	Crohn's Disease	Polycystic Ovaries
Anemia	Bipolar Illness	Ulcerative Colitis	Menopause
Cancer	Alcohol/Drug	Liver/Gallbladder disease	Suicide Attempt
Eczema	Headache/Migraine	Stomach Ulcers	Other_____

Surgeries I have EVER had include:

Type	Date	Type	Date
1.		4.	
2.		5.	
3.		6.	

Medical History (page 2 of 2)

***Prescription* Medications** I CURRENTLY take are:

Medication Name	Dose and Frequency	Medication Name	Dose and Frequency
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Drug Allergies*:*_____

My **Family's Health** History (circle brother or sister as appropriate, check all that apply)

Disease	**Father** Age: Living: Y N	**Mother** Age: Living: Y N	**Brother/Sister** Age: Living: Y N	**Brother/Sister** Age: Living: Y N	**Brother/Sister** Age: Living: Y N	**Brother/Sister** Age: Living: Y N
Heart Attack/Stroke						
Diabetes						
Cancer						
Psychiatric						
Obesity						
Thyroid Cancer						
Other						

☐ Patient given Semaglutide / Tirzepatide handout explaining risks and side effects.

☐ Provider reviewed the Semaglutide / Tirzepatide handout with the patient.

_____ Date _____

Provider Signature