

GENERAL

First Name <input type="text"/>	Last Name <input type="text"/>	SSN <input type="text"/>
D.O.B (DD-MM-YYYY) <input type="text"/>	Gender * <input type="text"/>	Marital Status * <input type="text"/>
Height(Inches) <input type="text"/>	Weight(Lbs) <input type="text"/>	Address <input type="text"/>
City <input type="text"/>	State <input type="text"/>	Zip code <input type="text"/>
Contact Number <input type="text"/>	Emergency Number <input type="text"/>	Emergency Contact Person <input type="text"/>

Parent's Details

Parent's Name <input type="text"/>	Parent Address <input type="text"/>	City <input type="text"/>
State <input type="text"/>	Zip Code <input type="text"/>	Parent Number <input type="text"/>

Lifestyle (optional)

Tobacco: Yes No	Coffee: Yes No	Alcohol: Yes No
Recreational Drugs: Yes No	Counseling: Yes No	Exercise Patterns: Yes No
Hazardous Activities: Yes No	Sleep Patterns: Yes No	Seatbelt Use: Yes No

Risk Factors: (optional)

<input type="checkbox"/> Hypertension	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Sickle Cell
<input type="checkbox"/> Fibroids	<input type="checkbox"/> PID (Pelvic Inflammatory Disease)	<input type="checkbox"/> Severe Migraine
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Thrombosis/Stroke	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Gall Bladder Condition	<input type="checkbox"/> Breast Disease	<input type="checkbox"/> Depression

- Allergies
- Epilepsy
- Varicose Veins

- Infertility
- Contact Lenses

- Asthma
- Contraceptive Complication (specify)

Medical Condition

List any medical conditions that you have been diagnosed with (Check all that apply)

- Type 2 Diabetes
- High Cholesterol
- Heart Disease including abnormal heart rhythm, heart failure, or stroke
- Diseases of the testes or prostate (Enlarged Prostate or Prostate Cancer)
- History of Priapism (erection lasting longer than 4 hours while on medication)
- Gastrointestinal disorders (stomach ulcers, gastroparesis, inflammatory bowel disease)
- Personal or Family history of Thyroid Cancer
- Kidney disease or impaired kidney function
- Psychiatric illness including eating disorders or body dysmorphia
- High Blood Pressure (Hypertension)
- Sleep Apnea
- Diseases of the Breast, Ovaries, or Uterus
- Erectile dysfunction or decreased libido (sex drive)
- Hair loss of the scalp
- Pancreatitis or pancreatic disease
- Personal or Family History of Multiple Endocrine Neoplasia syndrome type 2 (MEN2)
- Liver or gallbladder disease
- Abnormalities of the blood (Sickle cell anemia, leukemia, blood clots, etc)

Others (List)

List any prescription medications or herbal supplements that you are currently taking (Check all that apply)

- Medication containing nitrates (Nitroglycerin, Isosorbide mononitrate, Imdur)
- Aspirin
- Riociguat (Adempas)
- Alpha blockers (doxazosin/Cardura, prazosin/Minipress, terazosin/Hytrin)
- Sildenafil (Revatio)

Other (List)

Previous GLP-1 Use (past use including dates and doses)

Are you pregnant, planning to become pregnant, or breastfeeding?

Known allergies (medications, supplements, environmental)

Surgeries

Recreational drug use

Family history (optional)

Father

Mother

Siblings

Spouse

Offspring

Relatives (optional)

Cancer: Father Mother Sibling Spouse Offspring

Tuberculosis: Father Mother Sibling Spouse Offspring

Diabetes: Father Mother Sibling Spouse Offspring

High Blood Pressure: Father Mother Sibling Spouse Offspring

Heart Problems: Father Mother Sibling Spouse Offspring

Stroke: Father Mother Sibling Spouse Offspring

Epilepsy: Father Mother Sibling Spouse Offspring

Mental Illness: Father Mother Sibling Spouse Offspring

Suicide: Father Mother Sibling Spouse Offspring

Stats (optional)

Language

Ethnicity

Race

Family Size

Employer (optional)

Occupation

Employer Name

Employer Address

City

State

Postal Code

Country

HEALTH — ADD HEALTH RECORD

Doctor Name

Contact Number

Last Seen (DD-MM-YYYY)

Additional Problem

Lab/Diagnostic Result

Current Medication Taken

Prescription

INSURANCE — ADD INSURANCE

Company *

Bin

Policy Number

Group Number

Policy Start Date (DD-MM-YYYY)

Policy End Date (DD-MM-YYYY)

Policy Coverage *