



Patient Medical History Information

Name: _____ Date: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: (H) _____ (C) _____ (other) _____

Date of Birth: (MM/DD/YY) _____ Age: _____ Sex: M / F (Circle One)

Occupation: _____ Email address: _____

In case of emergency, please contact

Name: _____ Phone: _____ Relation: _____

Medical History

Height: _____ Weight: _____ BMI: _____

*Do you have **any medication or food allergies**? Yes / No

If Yes, please list (including reaction):

Are you pregnant or breastfeeding? Yes / No

*Date of last chemistry screen or other lab testing _____

Have you ever been told that you have an electrolyte imbalance or other abnormal labs?

(Please check all that apply)

- Hypermagnesemia (High magnesium levels)
- Hypercalcemia (High calcium levels)
- Hypokalemia (Low potassium levels)
- Hemochromatosis (High iron levels)

***Are you a diabetic?** Yes / No

Are you a smoker? Yes / No If Yes, how much do you smoke? _____

How many alcoholic drinks do you consume in a week? _____

Do you use any recreational drugs? Yes / No If Yes, which ones and how often? _____

Please list everything you are currently taking:

Prescription Medications – Strength – Frequency-Condition being treated





Over the Counter Drugs – Strength – Frequency – Condition being treated

Vitamins and Other Supplements – Strength – Frequency – Condition being treated

MEDICAL HISTORY CONTINUED:

Do you take Digoxin (Lanoxin) for a heart problem? Yes / No

Do you take any diuretics or water pills? Yes / No If Yes, please list:

Do you take any steroids, i.e. Prednisone? Yes / No If Yes, please list:

Do you have any of the following conditions? (Please check all that apply)

- History of pancreatitis
- Kidney Disease/Kidney Insufficiency
- Stomach problems (semaglutide may exacerbate symptoms)
- Personal or family history of Medullary Thyroid Carcinoma (MTC)***
- Personal or family history of Multiple Endocrine Neoplasia type 2 (MEN)***
- Taking any other diabetic related medications Yes _____ No _____ ***
- Depression or Suicidal thoughts ***

List any other medical conditions you have (not mentioned above):

List of all surgical procedures you've had with approximate dates:

Is there anything else you'd like the nurse and physician to know?

