Name: Date Of Birth:

Sex: Female/Male/Other Phone: Age:

Address:

City: State: Zip:

Email: Referral:

Emergency Contact Name: Emergency Contact Phone:

Height: Weight: BMI:

Current Medical Conditions that you are being treated for or have been diagnosed with:

Surgical History:

Have you been hospitalized or received acute medical care, including surgeries, in the past year? Yes / No Please Explain

Prescription Medications: Please list medication and dose. Please include any prescription topical creams and hormone replacement therapy medications/implants.

Herbal Supplements: List all and dose

Do you have any allergies or sensitivities to foods, medications, implants, etc? Yes No

List Allergies and Reaction:

Exercise Programs (Any form and how often including intensity):

Do any of these apply to you: Binge Eating / Skipping Meals / Stress Eating

Which of these apply to your food choices:

Low Energy/Fatigue	Hormone Changes	Busy Lifestyle
Medical Condition	Sedentary Lifestyle	Excess Snacking Increased Stress
Family History	Comfort Foods	Sleep Disruptions

Alcohol Intake: Please indicate amount per day

Do you Binge drink: Y / N Drug Use: Specify Current or Past Use, Type and How Often

Do you use tobacco products: Vape / Chew / Smoke? How much and how often:

What are your main motivating factors for wanting to lose weight?

Have you ever fainted during injections or blood draws? Yes No

Are you taking: Blood Thinners / Corticosteroids / NSAIDS / Anti-Platelets

What foods do you crave the most and how often do you eat these foods?

What has been your Heaviest Weight:

How long has weight been an issue? What is your ideal weight?

Are you currently at your heaviest weight? Yes / No

What methods and/or interventions have you used for weight loss in the past?

Have you ever had an adverse reaction or significant side effects to any weight loss meds?

Do you take any medications that may cause increased risk of bleeding or delayed healing?

If yes, please check all that apply:

Do you take blood pressure medication?

If yes, please list:

Any Autoimmune Disorders for you or Immediate family member? List type and relationship

Have you ever been diagnosed with or currently have:

Intestinal Issues	Blood Clotting Disorder	Cancer
Digestive Issues	Chemical Dependence	Eating Disorder
Heart Disease/Arrhythmia	Diabetes	Anemia
Blood Disorders	Congestive Heart Failure	Liver Disease
High Blood Pressure	High Cholesterol	Retinopathy
Kidney Disease/Stones	Asthma	Gallbladder Disease
Neurological Disorder	Stroke/TIAs	Thyroid Disease

Immune Deficiency	Mental Health Disorder	Pancreas Disease
Depression Poor Wound Healing	Adrenal Fatigue/Issues	Ulcers (Gastric)

Date of last physical: Primary Care Physician:

Date of last blood work:

Describe any abnormal results:

Male Medical History: Vasectomy? Yes / No

Trying To Conceive? Yes / No	Are you Pregnant Y / N	Breastfeeding Y/N
Date of Last Menses:	Pregnancies:	Live Births:

Birth Control Method:

Abstinence	Birth Control Pill	Depo Provera IUD
Menopause	Nexplanon	NuvaRing
Tubal Ligation	Hysterectomy	Vasectomy
Post-Menopause		

Do you or Family Member Have History of Medullary Thyroid Carcinoma (Thyroid Cancer) or Multiple Endocrine Neoplasia syndrome type 2 (MEN2)?

If there is anything else you'd like the Provider to know, please let us know 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 acknolwedge that REAL Medicine, LLC is not responsible forany errors that may occur as a result of any omissions or incorrect information on this form.

Patient Name (Printed): Patient Signature:

What To Expect During Treatment: Your treatment provider will begin with a consultation that includes blood draws to check lab values and will review your health and medication history to ensure you are a good candidate for weight loss injections. You will be counseled on nutrition and exercise recommendations to be used along with Tirzepatide injections for chronic weight management, including reducing calories and increasing physical activity. You will be taught how to perform these injections at home just below the surface of the skin (subcutaneously) and will be prescribed a dosage that is adjusted for your individual needs, in accordance with your treatment plan. There is no downtime associated with this treatment. You may feel minor discomfort during the injection, similar to an insulin injection. Common side effects include: nausea, vomiting, diarrhea, indigestion, abdominal pain, constipation, fatigue, and dizziness. Multiple injections will be needed over the course of months to achieve desired results using Tirzepatide (GIP/GLP-1 RA)/Pyridoxine (B6) injections for elective chronic weight management treatment.