REVITALIZE
PLASTIC SURGERY & MEDICAL SPA

WEIGHT LOSS PROGRAM

PATIENT SUPPLEMENTAL QUESTIONNAIRE

Name: _____ Birth Date: _____ Today's Date: _____

Measurements (done in clinic with provider): chest/under bust: ____ waist: ____ hips: ____

W EIGHT HISTORY

What is the reason you want to lose weight? _____

_____

_____

_____

What have you tried in the past to lose weight? How did this work? _____

_____

_____

_____

_____

How long have you been struggling with your weight? _____ How long have you been trying to lose weight? _____

What is your highest weight during your adult life? _____What is your lowest weight during your adult life? _____

What is your realistic goal weight? _____

What is the reason you want to try GLP-1 medications (semaglutide or tirzepatide)? _____

_____

Have you ever had an unusual or allergic reaction to GLP-1 agonists, other medications, foods, dyes, or preservatives? ☐ NO ☐ YES If yes, what? _____

DIET

Are you currently following a specific diet or have you in the past? If so, what is/was it and is/was it effective? _____

_____

_____

How many servings of each do you estimate that you eat in a day:

carbohydrates (bread, cereal, rice, pasta, etc)		dairy (milk, yogurt, cheese, etc)	
vegetables		protein (meat, poultry, beans, eggs, and nuts)	
fruit		fats, oils, and sweets	

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How many beverages containing sugar do you consume per day? _____

ACTIVITY LEVEL

☐	sedentary (< 60 minutes of exercise per week)	☐	moderately active (30-50 minutes of exercise 5 days a week)
☐	lightly active (30 minutes of exercise 3 days a week)	☐	very active (> 60 minutes of exercise 7 days a week)

PAST MEDICAL CONDITIONS AND FAMILY HISTORY: Check (√) conditions as applicable.

Self	Family	Condition	Self	Family	Condition
☐	☐	delayed gastric emptying	☐	☐	pancreas issues (including pancreatitis, insufficiency, etc.)
☐	☐	digestion problems	☐	☐	parathyroid or adrenal gland issues
☐	☐	gallbladder disease/gallstones	☐	☐	prolonged QT interval
☐	☐	MEN 1 (multiple endocrine neoplasia type 1)	☐	☐	suicidal thoughts
☐	☐	MEN 2 (multiple endocrine neoplasia type 2)	☐	☐	previous suicide attempts
☐	☐	neurological issues	☐	☐	thyroid cancer

Are you scared of needles? ☐ NO ☐ YES

Are you taking any stimulants (Adderall, Adipex, Vyvanse, etc.) ☐ NO ☐ YES

Have you listed all self-prescribed medications, dietary supplements, or vitamins you are now taking on the Patient Health History form? ☐ NO ☐ YES

I certify that the above information is correct to the best of my knowledge. I will not hold Revitalize Plastic Surgery and their providers responsible for any omissions/errors I have made in completing this form. This information is confidential and will not be released without consent.

Signature: _____ **Date:** _____ **Reviewed By:**_____ **Date:** _____