

Weight-Loss Program – New Patient Health Questionnaire

Doctor-supervised care · Phone consultations · Please answer every question

Welcome! Thank you for choosing MultiMedRx.

These questions help our doctors make sure a weight-loss medicine is safe and right for you. Your answers are private and protected. A licensed doctor reviews every answer before your phone review. Answering "yes" does not mean you can't be helped - it simply helps us plan the safest care for you. If you are not sure about an answer, check "Not sure" and we will go over it together. A family member or caregiver is welcome to help you fill this out.

1. About You

Full name

Phone number

Email

Home address (street, city, state, ZIP)

Date of birth (MM/DD/YYYY)

Height (ft / in)

Weight (lbs)

Goal weight (lbs)

Sex assigned at birth

☐ Male

☐ Female

Which Medicare GLP-1 Bridge Program medicine are you most interested in? (Your doctor makes the final choice.)

☐ Wegovy (semaglutide) — weekly injection

☐ Zepbound (tirzepatide) — KwikPen

☐ Foundayo (orforglipron) — daily oral tablet

☐ No preference / Not sure

2. Your Insurance & Pharmacy

Do you have Medicare?

☐ Yes ☐ No ☐ Not sure

Which Medicare coverage do you have? (check all that apply)

☐ Part A / B ☐ Part D drug plan
☐ Medicare Advantage ☐ Medigap / supplement
☐ Not sure

Medicare or Medicare Advantage plan name and member ID

Part D drug plan name (if separate)

Any other insurance (name and member ID), if you have it

1. Has your Medicare drug plan ever paid for a medicine like Ozempic, Wegovy, Mounjaro, Zepbound, Trulicity or Victoza for you?

☐ Yes ☐ No ☐ Not sure

Preferred pharmacy - name

Pharmacy phone number

Pharmacy address

3. Your Health History

2. Has a doctor told you that you have type 2 diabetes?

☐ Yes ☐ No ☐ Not sure

3. Do you have type 1 diabetes?

☐ Yes ☐ No ☐ Not sure

4. Have you been told you have prediabetes or insulin resistance (blood sugar a little higher than normal)?

☐ Yes ☐ No ☐ Not sure

5. Do you ever have low blood sugar (feeling shaky, sweaty or confused), or have you passed out? ☐ Yes ☐ No ☐ Not sure

6. Do you have high cholesterol or high triglycerides? ☐ Yes ☐ No ☐ Not sure

7. Have you been told you have sleep apnea (stopping breathing during sleep)? ☐ Yes ☐ No ☐ Not sure

If yes, did you have a sleep study? How severe? _____

8. Have you been told you have liver problems, such as fatty liver, liver scarring (cirrhosis), hepatitis, or abnormal liver tests? ☐ Yes ☐ No ☐ Not sure

If yes, please explain: _____

Any other medical conditions you have been diagnosed with (not already asked above)

Please list any surgeries, hospital stays, accidents, serious illnesses or injuries

Drug allergies - list any medicines you are allergic to and what happens

If none, write "None".

4. Family History

Blood relatives means parents, brothers, sisters and children.

Health problems that run in your family (for example: heart disease, diabetes, cancer)

Questions about thyroid cancer in you or your family are in Section 9.

5. Your Heart & Blood Pressure

9. Do you have high blood pressure? ☐ Yes ☐ No ☐ Not sure

10. Is your blood pressure often above 140/90 even though you take 2 or more blood pressure medicines? ☐ Yes ☐ No ☐ Not sure

11. Has a doctor ever told you that you had a heart attack, stroke, heart stent or bypass, or blocked arteries (in your heart, neck or legs)? ☐ Yes ☐ No ☐ Not sure

If yes, what and when? _____

12. Did any of those happen in the last 3 months, or did you have a mini-stroke (TIA) in the last 3 months? ☐ Yes ☐ No ☐ Not sure

13. Do you have heart failure (a weak heart, or fluid in your lungs or legs), or get short of breath lying flat? ☐ Yes ☐ No ☐ Not sure

14. Do you have a fast or irregular heartbeat (like atrial fibrillation), a pacemaker, or fainting spells? ☐ Yes ☐ No ☐ Not sure

15. Do you have any other heart or blood vessel condition (like a heart valve problem)? ☐ Yes ☐ No ☐ Not sure

If yes, please explain: _____

16. Do you feel dizzy or light-headed when you stand up, or have low blood pressure? ☐ Yes ☐ No ☐ Not sure

6. Stomach & Digestion

17. Have you ever had pancreatitis (a swollen, painful pancreas), now or in the past? ☐ Yes ☐ No ☐ Not sure

If yes, when? _____

18. Do you have gallstones or gallbladder pain right now? (Check "No" if your gallbladder was removed.) ☐ Yes ☐ No ☐ Not sure

19. Have you been told your stomach empties slowly (gastroparesis), had Botox in your stomach, or do you vomit often? ☐ Yes ☐ No ☐ Not sure

20. Have you had a bowel blockage, chronic or very bad constipation, Crohn's disease or ulcerative colitis? ☐ Yes ☐ No ☐ Not sure

21. Have you had weight-loss surgery (gastric bypass, sleeve, band or balloon)? ☐ Yes ☐ No ☐ Not sure

If yes, what type and year? _____

22. In the past 3 months, have you had trouble swallowing, vomited blood, had black stools, or had belly pain that won't go away? ☐ Yes ☐ No ☐ Not sure

7. Kidneys

23. Have you been told you have kidney disease or weak kidneys, high creatinine, or protein in your urine? ☐ Yes ☐ No ☐ Not sure

If yes, please explain: _____

24. Are you on dialysis, or have you had a kidney transplant? ☐ Yes ☐ No ☐ Not sure

25. In the past year, did you need IV fluids for dehydration? ☐ Yes ☐ No ☐ Not sure

8. Your Eyes

26. Do you have diabetic eye disease (retinopathy), or have you had laser treatment or shots in your eyes? ☐ Yes ☐ No ☐ Not sure
27. Have you ever suddenly lost vision in one eye, or been told you had a "stroke" of the optic nerve (NAION)? ☐ Yes ☐ No ☐ Not sure

9. Thyroid & Cancer

28. Have you or any blood relative ever had a type of thyroid cancer called medullary thyroid cancer (MTC)? ☐ Yes ☐ No ☐ Not sure
29. Have you or any blood relative been told you have MEN 2 (Multiple Endocrine Neoplasia type 2)? ☐ Yes ☐ No ☐ Not sure
30. Do you have a thyroid condition (underactive or overactive thyroid, Hashimoto's or Graves') or take thyroid medicine? ☐ Yes ☐ No ☐ Not sure
31. Do you have a thyroid nodule or lump in your neck, hoarseness that won't go away, or any other thyroid cancer history? ☐ Yes ☐ No ☐ Not sure
32. Are you being treated for cancer now, or have you had cancer (other than skin cancer) in the past 5 years? ☐ Yes ☐ No ☐ Not sure

If yes, what type? _____

10. Medicines You Take

Prescription medicines - please include the dose and what each one is for

Example: Lisinopril 10 mg once a day - blood pressure

- If yes: which one, dose, last dose? _____

39. Do you take sleeping pills or anxiety pills (like Valium, Xanax or Ambien)? ☐ Yes ☐ No ☐ Not sure

Page 7 of 11

What kind of exercise or activity do you do?

How many alcoholic drinks do you have per week? ☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5-7 ☐ 8+

40. Do you ever have 4 or more alcoholic drinks in one day? ☐ Yes ☐ No ☐ Not sure

Do you smoke or vape? ☐ Yes ☐ No ☐ In the past

41. Do you use recreational drugs (including marijuana, stimulants like meth or cocaine, opioids, or diet pills not prescribed to you)? ☐ Yes ☐ No

If yes, which ones and how often? _____

Your stress level right now (5 is the highest) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

What are the main sources of your stress?

How often do you eat fast food or restaurant meals? ☐ Rarely / never ☐ 1-2 a week ☐ 3-5 a week
☐ 6+ a week

How many times do you eat per day?

Sodas per day (including diet)

Cups of coffee per day ☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+

Glasses of water or other fluids per day ☐ 1-3 ☐ 4-5 ☐ 6-8 ☐ 9+

12. Mood & Eating

42. Have you been diagnosed with depression, anxiety, or another mental health condition? ☐ Yes ☐ No ☐ Not sure

If yes, please explain: _____

43. Have you ever had an eating disorder (like anorexia, bulimia or binge eating), or do you make yourself throw up or use laxatives to control your weight? ☐ Yes ☐ No ☐ Not sure

44. In the past month, have you had thoughts of hurting yourself, or felt you would be better off dead? ☐ Yes ☐ No ☐ Not sure

If you are having thoughts of hurting yourself right now, please call or text 988 (Suicide & Crisis Lifeline) any time, day or night, or call 911.

13. Everyday Health

Falls, strength, memory and food

45. Have you lost 10 pounds or more in the past 6 months without trying, or has your appetite been poor? ☐ Yes ☐ No ☐ Not sure

46. Have you fallen in the past 12 months, are you afraid of falling, or do you use a cane or walker? ☐ Yes ☐ No ☐ Not sure

47. Is it hard for you to walk one block, climb 10 stairs, or get up from a chair without using your arms? ☐ Yes ☐ No ☐ Not sure

48. Do you have osteoporosis or thin bones, or have you broken a bone from a small fall after age 50? ☐ Yes ☐ No ☐ Not sure

49. Do you have trouble chewing, loose dentures, or trouble getting groceries or meals? ☐ Yes ☐ No ☐ Not sure

50. Do you have memory problems, or does someone help you keep track of your medicines? ☐ Yes ☐ No ☐ Not sure

If yes, helper's name & phone: _____

14. Upcoming Procedures

51. Do you have a surgery, colonoscopy, endoscopy, or any procedure where you will be put to sleep or sedated in the next 6 weeks? ☐ Yes ☐ No ☐ Not sure

If yes, what and what date? _____

15. Women's Health (women only)

52. Are you pregnant, breastfeeding, or trying to get pregnant? ☐ Yes ☐ No ☐ Not sure

53. Do you take birth control pills? ☐ Yes ☐ No ☐ Not sure

54. Have you been told you have polycystic ovary syndrome (PCOS)? ☐ Yes ☐ No ☐ Not sure

16. Your Goals

What are your main health goals?

How motivated are you to reach your goals? ☐ Strongly motivated ☐ Motivated ☐ Somewhat motivated ☐ Not sure

Anything else you would like your doctor to know?

17. Your Agreement & Signature

By signing below, I confirm that the information I have given on this form is true and complete to the best of my knowledge. I understand that my doctor will use this information to decide on safe treatment for me, and I agree to tell MultiMedRx if my health, medicines or insurance change. I understand my information is kept private and confidential.

Patient signature

Date

Printed name

If someone helped you fill this out: their name and relationship to you

Thank you! Please return this form to MultiMedRx. We look forward to helping you reach your goals.