First name: _____ Last name: _____

Address: _____ City: _____State: _____ Zip code: _____

Best Phone: _____ Email: _____

Date of birth: _____ Height: _____ Profession: _____

How did you find us? ☐ Google ☐ Facebook ☐ Instagram ☐ OBH Client _____ ☐ Other: _____

Do you exercise: ☐ Daily ☐ Weekly ☐ Never ☐ Other : _____

On a scale of 1 to 10, indicate the level of importance you give to losing weight:

Not important 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Very important

Please list any physicians you currently see and their specialty:
Dr. _____ Specialty: _____
Patient Since: _____ Last Visit: _____
Dr. _____ Specialty: _____
Patient Since: _____ Last Visit: _____

Please check ☑ if you presently have or have had any of the following conditions or circumstances:

☐ Severe Liver Disease
☐ Severe Kidney Disease
☐ Diagnosis of Parkinson's
☐ Currently on Lithium Therapy
☐ Heart Attack within 6 Months
☐ Currently Undergoing Cancer Treatment
☐ Strict Vegan Lifestyle
☐ Currently Pregnant
☐ Alzheimer's Disease
☐ None of These Conditions Apply

☐ Arrhythmia (Abnormal Heart Rhythm)
☐ Kidney Disease
☐ Kidney Transplant
☐ Coronary Artery Disease
☐ Heart Valve Problem
☐ Epilepsy -seizure w/in 1 year
☐ Blood Clot-Taking Blood Thinner
☐ Hyperkalemia (High Potassium Level)
☐ Pulmonary Embolism- Taking Blood Thinner
☐ Currently on a Sodium-Glucose Co-Transporter inhibitor (SGLT-2)
☐ Stroke or Transient Ischemic Attack (TIA)
☐ History of Congestive Heart Failure
☐ Child Under Age 17
☐ Gastric Ulcer
☐ Heart Valve Replacement
☐ History of Heart Attack w/in 1 year
☐ Hypokalemia (Low Potassium Level)
☐ History of Cancer:
  ☐ 5 Years or Less
  ☐ More than 5 years
☐ None of These Conditions Apply

Do you have a surgery within the next month? ☐ Yes ☐ No
Do you have a vacation scheduled within the next month? ☐ Yes ☐ No

List ALL medications (prescription and OTC) and supplements you currently take, as well as any recent vaccines.

Name:_____ Dose: _____

Name:_____ Dose: _____

Name:_____ Dose: _____

Name:_____ Dose: _____

Name:_____ Dose: _____

Name:_____ Dose: _____

Name:_____ Dose: _____

Name:_____ Dose: _____

Name:_____ Dose: _____

Name:_____ Dose: _____

Name:_____ Dose: _____

Name:_____ Dose: _____

Name:_____ Dose: _____

Name:_____ Dose: _____

Name:_____ Dose: _____

Name:_____ Dose: _____

Name:_____ Dose: _____

Name:_____ Dose: _____

Name:_____ Dose: _____

Name:_____ Dose: _____

Semaglutide/Tirzepatide Informed Consent Form

Semaglutide is a human-based glucagon-like peptide-1 receptor agonist prescribed as an adjunct to a reduced calorie diet and increased physical activity for chronic weight management in adults with an initial body mass index (BMI) that is considered outside a healthy range.

While using Semaglutide or Tirzepatide it is highly recommended that you:

- Eat a fibrous diet. Focus on fruits and vegetables that are high in fiber
- Eat small high protein meals as digestion is slowed down while on this medication
- Avoid foods high in fat as they take longer to digest
- Limit alcohol intake as this medication can lower blood pressure
- Drink at least 32oz of water a day to avoid constipation, and 64oz is optimal

Do any of the following apply?

Yes	No	
☐	☐	Personal or family history of medullary thyroid carcinoma (Thyroid Cancer)
☐	☐	Multiple Endocrine Neoplasia syndrome type 2
☐	☐	Pregnant or plan to become pregnant while taking this medicine
☐	☐	Diabetic and/or taking any medications related to lowering your blood sugar - Specifically, if you are prescribed Insulin because the combination may increase your risk of hypoglycemia (low blood sugar) and dosage adjustments by your provider may be necessary.
☐	☐	History of Pancreatitis
☐	☐	You are allergic to Vitamin B12, BPC-157, Semaglutide or any other GLP-1 agonist such as: Adlyxin®, Byetta®, Bydureon®, Ozempic®, Rybelsus®, Trulicity®, Victoza®, Wegovy®;

List ALL Allergies: _____

_____

_____

Possible drug interactions: Anti-diabetic agents, specifically: Insulin and Sulfonylureas (e.g., g lyburide, glipizide, gl imepiride, tolbutamide) due to the increased risk of hypoglycemia (low blood sugar). Do not take with other GLP-1 agonist medicines such as: Adlyxin®, Byetta®, Bydureon®, Ozempic®, Rybelsus®, Trulicity®, Victoza®, Wegovy® (THIS IS NOT AN ALL-INCLUSIVE LIST). Other medications used in diabetes, please tell your provider about any medications that may lower your blood sugar.

Possible side effects: Nausea, diarrhea, vomiting, constipation, abdominal pain, headache, fatigue, dyspepsia, dizziness, abdominal distension, belching, hypoglycemia, flatulence, gastroenteritis, and gastroesophageal reflux disease. Subcutaneous Injections: common injection site reactions characterized by itching, burning at site of administration with or without thickening of the skin(welting). If you notice other side effects not listed above, contact your doctor or pharmacist.

A very serious allergic reaction to this drug is rare. However, get medical help right away if you notice any symptoms of a serious allergic reaction, including rash, itching/swelling (especially of the face/tongue/throat), severe dizziness, trouble breathing. Report adverse side effects to your doctor or pharmacist. In the event of any emergency, call 911 immediately.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THIS TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT, SPEAK WITH YOUR PRACTITIONER BEFORE BEGINNING YOUR TREATMENT.

By signing, I certify that I have read and understand the contents of this form. I am aware of the possible side effects and drug interactions. I have informed the medical staff of any known allergies to drugs or other substances, and any past adverse reactions I've experienced. I have informed the medical staff of all medications and supplements I'm currently taking. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and acknowledge that no guarantees have been made to me concerning my results. If I choose to proceed, I give my consent for treatment.

Printed Name:_____ Date of Birth: _____

Patient Signature: _____ Date Signed: _____

Consent to Use or Disclose Health Information
(HIPAA Disclosure)

I authorize **Optimal BioHealth** to use and disclose the health and medical information of for the purposes of Treatment, Payment and Health Care Operations including communication via email, phone, and text message. I understand I may opt-out of individual forms of communication in writing.*

***Treatment** includes activities performed by a health care provider, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician.

***Payment** includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

***Health Care Operations** includes the necessary administrative and business functions of our office.

You may review Optimal BioHealth's "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that Optimal BioHeal has already used or disclosed the information in reliance on this Consent, I understand health care providers generally may not condition treatment on the provision of the authorization. This consent expires one year from termination of care unless otherwise revoked.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

FEMALE HEALTH ASSESSMENT QUESTIONNAIRE

NAME: _____ EMAIL: _____

TODAY'S DATE: _____ PHONE: _____

Please mark the appropriate box for each symptom you may be experiencing.

SYMPTOMS	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
Physical Exhaustion (fatigue, lack of energy, stamina or motivation)	☐	☐	☐	☐	☐
Sleep Problems (difficulty falling asleep or sleeping through the night)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous)	☐	☐	☐	☐	☐
Decline in drive or interest (loss of "zest for life," feeling down or sad)	☐	☐	☐	☐	☐
Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
Difficulties with memory (concentration, finding the right word, or retaining information)	☐	☐	☐	☐	☐
Vaginal dryness or difficulty with sexual intercourse	☐	☐	☐	☐	☐
Sexual Problems (change in desire, activity, orgasm and/or satisfaction)	☐	☐	☐	☐	☐
Sweating (night sweats or increased episodes of sweating)	☐	☐	☐	☐	☐
Hot Flashes (burst that starts in chest and lasts for short duration)	☐	☐	☐	☐	☐
Hair loss, thinning or change in texture of hair	☐	☐	☐	☐	☐
Feeling cold all the time, having cold hands or feet	☐	☐	☐	☐	☐
Headaches or migraines (increase in frequency or intensity)	☐	☐	☐	☐	☐
Weight (difficulty losing weight despite diet/exercise)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	☐	☐	☐	☐	☐

Other symptoms or unique health circumstances to take into consideration: