NAME DATE

WELLNESS/PEPTIDE FOLLOWUP

GLP-1 RA INTAKE FORM

1) Since your last visit, have there been any changes to your medical history? ☐ NO ☐ YES, please advise:

_____

_____

_____

2) Are you having any of the following symptonms? ☐ NO ☐ YES, please check all that apply:

☐ Nausea ☐ Vomiting ☐ Trouble swallowing ☐ Diarrhea

☐ Abdominal Pain ☐ Hoarseness ☐ Constipation ☐ Shortness of Breath

☐ Heartburn ☐ Lump or swelling in the neck

3) Are you experiencing any other symptoms, or any concerns related to this treatment that you need addressed by the Practitioner? ☐ NO ☐ YES, please advise:

_____

_____

_____

----- FOR OFFICE USE ONLY -----

Dosing Changes: _____

_____

Current Dose of Medication: _____

Notes: _____

_____

_____

_____

Next Visit: _____