

BARBER

Facial Plastic Surgery

Injectable Peptide & GLP-1 Therapy – Intake Form

Patient Information

Name: _____ DOB: _____

Phone: _____ Email: _____

Height: _____ Weight: _____

Primary Care Provider: _____

PROGRAM INTEREST

- Injectable Peptide Therapy
- GLP-1 Weight Management
- Combination Program

Primary reason for treatment (check all that apply):

- Regenerative Aesthetics: Collagen stimulation / Skin quality / Hair restoration
- Post-procedure recovery
- Body composition: Weight loss / appetite control
- Other: _____

Briefly describe your goals:

CURRENT MEDICATIONS & REGIMEN

Are you currently using any of the following?

- GLP-1 medication
- Peptides
- Supplements only
- Weight loss medications
- Hormone therapy
- None

List current medications / supplements:

MEDICAL HISTORY (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Diabetes / Prediabetes | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Thyroid cancer or nodules | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> GERD / gastroparesis | <input type="checkbox"/> Depression / anxiety |
| <input type="checkbox"/> Cancer (type): _____ | <input type="checkbox"/> Other: _____ |
-

GLP-1 & PEPTIDE SAFETY SCREEN

Have you ever had:

Pancreatitis? Yes No

Medullary thyroid carcinoma (personal or family)? Yes No

MEN2 syndrome? Yes No

Are you pregnant, trying to conceive, or breastfeeding? Yes No

Do you have severe GI disease or delayed stomach emptying? Yes No

ALLERGIES

Medication allergies: _____

PATIENT ACKNOWLEDGMENT

_____ I understand this is a medically supervised injectable therapy program.

_____ I understand results vary and require adherence and follow-up.

_____ I confirm the information provided is accurate and complete.

Patient Signature: _____ Date: _____

PROVIDER USE ONLY

Vitals: BP _____ HR _____ Weight _____

Candidate for therapy: Yes No

Program / Medication recommended:

Provider Signature: _____ Date: _____