For Doctor Use Only **Subq Weekly** **Lipotropic .25ml Semaglutide .25mg Tirzepatide 1.25mg Glutathione .1ml** **LIPOX 0.5mL Testosterone 0.05mL TREATMENTS: Cavitation /Verdant Laser**

Date of Visit:

Blood pressure: Temp.

Pre-Screening Form

Patient Information

First Name: _____ **Last Name:** _____ **Suffix:**____

DOB: _____/_____/_____ **Age:** _____ **Sex:**_____ **Phone:**_____-_____-_____

Height:_____ **ft.** _____ **in. Weight:** ____ **lbs. Preferred Pharmacy:** _____

Home Address: _____

Past Medical History (Circle Y or N and explain below)

Do you drink alcohol:	Y	N	COPD:	Y	N	Renal Disease:	Y	N
Angina:	Y	N	Diabetes:	Y	N	Gastrointestinal issues:	Y	N
Arrhythmia	Y	N	Heart Attack:	Y	N	Seizures:	Y	N
Arthritis:	Y	N	Thyroid cancer: Medullary/papillary	Y	N	Smoker/Vaper:	Y	N
Asthma:	Y	N	Hypertension:	Y	N	Stroke History:	Y	N
Blood Disorder:	Y	N	Murmur:	Y	N	Use of weight loss medications:	Y	N
Cancer:	Y	N	Pre-Diabetic:	Y	N	Transfusions:	Y	N
Congestive Heart Fail:	Y	N	Pregnant:	Y	N	Ulcers:	Y	N

Surgical History (Past 5 years): _____

_____

_____

List Medications and Dosages: _____

_____

_____

Allergies: _____

Family History Of: _____

How did you hear about us?: _____