

ELECTIVE WEIGHT LOSS™ —INTAKE FORM

Name: Date:

Height: Weight:

High weight as an adult: Low weight as an adult (pre/post college):

Target weight:

Have you tried to lose weight and not succeeded? Yes No

Do you or anyone in your family have medullary thyroid cancer or MEN (multiple endocrine neoplasia) syndrome? Yes No

Are you taking any medication to lower your blood sugar? Yes No

Are you taking oral contraceptives? Yes No

Are you pregnant? Yes No

If so, I recommend additional protection while taking semaglutide.

Do you have a history of an eating disorder? Yes No

How many hours per night do you sleep?

How many alcoholic beverages do you consume per week?

Do you have a history of depression? Yes No

Are you taking a SSRI (selective serotonin reuptake inhibitor)? Yes No

Common ones are: Celexa, Lexapro, Prozac, Paxil, Zoloft

I agree not to share my vial of medication with anyone else. The medication is solely prescribed to me.

I agree to report photographic evidence of my weight prior to starting the medication and at 6 weeks, 4 months, and one year later.

I agree: If you are eating 800 calories a day or less you agree to supplement your diet with a basic supplement multivitamin and 20 grams of protein.

I have watched the 6 informational videos on www.sharongiesemd.com and have read the informational brochure.

Most common side effects of semaglutide are nausea, vomiting, abdominal pain, diarrhea, and constipation. Serious side effects can include pancreatitis, changes in vision, low blood sugar, allergic reactions, gallbladder problems and/or stomach paralysis.

I understand it is a tool to suppress my appetite. No Guarantees; Disclaimer. I understand that Dr. Giese is not guaranteeing the effectiveness of this medication which may be subject to external factors outside of Dr. Giese's control. Dr. Giese specifically and additionally disclaims any warranties or guarantees that this medication will result in weight loss and I release Dr. Giese from any claims resulting from this treatment. Further, I assume all risk by my election to undertake this elective medication under the supervision of Dr. Giese's office. I also understand there are no refunds.

Signature:

