Sharon Giese MD, PC — (212) 421-3400 — info@sharongiesemd.com

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 multivitamn and 20 grams of protein.

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

☐ 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: _____

Sharon Giese MD, PC — (212) 421-3400 — info@sharongiesemd.com

Body Parts Satisfaction Scale

Directions: Below is a list of body parts. Please rate how satisfied you are, **at this moment,** with each body part according to the following scale. Remember, it is **very important** that you respond to all the items and that you answer them **honestly** as they apply to you. All of the information you provide will be kept **strictly confidential**.

	Extremely Dissatisfied	1	2	3	4	5	6	Extremely Satisfied
1. Height		☐	☐	☐	☐	☐	☐	
2. Weight		☐	☐	☐	☐	☐	☐	
3. Hair		☐	☐	☐	☐	☐	☐	
4. Complexion		☐	☐	☐	☐	☐	☐	
5. Overall face		☐	☐	☐	☐	☐	☐	
6. Shoulders		☐	☐	☐	☐	☐	☐	
7. Arms		☐	☐	☐	☐	☐	☐	
8. Stomach		☐	☐	☐	☐	☐	☐	
9. Chest		☐	☐	☐	☐	☐	☐	
10. Back		☐	☐	☐	☐	☐	☐	
11. Buttocks		☐	☐	☐	☐	☐	☐	
12. Legs		☐	☐	☐	☐	☐	☐	
13. Lower legs (calves)		☐	☐	☐	☐	☐	☐	
14. General muscle tone		☐	☐	☐	☐	☐	☐	
15. Overall satisfaction with size and shape of body		☐	☐	☐	☐	☐	☐	