METABOLIC PEPTIDE THERAPY INTAKE & CONTRAINDICATION SCREENING FORM

(GLP-Based / Incretin-Based Therapies)

Patient Name:

Date of Birth:

Date:

Provider:

PURPOSE OF THIS FORM

This screening form helps evaluate whether a metabolic peptide-based therapy may be appropriate based on my individual health history, goals, medications, and risk factors.

I understand that completion of this form does not guarantee treatment approval. Final treatment decisions are made by my healthcare provider based on clinical assessment and individualized medical decision-making.

THERAPY CONSIDERED

☐ GLP-based therapy

☐ GLP/GIP-based therapy

☐ GLP/GIP/Glucagon-based therapy

☐ Other metabolic peptide-based therapy

PATIENT GOALS

What are your primary goals?

☐ Weight management

☐ Metabolic health support

☐ Blood sugar regulation support

☐ Appetite regulation

☐ Body composition goals

☐ Other:

Describe your goals:

CURRENT HEALTH INFORMATION

Height:

Weight:

Recent weight changes:

METABOLIC HEALTH HISTORY

Have you ever been diagnosed with:

☐ Diabetes

☐ Prediabetes

☐ Insulin resistance

☐ Metabolic syndrome

☐ Hypoglycemia episodes

☐ Other metabolic condition

Explain:

MEDICAL HISTORY SCREENING

Please indicate if you have a history of:

☐ Pancreatic disease or concerns

☐ Gallbladder disease or gallstones

☐ Significant gastrointestinal disorders

☐ Severe digestive motility concerns

☐ Kidney disease

☐ Liver disease

☐ Endocrine disorders

☐ Thyroid-related conditions

☐ Hormone-related conditions

☐ Cancer history

☐ Other significant medical condition

Explain:

PREGNANCY / HORMONAL STATUS

Are you:

☐ Pregnant

☐ Planning pregnancy

☐ Breastfeeding

☐ None of the above

MEDICATION REVIEW

Current prescription medications:

Current supplements:

Previous weight management or metabolic therapies:

Allergies or medication reactions:

LIFESTYLE INFORMATION

Nutrition:

Exercise:

Sleep:

Stress:

PATIENT EDUCATION ACKNOWLEDGMENT

I understand:

• Metabolic peptide-based therapies vary in regulatory status, evidence, research, and clinical indications.

• Different therapies may work through different biological pathways.

• My provider will determine whether a specific therapy is appropriate based on my individual health information.

• Potential risks, benefits, and alternatives will be reviewed before treatment.

• Results vary between individuals.

PATIENT SIGNATURE:

Date:

PROVIDER REVIEW:

Contraindications/risk factors reviewed:

☐ Yes

Clinical considerations:

Provider Signature:

Date: