PATIENT REGISTRATION FORM

Date _____

Patient information:

First name _____ Last name _____MI_____

Preferred name _____

Date of Birth _____ Age _____

Address _____

City _____ State _____ZIP _____

Preferred phone _____

Email address _____

Marital Status (circle) Single Married Widowed Divorced Separated

Patient Employment Status:

Employed Y/N _____ Student Y/N _____

Employer Name _____ Occupation _____

Referred By _____

Emergency Contact:

Relative/Friend _____ Phone _____

Relationship _____

Pharmacy Information:

Pharmacy Name _____ Phone _____

May we contact you regarding your protected health information?

Email: yes no Cell phone: yes no Leave Voicemail: yes no

Print Patient Name _____

Signature _____

Health History

Name _____ **Age** _____

Primary Care Provider _____ **Location** _____

Reason for visit _____

_____

_____

_____

All prior surgeries _____

_____

_____

_____

_____

All prior hospitalizations _____

_____

_____

Current Medications _____

_____

_____

_____

_____

Medication allergies with reactions _____

_____

Date of last mammogram _____ Date of last pap _____

Any prior procedures on the breast? _____

History of abnormal paps? _____

Any prior procedures on the cervix _____

Date of last bone density _____ Result _____

Date of last colonoscopy _____ Result _____

Menstrual History:

Age when first period started _____ Number of days between periods _____

Flow (circle) light/medium/heavy Number of days of bleeding _____

Pain with periods (circle) yes/no

Age of menopause, if applicable _____

Pregnancy History:

Total number of pregnancies _____ Number of living children _____

Number of miscarriages _____ Number of abortions _____

Contraception History (including condoms and sterilization):

Current _____

Previous _____

Sexual History:

Have you ever been sexually active? Yes No

Have you been sexually active in the past 3 months? Yes No

Are you sexually active with men, women, or both _____

Have you ever had a sexually transmitted disease _____

If yes, which? (circle) Gonorrhea, Chlamydia, Genital Warts, Genital Herpes, Syphilis, HIV, HPV, Hepatitis

Social History:

Marital Status _____ Name of Spouse/Significant Other _____

Your current occupation _____

Do you exercise regularly? Yes No If yes, type/frequency_____

Do you smoke or use tobacco products? Yes No If yes, type used _____

Amount used _____ Number of years of use _____

If you no longer use tobacco products, what year did you quit? _____

Do you drink alcohol? Yes No If yes, number of drinks per week _____

Do you use recreational drugs? Yes No If yes, what type(s) _____

Do you have any personal or family history of the following:

	YOU	Family		YOU	
Addiction	☐	☐	**High Cholesterol**	☐	☐
Anemia	☐	☐	**Kidney Disease**	☐	☐
Breast/Ovarian Cancer	☐	☐	**Kidney Infections**	☐	☐
Cirrhosis/Liver Disease	☐	☐	**Kidney Stones**	☐	☐
Colon/Pancreatic Cancer	☐	☐	**Lupus/MS**	☐	☐
Depression/Anxiety	☐	☐	**Osteoporosis**	☐	☐
Diabetes	☐	☐	**Seizures/Epilepsy**	☐	☐
DVT/PE	☐	☐	**Stroke**	☐	☐
Endometriosis	☐	☐	**Thyroid Problems**	☐	☐
GI problems/Reflux/IBS	☐	☐	**Transfusions**	☐	☐
Headaches	☐	☐	**Ulcerative Colitis Crohns**	☐	☐
Heart Disease	☐	☐	**Other**	☐	☐
High Blood Pressure	☐	☐	**Eating Disorders**	☐	☐

Worksheet for Weight Loss

Complete this worksheet to gauge where you might want to make simple changes in your life to get to or maintain a healthy weight. Share this with your doctor or other healthcare professional for additional insight or support.

What concerns you about your weight?

Why is now a good time for you to lose weight?

What do you expect will change at a lower body weight?

What steps are you currently taking to manage your weight?

On a scale of 0-5, (0 = not willing, 5 = very willing) how willing are you to change your diet to lose weight?
0 1 2 3 4 5

On a scale of 0-5, (0 = not willing, 5 = very willing) how willing are you to increase your physical activity?
0 1 2 3 4 5

Medical:
List any medical conditions that make weight loss difficult for you:

Weight History:
Previous attempts at weight loss: (check all that apply)
_____Low calorie, low carb, low fat
_____Exercise
_____Commercial self-select plan (Weight Watchers, Healthy Weigh, other)
_____Meal replacement program (Nutrisystem, Jenny Craig, HMR, Slim Fast, other)
_____Supervised weight loss (physician, dietitian, other)
_____Weight loss surgery, _____ year of surgery _____ type of surgery
_____Weight loss medications (prescribed, over the counter) List: _____
_____Other: List _____

What do you think are the causes of your excess weight?

Social:
Who supports your effort to lose weight?
How do they support you?

Who makes weight loss harder for you?

Lifestyle:

How do you spend your time during the day?

Estimate how many hours per day to you spend sitting?
How many hours per day are spent in front of a screen (TV, computer, e-reader)?
How many hours do you usually sleep?
How would you describe your sleep quality? ___ Good ___ Poor

Do you smoke? ___ yes ___ no
Are you interested in resources to quit smoking? ____ yes ____ no

Diet:

Are you currently following a special diet?
__ Diabetic __ Low fat/heart healthy
__ Low sodium __ Gluten-free
__ Vegetarian __ Other (please list)

List all supplements you take:

List all food allergies or intolerances:

Who does the grocery shopping?
Who cooks meals?
Who do you coordinate meals with?
How frequently do you eat meals outside the home? _____ times per week
(Example: fast food, restaurant, take-out, cafeteria)

Food Frequency:

How many meals do you eat per day? ____ 1-2 ___ 2-3 ___ 4-5 ___ 6-7 ____ 8+
How many snacks do you eat per day? ____ 1-2 ___ 2-3 ___ 4-5 ___ 6-7 ____ 8+
Which is your largest meal? __ breakfast __lunch __dinner __ snacks

How many 1 cup servings of vegetables do you eat per day ___ 0-1 ___ 2-3 ___ 4-5 ___6+
How many 1 cup or 1-piece servings of fruit do you eat per day ___ 0-1 ___ 2-3 ___ 4-5 ___6+
How many 1 cup servings of dairy to you eat per day ___ 0-1 ___ 2-3 ___ 4-5 ___6+
How many times per **day** do you eat whole grains ___ 0-1 ___ 2-3 ___ 4-5 ___6+
How many times per **week** do you eat red meat ___ 0-1 ___ 2-3 ___ 4-5 ___6+
How many times per **week** do you eat sweets ___ 0-1 ___ 2-3 ___ 4-5 ___6+
How many times per **week** do you eat snack foods ___ 0-1 ___ 2-3 ___ 4-5 ___6+

Usual beverages: (check all that apply)
___ water ___soda
___ diet beverages ___ juice / sweetened beverages
___ coffee ___ milk
___ tea ___ other
___ energy drinks
Alcohol consumption: ____ drinks per day / week / month / year
I usually eat/drink too much _____
I don't eat/drink enough _____

Physical Activity

Physical activity is defined as moving your body through space. This includes lifestyle activity. *Exercise* is planned activity that is in addition to your usual daily activities of living.

In what ways are you physically active? (check all that apply)

___ shopping
___ housekeeping
___ gardening / yard work
___ pet walking
___ other (please list)

What types of exercise do you do? (check all that apply)

___ walk
___ cycle
___ elliptical / other cardio
___ physical therapy exercises
___ weights or resistance exercise
___ chair exercise
___ fitness classes or videos
___ yoga / tai chi / stretching
___ swimming or pool exercise

How frequently do you exercise? ____ hours ____ minutes per week

How would you rate the level of intensity of your exercise?

0	1	2	3	4	5	6	7	8	9	10
Nothing		Very light			Light		Moderate		Hard	Very hard

What prevents you from exercising?

___ pain
___ time
___ disliking it
___ not motivated
___ fatigue
___ not sure how to exercise
___ other:

_____

_____

Goal Setting

What is one dietary change you would be willing to make to promote weight loss?

What is one physical activity improvement you would be willing to make?

Semaglutide/cyanocabalamin
Price list

Our weight loss program fee is a **$75/monthly subscription** due the first of each month. We will keep a credit card on file. You can cancel at any time. No refunds will be given. We do not accept back opened medication vials. Weight loss visits can be conducted monthly, or more frequently as needed, in the office or via telehealth for your convenience. Please call our office to schedule those appointments (615) 790-4140.

Prior to starting your medication and every 3 months during therapy, you will need to have blood work drawn at a local lab, our office, or another provider. Your lab bill will be processed through your insurance. We will monitor the following values:

Initial lab work
CMP
Hemoglobin A1C
Vitamin D
Fasting lipid panel
B12
Magnesium
TSH

Quarterly lab work
CMP
Any follow up labs as needed

Medication is $400/2.5mL vial (250 units). Titration schedule is as follows:
lower concentration (1mg/0.5mL). One 2.5mL vial will last 7 weeks
0.25mg (25 units) weekly x 4 weeks. If side effects allow then
0.5 mg (50 units) weekly x 3 weeks. If side effects allow then

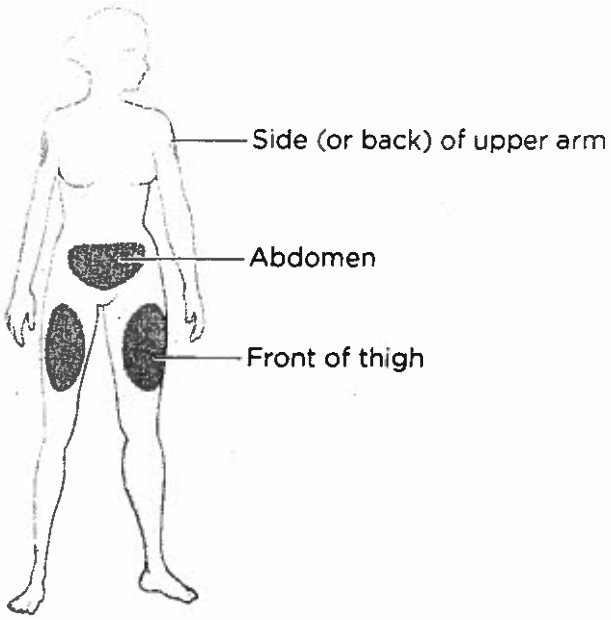
Higher concentration (5mg/0.5mL) in a 2.5mL vial (250 units). Once you achieve 2.4mg weekly injections, one vial will last you 10 weekly doses (<$200/month)
1mg (10 units) weekly x 4 weeks. If side effects allow then
1.7mg (17 units) weekly x 4 weeks. If side effects allow then
2.4mg (24 units) weekly ongoing.

If you would like for our office to send you prefilled syringes, please let us know. Our fee is $100/prefilled syringe.

You will be supplied the appropriate syringes to use. You can dispose of used syringes in a plastic bottle and discard as needed at your local pharmacy.

Due to high demand and limited supply, our pharmacy has recommends each client stays ahead of their supply by a month to avoid interruption in therapy. Refrigeration is during shipping is not necessary. However, upon arrival, your medication will need to be **stored in the refrigerator** for longterm stability.

Semaglutide



Semaglutide is a weekly injectable medication that may help adults with a BMI >/= 27 lose weight and keep it off when used **in combination of a reduced calorie meal plan and regular exercise.**

The most common side effects include nausea, diarrhea, vomiting, constipation, stomach pain, headache, fatigue, dizziness, feeling bloated, gas, heartburn, runny nose, or sore throat.

More serious side effects include pancreatitis, gallbladder problems, hypoglycemia and vision changes (particularly with diabetes), kidney failure, anaphylaxis, possible thyroid tumors including cancer, increased heart rate, and depression.

Do not use semaglutide if you have a personal or family history of thyroid cancer, particularly Medullary Thyroid Carcinoma or if you have a personal history Multiple Endocrine Neoplasia Syndrome type 2 (MEN 2). **Before using semaglutide, please tell your provider if you have any problems with your pancreas or kidneys, history of diabetic retinopathy, depression or other mental health issues, pregnant or plan to become pregnant, or breastfeeding.**

Due to high demand and a national shortage, our pharmacy has advised our patients have a month of medication on hand to avoid interruption in therapy. Please let us know when you have a month of medication remaining and we will place an order on your behalf.

We recommend at least once monthly visits to our office or via telehealth to monitor your progress. However, we are here to support you in your weight loss journey. If you need to check in more often, no problem. Either way, please call our office (615-790-4140) to schedule an appointment.

If my health status or medication regimen changes, I will notified my provider at Naomi Paschall, MD. I consent to using semaglutide to aid in my weight loss efforts.

_____ _____

signature date

_____

printed name

Recurring Payment Authorization Form

Naomi Paschall, MD

Julie Park, APRN

Schedule your payment to be automatically deducted from your bank account, or charged to your Visa, MasterCard, American Express or Discover Card.

Here's How Recurring Payments Work:
You authorize regularly scheduled charges to your checking/savings account or credit card. You will be charged the amount indicated below each billing period. A receipt for each payment will be emailed to you and the charge will appear on your bank statement as an "ACH Debit." You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

Please complete the information below:

I authorize Naomi Paschall, MD PC to auto draft $_____ on the first day of each month for my subscription to the weight loss program.

Billing Address_____ City, State, Zip_____

Phone number _____

_____ _____

Signature Date

_____

Printed Name

Tirzepatide Price list

Our weight loss program fee is a **$75/monthly subscription** due the first of each month. We will keep a credit card on file. You can cancel at any time. No refunds will be given. We do not accept back opened medication vials or unused syringes. Weight loss visits can be conducted monthly, or more frequently as needed, in the office or via telehealth for your convenience. The cost of shipping the medication to your home is included in your monthly subscription. Please call our office to schedule those appointments (615) 790-4140.

Prior to starting your medication and every 3 months during therapy, you will need to have blood work drawn at a local lab, our office, or another provider. Your lab bill will be processed through your insurance. We will monitor the following values:

Initial lab work
CMP
Hemoglobin A1C
Vitamin D
Fasting lipid panel
B12
Magnesium
TSH

Quarterly lab work
CMP
Any follow up labs as needed

Cost of medication is dose dependent. Dose changes are made every 4 weeks as side effects allow. Your medication will be provided in syringes drawn up and labeled by our office, 4 weeks at a time.
2.5mg once weekly x 4 syringes = $250
5mg once weekly x 4 syringes = $300
7.5mg once weekly x 4 syringes = $350
10mg once weekly x 4 syringes = $400
12.5mg once weekly x 4 syringes = $450
15mg once weekly x 4 syringes = $500

You can dispose of used syringes in a plastic bottle and discard as needed at your local pharmacy. Or visit www.bd.com to order a sharps disposal container delivered to your home with mail order return service.

Due to high demand and limited supply, our pharmacy has recommends each client stays ahead of their supply by a month to avoid interruption in therapy. Refrigeration is during shipping is not necessary. However, upon arrival, your medication will need to be **stored in the refrigerator** for longterm stability.

Tirzepatide

Tirzepatide is a weekly injectable medication created to help patient with Type 2 diabetes gain better control over their blood sugars. While tirzepatide has helped people lose a significant amount of weight, it has not been FDA approved for weight loss yet. Many people are using it off label to lose weight and keep it off when used **in combination of a reduced calorie meal plan and regular exercise**.

The most common side effects include nausea, diarrhea, vomiting, constipation, stomach pain, headache, fatigue, dizziness, feeling bloated, gas, heartburn, runny nose, or sore throat.

More serious side effects include pancreatitis, gallbladder problems, hypoglycemia and vision changes (particularly with diabetes), kidney failure, anaphylaxis, possible thyroid tumors including cancer, increased heart rate, and depression.

Do not use Tirzepatide if you have a personal or family history of thyroid cancer, particularly Medullary Thyroid Carcinoma or if you have a personal history Multiple Endocrine Neoplasia Syndrome type 2 (MEN 2). **Before using Tirzepatide, please tell your provider if you have any problems with your pancreas or kidneys, history of diabetic retinopathy, depression or other mental health issues, pregnant or plan to become pregnant, or breastfeeding.**

Due to high demand and a national shortage, our pharmacy has advised our patients have a month of medication on hand to avoid interruption in therapy. Please let us know when you have a month of medication remaining and we will place an order on your behalf.

We recommend at least once monthly visits to our office or via telehealth to monitor your progress. However, we are here to support you in your weight loss journey. If you need to check in more often, no problem. Either way, please call our office (615-790-4140) to schedule an appointment.

If my health status or medication regimen changes, I will notified my provider at Naomi Paschall, MD. I consent to using Tirzepatide to aid in my weight loss efforts.

_____ _____

signature date

_____

printed name