YOUR HEALTH, OUR PRIORITY

At our health care clinic we want to provide the best care possible to our patients. We are always actively looking for ways to make our patients more comfortable, happier and live their lives to the fullest.

Our team of qualified medical providers have over 20 years of experience over a wide range of subjects. Your health is our biggest priority so we are constantly researching new methods to provide you with better care.

1728 Tower Ave
Superior WI 54880
(715)395-0928
twinportshealth.com

TWIN PORTS WELLNESS + AESTHETICS

1728 Tower Avenue Superior, WI 54880

PATIENT INTAKE FORM

Name _____ Date _____

Date of Birth _____ Age _____ Gender _____

Address _____

City _____ State _____ Zip Code _____

Email Address _____ Phone No _____

Emergency Contact _____ Phone No _____

How did you hear about us? _____

Do you consent to receive labs and other information via email (unsecured, not HIPPA protected)? ☐ NO ☐ Yes

MEDICAL HISTORY

Are you allergic to any of the following? ☐ GLP-1 Receptor Agonists ☐ Sodium Phosphate

☐ Adhesives/latex ☐ Lidocain/xylocain ☐ Iodine/Betadine ☐ Benzoin

☐ Other allergens: (Please list allergen and reaction):

_____

Are you currently taking blood thinners (i.e., Aspirin/Warfarin), Bexarotene, Gatifloxacin, or any Diabetes medication (i.e. Insulin or sulfonylureas)? ☐ NO ☐ Yes

Have you ever been diagnosed with cancer? ☐ NO ☐ Yes

Type(s): _____

Date of last Mammogram? _____ Abnormal Findings or Follow up? ☐ No ☐ Yes:

_____

Have you had a colonoscopy? ☐ No ☐ Yes: Date of last colonoscopy? _____

Abnormal Findings or Follow up?

_____

Have you had surgery in the past year? ☐ No ☐ Yes: _____

_____

Have you or a family member been diagnosed with either of the following? ☐ No ☐ Yes:

☐ Multiple Endocrine Neoplasia Syndrome Type 2 (MEN2) ☐ Medullary Thyroid Carcinoma

_____

Date of last physical: _____ Primary Care Provider: _____

Relevant results:

_____

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PATIENT INTAKE FORM

MEDICAL HISTORY

Please select any relevant conditions below:

- ☐ Adrenal disorder
- ☐ Alopecia (hair loss)
- ☐ Anemia
- ☐ Angina
- ☐ Angioedema
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Autoimmune Disease
- ☐ Breast Cancer
- ☐ Cardiovascular Disease
- ☐ Congestive Heart Failure
- ☐ COPD (chronic obstructive pulmonary disease)
- ☐ Deep vein thrombosis (DVT)
- ☐ Depression/Anxiety
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Epilepsy/seizures
- ☐ Endocarditis
- ☐ Gastric/duodenum ulcer
- ☐ Heart failure/valve disease
- ☐ Hemochromatosis
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Hypotension (low BP)
- ☐ Hypertension (elevated BP)
- ☐ Hyperthyroidism (overactive thyroid)
- ☐ Hypothyroidism (underactive thyroid)
- ☐ IBD/IBS
- ☐ Kidney disease
- ☐ Lupus
- ☐ Liver Disease: what type(s):
- ☐ MI / Heart Attack
- ☐ Osteoporosis
- ☐ Pancreatitis
- ☐ Parathyroid disorder
- ☐ PCOS
- ☐ Psychiatric Disorder
- ☐ Pulmonary Embolism
- ☐ Renal failure
- ☐ Sleep Apnea
- ☐ Suicidal Ideation
- ☐ Substance abuse
- ☐ Stroke

Details or any other condition:

HEALTH HABITS

Do you smoke? ☐ No ☐ Yes How many per day? ☐ How long? ☐ Years

Do you drink alcohol on a regular basis? ☐ No ☐ Yes Weekly units ☐

Do you drink caffeine? ☐ No ☐ Yes How much per day: ☐

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REVIEW OF SYSTEMS

Eyes

Do you have glaucoma?	Yes	No
Do you have retinopathy? (diabetes-related eye disease)	Yes	No
Do you have blurry vision?	Yes	No

Neurologic

Do you have tingling in your hands or feet?	Yes	No
Do you have hand tremor, or does your hand shake when you hold it out?	Yes	No
Have you ever had migraine headaches?	Yes	No
Do you take medication to prevent migraine headaches?	Yes	No
Have you ever had a seizure?	Yes	No
Have you ever had a stroke or TIA (transient ischemic attack)?	Yes	No

Respiratory

Do you snore?	Yes	No
Have you ever been diagnosed with sleep apnea?	Yes	No
Do you get short of breath when walking?	Yes	No
Do you wheeze?	Yes	No

Cardiac

Have you been diagnosed with angina?	Yes	No
Have you ever had a heart attack?	Yes	No
Have you ever been diagnosed with an arrhythmia (irregular heartbeat)?	Yes	No
Have you ever been told you have a heart murmur?	Yes	No
Do you get short of breath when lying down flat?	Yes	No
Do your feet swell?	Yes	No
Do you ever have palpitations? (racing heart)	Yes	No
Do you ever have chest pain?	Yes	No
Do you take medication for high cholesterol?	Yes	No
Do you take medication for high blood pressure?	Yes	No

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REVIEW OF SYSTEMS

Gastrointestinal

Have you been diagnosed with GERD (gastroesophageal reflux disease?	Yes	No
Do you ever have heartburn?	Yes	No
Have you had gallstones?	Yes	No
Have you had your gallbladder removed (choleysystectomy)?	Yes	No
Have you ever been diagnosed with pancreatitis?	Yes	No
Do you have abdominal pain?	Yes	No
Have you had part of your intestine removed?	Yes	No
Have you been diagnosed with gastroparesis?	Yes	No
Do you frequently have diarrhea?	Yes	No
Do you frequently have nausea?	Yes	No
Do you vomit frequently?	Yes	No

Nephrology

Do you have a history of kidney stones?	Yes	No
Do you have trouble holding your urine?	Yes	No
Do you experience excessive urination?	Yes	No
At night do you wake up to urinate?	Yes	No
Do you ever have blood in your urine?	Yes	No

Musculoskeletal

Do you have a history of arthritis?	Yes	No
Do you have pain in your knees?	Yes	No
Do you have pain in your hips?	Yes	No
Do you have chronic back pain?	Yes	No
Do you have trouble walking or exercising due to joint pain?	Yes	No
Do you take medication for joint or back pain?	Yes	No
Have you had a joint replacement (ex. hip or knee surgery)?	Yes	No

TWIN PORTS WELLNESS + AESTHETICS

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REVIEW OF SYSTEMS

Endocrine

Have you been told that you have prediabetes?	Yes	No
Do you have dry mouth?	Yes	No
Do you have excessive thirst?	Yes	No
Are you planning to have children within the next year?	Yes	No
Have you been diagnosed with infertility or been told you're infertile?	Yes	No
Do you have low sex drive?	Yes	No

Woman

Do you have acne?	Yes	No
Do you have increased facial hair?	Yes	No
Do you have irregular periods?	Yes	No
Do you have breast pain or have fibrocystic breast disease?	Yes	No

Men

Have you been diagnosed with low testosterone (low-T)?	Yes	No
Have you been diagnosed with erectile dysfunction?	Yes	No

Psychiatric

Have you been diagnosed with anxiety?	Yes	No
Have you been diagnosed with depression?	Yes	No
Have you ever been diagnosed with ADD/ADHD?	Yes	No
Have you ever been diagnosed with bipolar disorder?	Yes	No
Do you have trouble sleeping?	Yes	No
Do you drink more than 2 alcoholic beverages per day?	Yes	No
Do you take pain medication or opiates on a regular basis?	Yes	No
Do you have memory problems?	Yes	No
Do you take medication for depression or anxiety?	Yes	No

WEIGHT HISTORY

Height: **Current Weight:** **BMI:**

How old were you when you first became more than 20 lbs overweight?

Were you overweight as a child? No Yes

What was your highest lifetime weight? What was your Highschool weight?

What factors do you consider contribute to your experience of excess weight?

- Low energy
- Sedentary lifestyle
- Hormonal changes
- Medical condition
- Sleep disruptions
- Alcohol
- Pregnancy
- Stress/busy lifestyle
- Excess calories
- Perimenopause
- Other: _____
- Family history

Have any of your close relatives been overweight or had obesity (check all that apply):

Mother Father Siblings

During the last 3 months, did you have any episodes of excessive overeating?
(i.e., eating significantly more than what most people would eat in a similar period of time).

Yes No If yes, about how many times?

Do you sometimes make yourself vomit as a means to control your weight? Yes No

Have you ever been diagnosed with (check all that apply): Bulimia Anorexia Binge eating disorder No

Do you feel distressed about episodes of overeating? Yes No

Do you often feel like you have no control over your eating or cannot stop? Yes No

Are you often embarrassed by how much you eat? Yes No

Do you feel disgusted with yourself for overeating, or do you feel guilty for overindulging? Yes No

Do you avoid social interaction because of your weight? Yes No

Does being overweight cause you to feel depressed? Yes No

WEIGHT HISTORY

Have you ever been treated by a doctor for your weight? Yes No

When? Successful? Yes No How much weight did you loose?

Have you participated in a weight loss program? Yes No

Please indicate which of the following weight loss programs you have tried:

Jenny Craig Weight Watchers Diet Exercise Therapy

Optavia Nutri-system Herbal Supplements Other:

Please indicate which of the following medications you have tried for weight loss:

Phentermine Belviq (lorcaserin) Contrave(naltrexone/bupropion)

Xenical (orlistat) Topamax (topiramate) Saxenda (liraglutide) for weightloss

Other: _____ Victoza (liraglutide) for DM2

Have you ever consulted with a registered dietitian? Yes No

Have you ever had bariatric surgery? Yes No

Have you ever consulted a surgeon regarding bariatric surgery? Yes No

What are your main motivations and concerns for wanting to lose weight with a GLP-1 RA/GIP (Semaglutide/Tirzepatide) medication?

_____

_____

What is your goal Weight? Short term: Long term:

How do you plan to achieve your weight loss goals? (action steps or lifestyle modification):

_____

_____

_____

_____

Please list any specific concerns or questions you want to discuss with provider:

_____

_____

_____

_____

Female Medical History

Have you completed your family?: ☐ Yes ☐ No

Date last menses: _____ Pregnancies: _____ Live births: _____

Are you currently: ☐ Pregnant ☐ Trying to conceive ☐ Breastfeeding ☐ Post-menopause

Are you sexually active? ☐ Yes ☐ No Do you have issues with low sex drive? ☐ Yes ☐ No

Currently using contraceptives: ☐ Yes ☐ No Contraceptive Name: _____

Birth control method: Check below or specify type/method: _____

☐ Menopause ☐ Hysterectomy ☐ Birth Control Pills ☐ Condoms

☐ Ablation ☐ Nuva Ring ☐ Hormonal Implant ☐ Hormonal Injections

☐ IUD ☐ Tubal Ligation ☐ Vasectomy ☐ Infertility

☐ Other: _____

Dates & other info (i.e. initiation of pills, IUD placement, ablation, menopause, ect.):

Please select any relevant conditions below:

- ☐ Uterine Cancer
- ☐ Uterine fibroids
- ☐ Endometriosis
- ☐ Polycystic Ovaries /PCOS
- ☐ Ophorectomy (removal of ovaries only)
- ☐ History of seizure/epilepsy
- ☐ Fibrocystic Breast
- ☐ Hysterectomy (total) ovaries & uterus
- ☐ Hysterectomy (partial)Uterus only
- ☐ Menstral Migraines
- ☐ Ovarian Cancer
- ☐ Heavy Cycles
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Uterine Ablation (when/why?)
- ☐ Loss of Scalp Hair
- ☐ Hot Flashes
- ☐ Breast Cancer
- ☐ Water weight
- ☐ Fibromyalgia
- ☐

Do you take hormones of any kind? ☐ No ☐ Yes: if so, list (include birth control, HRT, natural hormones):

_____

_____

Past BHRT pellet Therapy? ☐ No ☐ Yes: Date/Dose of last pellets?

_____

_____

Male Medical History

Have you completed your family?: ☐ Yes ☐ No **Are you sexually active?** ☐ Yes ☐ No

☐ I want to be sexually active?

Erectile function (select any relevant symptoms)

- ☐ Trouble getting an erection during sex?
- ☐ Erections not hard enough for penetration?
- ☐ Trouble maintaining erection during sex
- ☐ Lack of sexual satisfaction from sex

Low Testosterone (select any relevant symptoms):

- ☐ low sex drive
- ☐ lost height
- ☐ low energy
- ☐ decreased strength
- ☐ sleep disturbance
- ☐ less strong erections
- ☐ sad or grumpy
- ☐ decreased endurance
- ☐ hot flashes or night sweats

Other: _____

Please list any specific concerns and questions you want to discuss with provider:

Please select any relevant conditions below:

- ☐ BPH (prostate enlargement)
- ☐ Painful urination
- ☐ cloudy, bloody urine
- ☐ urinating too often
- ☐ trouble passing urine
- ☐ loss of urine (incontinence)
- ☐ taking medicine for prostate
- ☐ sleep apnea
- ☐ had a sleep study: (normal / abnormal)
- ☐ elevated PSA
- ☐ Hair loss
- ☐ Vasectomy
- ☐ History of anemia
- ☐ taking medication for male pattern balding
- ☐ erectile dysfunction
- ☐ testicular or prostate cancer
- ☐ kidney disease or decreased function
- ☐ frequent blood donations
- ☐ non-cancerous testicular lesions
- ☐ severe snoring
- ☐ I wish to have children in the future

Current hormone replacement? ☐ No ☐ Yes: if so, list (all modalities, TRT, HRT, natural hormones):

Past Hormone Therapy? ☐ No ☐ Yes:

Last Pellet therapy? ☐ No ☐ Yes: Date/Dose of last pellets?

GENERAL MOOD AND FEELINGS

Check the answer that best describes your feeling:

I have little interest or take little pleasure in doing things.

☐ Always ☐ Freqently ☐ Occassionally ☐ Rarely ☐ Never

I feel down, depressed, and hopeless.

☐ Always ☐ Freqently ☐ Occassionally ☐ Rarely ☐ Never

I have trouble falling or staying asleep.

☐ Always ☐ Freqently ☐ Occassionally ☐ Rarely ☐ Never

Family medical history:

☐ Heart Disease ☐ Osteoporosis ☐ Breast Cancer

☐ Diabetes ☐ Alzheimer's/dementia ☐ Other:

Activity Level:

☐ low ☐ moderate ☐ average ☐ high

Marital Status:

☐ Married ☐ Divorced ☐ Widow ☐ Single ☐ Living with Partner

Sexual Health:

☐ I'm sexually active ☐ My sex life has suffered. ☐ I want to be sexually active.

☐ I have difficulty achieving organism ☐ I do not want to be sexually active.

Have any of your close relatives been overweight or had obesity (check all that apply):

☐ Mother ☐ Father ☐ Siblings

Does your family support your efforts to have a healthier lifestyle? ☐ No ☐ Yes

Do you exercise regulary? ☐ No ☐ Yes What kid of exercise? _____

How many times per week? ☐ How many minutes per session? ☐

Do you work outside your home? ☐ No ☐ Yes: If yes what type of work? _____

Please provide a list of all medications or supplements you take:

MEDICATION OR SUPPLEMENTS	DOSE	FREQUENCY	COMMENTS

By signing below, I acknowledge that I have provided complete and accurate information and understand that it will be used to assess my suitability for any treatment. I understand that it is my responsibility to inform the practitioner of any changes to my medical history or skincare routine. I agree to waive all liabilities of the practitioner or employer for any injury or damages incurred due to misrepresentation of my health history.

Client Name (printed)	Client Name (signed)	Date
Witness Name (printed)	Witness Name (signed)	Date

TWIN PORTS
WELLNESS +
AESTHETICS

CONSENT FORM

Medical Weight loss Therapy (Semaglutide/Tirzepatide)

I consent to taking a GLP-1 RA (Semaglutide) or a GIP/GLP-1 RA(Tirzepatide) injection as prescribed by my healthcare provider. Semaglutide is a GLP-1 receptor agonist for diabetes management, with off-label usage for chronic weight management. Tirzepatide is a glucose-dependent insulinotropic polypeptide (GIP) receptor and GLP-1 receptor agonist for diabetes management, with off-label usage for chronic weight management. I have been informed of the correct administering method and dosage. I will not take this medication if I have a history of the following: (please initial each box in acknowledgement).

- ☐ You are pregnant or planning to conceive while using this medication.
- ☐ You have a personal or family history of Medullary Thyroid Carcinoma (Thyroid Cancer) or Multiple Endocrine Neoplasia Syndrome Type 2 (MEN2).
- ☐ You have a history of pancreatitis, kidney failure/disease, liver failure/disease, digestive issues, or gastroparesis.
- ☐ You are allergic to Semaglutie/Tirzepatide or any GIP/GLP-1 R agonist medications (e.g., Adlyxin®, Byetta®, Bydureon®, Ozempic®, Rybelsus®, Trulicity®, Victoza®, Wegovy®), or you have other undisclosed allergies.
- ☐ You are diabetic, have retinopathy, or take medication to lower blood sugar without consulting your endocrinologist or Primary Care Provider.

Common side effects: nausea, diarrhea, decreased appetite, vomiting, constipation, abdominal pain, and indigestion.
Severe side effects: Contact your medical professional immediately if you experience the following:

- Severe stomach pain or changes.
- Eye and vision changes, including blurry vision.
- Symptoms of hypoglycemia (dizziness, headache, increased hunger, raised heart rate, sweating, anxiety, irritability, and confusion).
- Kidney problems, including decreased urination, swelling in the ankles or feet, shortness of breath, and increased tiredness.
- Gallbladder pain or changes, including symptoms of chalky stool, upper abdominal pain, nausea and vomiting, bloating, and heartburn.
- Signs of a thyroid tumor, with a lump or swelling in the neck, trouble swallowing, voice hoarseness, or shortness of breath. Contact your doctor immediately.

Stop the medication and seek immediate medical attention if you experience the following:

- Pancreatitis, with severe upper abdominal pain that radiates to the back, which may be accompanied by vomiting.
- Serious allergic reaction, with rash, itching, swelling of the face, tongue, or throat and trouble breathing.

TWIN PORTS WELLNESS + AESTHETICS

CONSENT FORM

Medical Weight loss Therapy (Semaglutide/Tirzepatide)

Possible drug interactions: anti-diabetic agents (i.e., Insulin and Sulfonylureas) can lead to an increased risk of hypoglycemia (low blood sugar). Gatifloxacin also increases the risk of hypoglycemia. Inform your provider of any medications that may lower blood sugar. Do not combine with other GLP-1-RA or GIP/GLP-1 RA medicines (i.e., Adlyxin®, Byetta®, Bydureon®, Ozempic®, Rybelsus®, Trulicity®, Victoza®, Wegovy®, Semaglutide, Tirzepatide). Bexarotene increases the risk of pancreatitis and should not be taken alongside Semaglutide or Tirzepatide.

Black Box Warning:
Semaglutide/Tirzepatide may cause thyroid tumors, as well as the following serious side effects: pancreatitis, hypoglycemia (low blood sugar), kidney problems, severe stomach pain and problems, changes in vision, gallbladder pain and issues, as well as allergic reactions.
If you take birth control pills, they may not work as effectively while taking Semaglutide/Tirzepatide. Discuss this with your healthcare provider to discuss the most appropriate options.

I acknowledge that Semaglutide/Tirzepatide is one part of a comprehensive lifestyle approach that includes a healthy diet and exercise, and regular follow-up visits to adjust dosages are necessary.

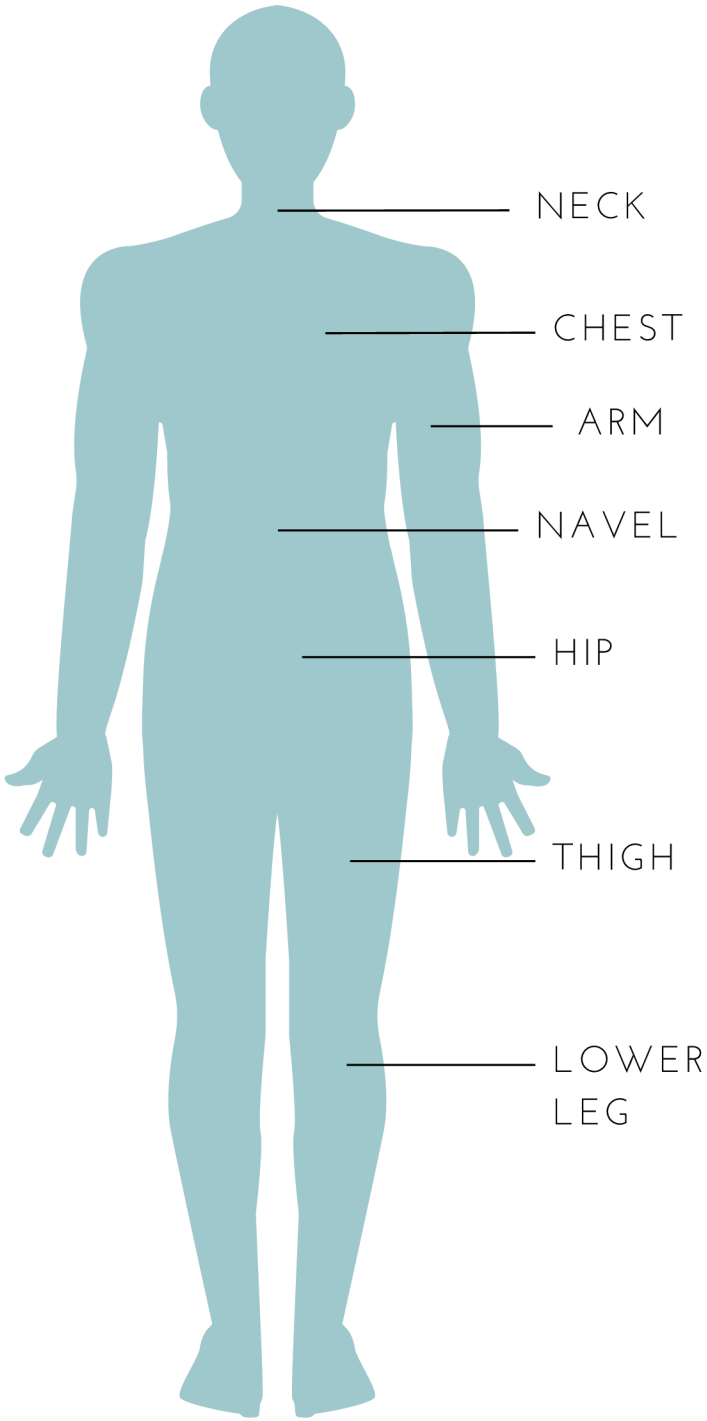
By signing below, I confirm that I have been fully informed of the potential risks, benefits, and complications and voluntarily agree to take this medication. I have had the opportunity to ask questions, and all my concerns have been taken care of to my satisfaction. I release Twin Ports Wellness and Aesthetics and the medical providers employed from any liability or claims arising from the treatment.

Client Name (printed)	Client Name (signed)	Date
Witness Name (printed)	Witness Name (signed)	Date

TWIN PORTS
WELLNESS +
AESTHETICS

CLIENT RECORD

Measurements



	BEFORE	AFTER
	Date:	Date:
NECK		
CHEST		
ARM		
NAVEL		
HIP		
THIGH		
LOWER LEG		

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