MEDIWORKS
REJUVENATION CENTRE

Please complete this form and bring it to your initial visit with Dr. Badesha

WEIGHT LOSS EVALUATION

Date:_____

Name (first and last):_____Birth date (D/M/Y):_____/_____/_____ Age:_____ Gender:_____

Weight (lbs):_____

How many pounds do you want to loose (lbs)?_____

What is your goal weight (lbs)?_____ Height (ft/in):_____

Do you have friends and family willing to support you positively during your weight loss journey? Yes____ No____

Do you have a family history of being overweight? Yes____ No____ If yes,
who?_____

Do you have a family history of diabetes, hypothyroid, heart disease? Yes___ No___ If yes,
who?_____

Women Only: Are you currently pregnant? _____

Address:_____

Telephone: Home: (____)_____
Cell: (____)_____
Work: (____)_____
Email: _____

Emergency contact: Name:_____ Telephone:(____)_____

Referred by (Check One):
Internet____
Friends and Family Members____If yes, please let us know by who_____
Yellow Pages____
Drive by____
Other_____

List all current health problems for which you are being treated:

_____

Please list all prescription/over the counter medications and supplements that you are currently taking or have taken in the past. Please include dosage and duration of use:

_____
_____
_____

PAST MEDICAL HISTORY

Major Illnesses past and present (eg. ulcer, diabetes, high blood pressure):

_____
_____
_____

Hospitalizations/Surgeries (year and reason):

_____
_____

Allergies and Sensitivities: Foods, environmental, etc.—Ever tested? Copies of Reports?

_____

Date of last blood test?_____ What was tested?_____

Have you ever had any abnormal blood work? Yes___ No___ If yes, please explain_____

Women Hormonal Health History:

Do you gain fat especially around the abdomen, hips, and thighs? Yes___ No___

Do you experience water retention and bloating? Yes___ No___

Do you experience PMS (premenstrual syndrome)? Yes___ No___ If yes, how severe? _____

Do you experience breast tenderness, painful breast or have fibrocystic breast disease? Yes___ No___

Have you had a history of gestational diabetes during pregnancy? Yes___ No___

Do you have Polycystic Ovary Syndrome? Yes___ No___

Men Hormonal Health History:

Do you have diminished sex drive? Yes___ No___

Are you experiencing sexual difficulties? Yes___ No___

Do you have decreased muscle tone (eg. sagging upper arms, cheeks or legs)? Yes___ No___

Are you experiencing muscle weakness? Yes ___ No___

Are you experiencing fatigue and/or poor exercise recovery? Yes___ No___

Do you experience irritability? Yes____ No____ Depression? Yes___ No___

Thyroid Health History:

Do you experience any of the following:

Constipation? Yes___ No___ Fatigue? Yes___ No___ Hair Loss? Yes___ No___

Nail Problems (dry, brittle)? Yes___ No___

Skin Changes (dry, itchy, patchy)? Yes___ No___ Thinning eyebrows? Yes___ No___ Weight Gain? Yes___ No___

Throat Problems (swallowing difficulty)? Yes___ No___

Low Body Temperature (feeling chilly at normal room temp.)? Yes___ No__

DIET AND WEIGHT HISTORY

How many and what kind of diets have you been on in the last 5 years (Dr. Bernsteins, Herbal Magic, cleanses etc) ?_____
_____
_____

Why do you think success is possible this time?_____

What was your highest adult weight and when?_____

What was your lowest adult weight and when?_____

What is your usual body weight range?_____

Reason/s for your weight gain_____

NUTRITION HISTORY

How many times a day do you eat? 1 2 3 4 5 6 7 8

How many days a week do you eat sweets (cookies, cakes, chocolate etc)?_____

How many litres of water do you drink daily?_____

Do you crave sugary or starchy foods? Yes___ No___

Do you eat protein at each meal? Yes ___ No___

Are you vegetarian? Yes___ No___Vegan? Yes___ No___

Do you have any dietary restrictions? (if yes, please explain) Yes___ No_____

DIGESTIVE HEALTH HISTORY

Do you constantly feel bloated and full? Yes___ No___

Do you have less than one bowel movement a day? Yes___ No___

Is your bowel movement strained? Yes___ No___

Does your waist circumference increase more than 1 to 2 inches from morning to evening? Yes___ No___

Do you continually have acid reflux, belching or bad gas? Yes___ No___

Do you have bloating, distension or pain after eating a meal? Yes___ No___

LFESTYLE HISTORY

What is the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest)_____

Do you have chronic pain or inflammation? Yes___ No___

Do you: Sleep well: Yes___No____

D you wake rested: Yes___ No_____

Average hours of sleep per night?_____

Do you exercise? Yes__ No___

On average how many days per week do you exercise? _____

Is there anything that prevents you from being physically active?_____

INFORMED CONSENT FOR HCG WEIGHT LOSS PROGRAMS

Purpose
This informed consent form is intended to give fair notice of the requirements of patients seeking to participate in the hCG Weight Loss Program at Mediworks Health and Weight Loss Centre to fully disclose any risks associated with participation in the program and to obtain written "Informed Consent" from the patient to undergo treatment at Mediworks Health and Weight Loss Centre

Risks and Discomforts
Below is a list of risks and discomforts that may be experienced by a small part of the population, in particular, those patients that are already predisposed to allergies; The patient shall inform the primary health care provider immediately if an allergic reaction occur. It is required that you stop using HCG and report your allergic response to your physician immediately. The following are signs of an allergic reaction:

- Hives
- difficulty breathing
- swelling of your face, lips, tongue, or throat

Before receiving HCG tell your doctor if you are allergic to any drugs or if you have:

- an ovarian cyst;
- cancer or a tumor of the breast, ovary, uterus, prostate, hypothalamus, or pituitary gland;
- undiagnosed uterine bleeding;

- heart disease, liver disease, kidney disease, epilepsy
- a history of, or are prone to developing blood clots

Less serious side effects may occur from the change in dietary patterns, until the blood sugar levels stabilize over a period of time with high protein intake. These less serious side effects include:

- headache (diet related)
- feeling restless or irritable;
- mild swelling or water weight gain;
- breast tenderness or swelling; or
- pain, swelling, or irritation where the injection is given.

It is not known whether HCG passes into breast milk. Do not use HCG without telling your doctor if you are breast-feeding a baby. Other drugs may affect HCG. There may be other drugs that can interact with HCG. Tell your doctor about all the prescription and overthe-counter medications you use. This includes vitamins, minerals, herbal products, and drugs prescribed by other doctors. Do not start using a new medication without telling your doctor.

To experience success on the clinic's HCG diet program, it is mandatory that you follow the diet protocol explicitly.

I, the undersigned patient of the Mediworks Health and Weight Loss Centre, agree to undergo weight loss treatment that includes the use of injectable hCG (Human Chorionic Gonadotrophin) along with diet and other therapies. I have disclosed my full medical history and know of no reason that would medically prohibit my participation in this protocol. I am aware of the significant and common risks, benefits, side effects, and adverse reactions to hCG, and I have had a full opportunity to ask questions. I understand that hCG has not been approved by the FDA, the United States Food and Drug Administration for adjunctive therapy in the treatment of the obesity. Nevertheless, considering all the above, I hereby give my informed consent to this treatment.

Patient Signature: _____ Date: _____

Print Name: _____

Mediworks Clinician: _____ Date: _____

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS INTAKE FORM! I LOOK FORWARD TO WORKING WITH YOU.