URGENT CARE
of Berwick, Sandfly, & Wilmington Island

LIFESTYLE QUESTIONNAIRE

Patient Information

Full Name: _____

Date of Birth: _____ Age: _____

Phone Number: _____

Email Address: _____

Primary Care Provider (Name & Phone): _____

Medical History

Please check **YES** or **NO** for each condition:

- Type 2 Diabetes ☐ Yes ☐ No
- Prediabetes ☐ Yes ☐ No
- High Blood Pressure ☐ Yes ☐ No
- High Cholesterol ☐ Yes ☐ No
- Heart Disease ☐ Yes ☐ No
- Thyroid Disease ☐ Yes ☐ No
- Pancreatitis ☐ Yes ☐ No
- Gallbladder Disease ☐ Yes ☐ No
- Kidney Disease ☐ Yes ☐ No
- Liver Disease ☐ Yes ☐ No
- Gastroparesis or chronic GI issues ☐ Yes ☐ No
- Eating Disorder (current or past) ☐ Yes ☐ No
- Depression or Anxiety ☐ Yes ☐ No

If YES to any above, please explain:

_____

_____

_____

Family History

- Medullary Thyroid Cancer ☐ Yes ☐ No
- MEN2 (Multiple Endocrine Neoplasia Type 2) ☐ Yes ☐ No

Surgical History

Have you had any surgeries? ☐ Yes ☐ No

If yes, please list:

_____

_____

Current Medications

Please list all prescription medications, over-the-counter medications, and supplements:

_____

_____

_____

Allergies

☐ No known drug allergies
☐ Allergic to (list): _____

Reaction: _____

Weight & Health Information

Current Weight: _____ Height: _____

Highest Adult Weight: _____

Goal Weight (optional): _____

Have you previously tried weight loss medications? ☐ Yes ☐ No
If yes, which ones and outcome:

Lifestyle Information

How would you describe your diet? ☐ Balanced ☐ High protein ☐ High carb ☐ High fat ☐ Unsure

How often do you exercise? ☐ None ☐ 1–2 days/week ☐ 3–4 days/week ☐ 5+ days/week

Alcohol use: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Tobacco or nicotine use: ☐ No ☐ Yes (type): _____

Pregnancy & Hormonal Status (if applicable)

Are you currently pregnant? ☐ Yes ☐ No
Are you breastfeeding? ☐ Yes ☐ No
Are you planning pregnancy in the next 6 months? ☐ Yes ☐ No

Review of Symptoms (Check all that apply)

☐ Nausea
☐ Vomiting
☐ Abdominal pain
☐ Heartburn/Reflux
☐ Constipation
☐ Diarrhea
☐ Fatigue
☐ Dizziness
☐ None of the above

Patient Acknowledgment & Consent

I understand that GLP-1 medications:

- May cause side effects including nausea, vomiting, and GI discomfort
- Require lifestyle changes for best results
- Are part of a long-term treatment plan
- Will not be filed to insurance

I confirm that the information provided above is accurate to the best of my knowledge.

Patient Signature: _____ Date: _____